Middle-classes and universal health care in Latin American welfare regimes: Chile, Ecuador and Uruguay

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Declaration of any previous submission of the work

The material presented here for examination for the award of a higher degree by research has not been incorporated into a submission for another degree.

Declaration of authorship

I am the author of this thesis, and the work described therein was carried out by myself personally.

Pamela Bernales Baksai

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Abstract

Universal health care - understood as sufficient and equitable coverage, generosity (in the extent and quality of services) and financial protection for obtaining health services - has remained elusive in Latin America. Instead, segmentation has endured, despite recent unprecedented fiscal effort and coverage expansion to counter it. Moreover, dissatisfaction with poor quality services has escalated from more disadvantaged groups to the middle-classes, who perceive themselves as abandoned by social protection, thus having progressively turned towards private options.

Latin American scholarship has broadly recognised the importance of middle-classes in pushing quality welfare provision and higher degrees of universalism. Furthermore, most recent contributions have benefited from the analytical framework of 'policy architectures` to explain the institutional drivers of universalism. Nevertheless, there is a clear lack of research considering the policy designs and middle-classes perceptions and practices in tandem, especially in the domain of health care.

This thesis presents a cross-national study that examines how the policy architecture of health care conditions middle-classes´ practices for meeting their health needs and how these practices contribute to the reproduction of segmented health care or advance universalism in three Latin American countries (i.e. Chile, Ecuador and Uruguay). The research involves drawing upon the critical realist ontological approach to understanding social processes, with a comparative case analysis design being adopted. Each case study examines the historical development of the health care policy; the current welfare regime, policy architecture and policy outputs as well as the middle-classes´ perceptions of and practices regarding health care. The empirical analysis draws on government reports; memories and public accounts elaborated by governments and international organisations; interviews with policy-makers and scholars; and 54 semi-structured interviews with members of the middle-classes conducted between October 2017 and July 2018.

It is concluded that the three countries studied have made progress towards universalism, especially regarding coverage. However, segmentation persists in Chile, generating equity gaps in generosity and financial protection. Segmentation also persists in Ecuador, especially with regard to the sufficiency and equity of generosity and financial protection. Meanwhile, Uruguay shows more significant advances, despite still having pending challenges. I argue that there are three key generative mechanisms that drive the relationship between the policy architectures, the middle-classes´ practices, and the policy outputs of health care in the three studied countries. First, the scope and mode of the market presence in health care provision; second, the presence/absence of a non-commodified alternative capable of providing sufficiently generous health services for the middle-classes; and finally, the effects of policy legacies on both the possibilities of policy reforms and day-to-day practices for health care.

Acronyms and abbreviations

AFAPs: Administratodas de Fndos de Ahorro Previsional / Administrators of Pension Savings Funds
AFPs: Aseguradoras de Fondos de Pensiones / Pension Fund Insurers
ASSE: Administración de los Servicios de Salud del Estado / State Administrator of Health Services
AUS: Aseguramiento Universal de Salud / Universal Health Insurance
BA: Basic Universalism
BDH: Bono de Desarrollo Humano / Human Development Voucher
BPS: Banco de Previsión Social. Recauda las cotizaciones sociales obligatorias para cobertura de salud y administra el Fondo Nacional de Salud (FONASA) / Social Welfare Bank
CAEC: Cobertura Adicional para Enfermedades Catastróficas / Additional Coverage for Catastrophic Illnesses
CCTs: Conditional cash transfer programmes
CIDE: Centro de Investigación y Docencia Económica
CHE: Current health expenditure
CSO: Caja del Seguro Obrero Obligatorio /Mandatory Insurance Fund for blue-collar workers
DISSE: Dirección de Seguros Sociales por Enfermedad / National Board of Social Insurance.
ECH: Encuesta Continua de Hogares / Continuos Household Survey
ECLAC: Economic Commission for Latin America and the Caribbean
EU: Efficient Universalism
FA: Frente Amplio
FLACSO : Facultad Latinoamericana de Ciencias Sociales
FNR: Fondo Nacional de Recursos / National Resources Fund
FONASA-Uruguay: Fondo Nacional de Salud / National Health Care Fund
GNI: Gross National Income
HDI: Human Development Index
IAMCs: Instituciones de Asistencia Médica Colectiva / Institutions of Collective Medical Assistance
IDB: Inter American Development Bank
IESS: Instituto Ecuatoriano de Seguridad Social / Ecuadorian Institute for Social Security
IFIs: International Financial Institutions
IHDI: Inequality-adjusted Human Development Index
ILO: International Labour Organization
IMAE: Institutos de Medicina Altamente Especializada / Institutes of Highly Specialised Medicine
IMF: International Monetary Fund
ISI: Importación por Substitución de Importaciones / Import Substitution Industrialisation
ISSFA: Instituto de Seguridad Social de las Fuerzas Armadas / Armed Forces Social Security Institute
ISSPOL: Instituto de Seguridad Social de la Policía Nacional / Social Security Institute of the National Police
JUNASA: Junta Nacional de Salud / National Board of Health
LRS: Ley Ricarte Soto / Law Ricarte Soto
MAI: Modalidad de Atención Institucional / Institutional Care Modality
MEF: Ministerio de Economía y Finanzas / Ministry of Financial Affairs
MLE: Modalidad Libre Elección / Free Choice Modality

MoH: Ministry of Health
MSP: Ministerio de Salud Pública / Ministry of Public Health
NHI: National Health Insurance
NHS: National Health Service
OOP: Out-of-pocket spending
PANES: Plan de Asistencia Nacional a la Emergencia Social / National Social Emergency Response Plan
PCT: Power Constellation Theory
PHI: Private Health Insurance
PIAS: Plan Integral de Asistencia a la Salud / Comprehensive Benefit Plan
PPS: Programa de Protección Social en Salud / Programme of Social Protection of Health
PRAIS: Programa de Reparación en Atención Integral en Salud / Programme for Victims of Human Rights Violations
PRT: Power Resources Theory
RPIS: Red Pública Integral de Salud / Compehensive Public Network of Health
SDGs: Sustainable Development Goals
SENPLADES: Secretaría Nacional de Planificación y Desarrollo / Secretariat for Planning and Development
SERMENA: Servicio Médico Nacional de Empleados / National Medical Service of white collar workers
SHI: Social Health Insurance
SNS: Servicio Nacional de Salud / National Health Service
SNS: Seguro Nacional de Salud / National Health Insurance
NSS: Sistema Nacional de Servicios de Salud / National System of Health Services
SNIS: Sistema Nacional Integral de Salud / Integrated National Health System
SPF: Social Protection Floor
SRM: Social Risk Management
SSC: Seguro Social Campesino / Rural Social Insurance
SSS: Servicio de Seguro Social / Social Insurance Service
TMSA: Transformational Model of Social Action
UHC: Universal Health Coverage
UMPS: Unidades Médicas Prestadoras de Salud / Medical Units for provision of health services
UN: United Nations
WB: World Bank
WHO: World Health Organization

CHAPTER I INTRODUCTORY CHAPTER

1.1.- Introduction

Nowadays, there is broad concern about the need for advancing universalism in the key areas of social welfare, such as pensions, health care, unemployment insurance, education and childcare. Examples of this can be found in the International Labour Organization (ILO)´s Social Protection Floor (SPF), the United Nations' (UN) call for Universal Health Coverage (UHC), and the Post-2015 Sustainable Development Goals (SDGs), among others. It is by offering universal social protection that societies can eradicate poverty, advance inclusive growth and promote sustainable development with equitable social outcomes (WB/ILO, 2016).

Universalism takes on particular significance in the health care realm. Health care policy needs to address the entire population over the whole life course, in such a way that its outputs affect all members of society like no other policy. Accordingly, in 2012, the UN General Assembly issued a Resolution to advance UHC, which meant that the advancement of universalism would reach wider international support than ever before. It further expanded this perspective in 2015, with the inclusion of UHC as one of the targets of the Post-2015 SDGs and, recently, was reaffirmed by the 2019 UN Political Declaration of the High-level Meeting on UHC.

In Latin America, pro-universal policy initiatives in all areas were enhanced by the strengthening of democracy and the progressive regional turn experienced in the early 2000s (Huber and Stephens, 2012; Garay, 2016). Countries made unprecedented fiscal efforts[5] to extend social protection[6]. In this context, universalist health care reforms notoriously thrived, especially after the 2012 UN Resolution and the Post-2015 SDGs (Cotlear, Nagpal, et al., 2015), adopting a variety of paths (Atun et al., 2015; Heredia et al., 2015). Nevertheless, health systems research demonstrates a lack of consensus between countries regarding the route to advancing universal health care and that, despite reforms, most health systems continue to be fragmented, delivering uneven levels of quality and frequently leading to financial hardship at the point of service (Cotlear, Gómez-Dantés, et al., 2015; Cotlear, Nagpal, et al., 2015).

From a social policy perspective, according to Mesa-Lago (2008), the health care reforms of the early 2000s achieved limited advances in terms of tackling the fragmentation of health systems and continued to deliver uneven standards of health care across groups of the population. Moreover, levels of out-of-pocket (OOP) spending remained high, thus exposing the population to financial risk. More recently, Sojo (2017) stated that despite countries like Costa Rica and Uruguay standing out as those with the most equitable health systems, insufficient and uneven access to health care continues to be a commonality in all Latin American countries. Along the same lines, Martínez Franzoni and Sánchez-Ancochea (2018) ranked Latin American countries in 2000 and 2013 in a continuum of universalism and segmentation, which considered the levels of coverage, generosity and equity of health care. The authors concluded that segmentation

[5] According to the ECLAC, between 2000 and 2018 social public spending in Latin America (17 countries) grew from 8.5% to 11.3% (share of GDP) and increased from 46.5% to 52.5% regarding total public spending (ECLAC, 2019).

[6] From the early 2000s, countries in the region substantially expanded coverage of primary and secondary education, health care, and cash benefits (ECLAC, 2020).

endured as a core feature, even after the expansionary phase. Within this ranking, Chile and Uruguay remained as leading countries over the period analysed, with Costa Rica also experiencing a positive performance. Several countries that presented a poor performance in 2000 (e.g. Paraguay, Nicaragua, Honduras, Guatemala and Bolivia) remained at the bottom of the ranking in 2013, whereas four countries (Colombia, Mexico, Peru and to a lesser extent, Ecuador) improved significantly.

These findings unveil that, despite the progressive regional shift in the early 21st century, universalism in health care has remained an elusive goal. This has been dramatically corroborated by mass citizen demonstrations in Brazil 2013-2014 and 2017, Bolivia 2019, Chile 2011, 2019-2020, Colombia 2019, Ecuador 2019 and many other countries, demanding more egalitarian societies, better governance as well as more state commitment to providing quality education, pensions and health care (Brodie, 2015; Daude et al., 2017; Araujo, 2020). Dissatisfaction has also extended from the more disadvantaged groups to the middle-classes, who perceive themselves as left behind by social protection and have responded to the low quality of public services by increasingly turning to private options (Ferreira et al., 2013; WB, 2017; UNDP, 2019).

The points discussed above raise three key reasons that make it important to study universalism in health care in Latin American countries. First, recent evidence indicates that despite the efforts that countries have made towards universalism, advances remain limited. Second, the diversity of paths adopted to address universal health care demonstrate that there is a lack of consensus about what universal health care actually means and how to pursue this aim. Last but not least, citizens have been strenuously calling for states to commit themselves to quality health care for all.

In addition, it is important to bear in mind that universal health care outputs are globally recognised not only as desirable, but also as an ethical imperative, as witnessed by the appeal that most international agencies and governments have made for advancing towards UHC (UN, 2012, 2019). Furthermore, the COVID-19 pandemic has made even more evident the shortcomings of health systems throughout the Latin American region and demonstrated that universal access to quality health care is essential for social welfare in the broadest sense (CEPAL-OPS, 2021). Moreover, this policy realm has been treated as a separate domain from the broader social welfare literature, with the gaps in knowledge remaining significant. However, the number of studies drawing attention to this policy area has been steadily increasing and the dialogue between social welfare and health systems research is becoming stronger (e.g. Bambra, 2005a, b; Wendt, Frisina and Rothgang, 2009; Béland et al., 2014; Martínez Franzoni and Sánchez-Ancochea, 2016b, 2018; Wendt, 2019).

The rest of the chapter is organised as follows. In the next section (1.2), I present the approach of the thesis. It begins by briefly discussing some of the mechanisms that the welfare literature has pointed out for explaining the (non)emergence of universalism, with a particular emphasis on Latin America. Subsequently, I explain the approach adopted for this research and present the central questions that guide the study, as well as an overview of the main findings and conclusions attained. I conclude the section by identifying the main gaps in knowledge related

to this subject matter, which the thesis seeks to contribute to filling. Lastly, the chapter ends (section 1.3) with a presentation of the contents included in the rest of the thesis.

1.2.- Approach of the thesis

1.2.1) Initial outlook on universalism and its drivers

In this section, I provide an introduction to the definition of universalism that I have adopted for this study, and to the approaches through which the analytical framework of the study was built, both of which are discussed in more detail in the literature review presented in the subsequent chapter.

This study develops and applies a new multidimensional definition of universalism in health care that builds upon Martínez Franzoni and Sánchez-Ancochea´s (2016) conceptualisation of policy outputs and the World Health Organization (WHO) framework of UHC. Specifically, universal health care is envisaged as the policy outputs of sufficiency and equity in coverage, generosity (i.e. the extent and quality of services) and protection against financial hardship when obtaining health services. In contrast, when population coverage, generosity of services or protection against financial hardship are insufficient or uneven across groups of the population, because of their position in society or previous background (e.g. have been a taxpayer), these policy outputs are defined as segmented health care. I will further elaborate upon the nuances of this conceptualisation and the universalism/segmentation polarity in Chapter II.

As for the mechanisms that drive universalism, or lack of it, in Latin America, the most extensively accepted explanations focus on the impact of past policies, the legacies of which have imposed barriers to reaching solidarity and the redistributive potential of the current attempts to advance universalism (see Ewig, 2010; Ewig and Kay, 2011; Pribble, 2013; Pribble and Huber, 2013). For instance, Barrientos (2004) and Filgueira, F. (2007, 2013, 2015) have shown the adverse impact of the strong commodification of welfare provision in the 1980s and 90s. They point out that the processes of commodification reinforced the production of two-tiered systems, with significant participation of the private actors, who supply benefits and services unevenly through the population, thus undermining the advances of universal social welfare.

In addition, and this is an essential consideration for this thesis, Filgueira, F. (2013) and Ferreira et al. (2013), highlight that the formation of two-tiered systems has created perverse cycles leading to the worsening of the quality of public services and consolidating the segmented access to social welfare in the region. In what he terms the *Trap of public goods*, Filgueira, F. (2013) explains that the enduring poor quality of public services has spurred the middle-classes towards taking up private options. The removal of such demanding and influential users from public services has resulted in a feedback loop that reinforces their lack of quality.

Indeed, the Latin American discussion on the determinants of social policy outputs broadly recognises the importance of middle-classes as agents with the power resources to increase the quality of welfare provision, thus resulting in higher degrees of universalism. This is particularly essential in the absence of a strong labour movement owing to a class-structure historically consisting of a large class of poor rural workers and an urban working class with a large informal sector, which weakened the ability of political mobilisation of lower-class groups. Moreover, there is consensus regarding the ankylosing effect of the absence of cross-class alliances between the middle and lower classes to counterbalance the power of the elites and push for more redistributive social policies (see Huber and Stephens, 2012; Filgueira, F., 2013; Martínez Franzoni and Sánchez-Ancochea, 2016a; Sojo, 2017).

The acknowledgement of the role played by the middle-classes is not new or specific to this region, for it can be found in some seminal works on social welfare. Among them, Esping-Andersen (1990) recognises the middle-classes as crucial to supporting the expansion of social benefits, thereby enhancing the capacity of social policies to confront the inequalities raised in the labour market (i.e. the effect of re-stratification of social policies). Baldwin (1990) holds to the centrality of the middle-classes for the consolidation and endurance of solidaristic welfare states. Further, Korpi and Palme (1998) brought the middle-classes into the spotlight in the development of the ´Paradox of redistribution`, revealing their critical role in supporting universal policies that attain higher levels of redistribution. These policies are characterised by being capable of offering benefits and services of sufficient standard for upper-middle and middle-income groups to support them, thus making solidaristic models viable.

In addition to these two lines of argument, that is, those that stress the significance of policy legacies and those that highlight the role of the middle-classes, the most recent debate on universalism in Latin America has benefited from the analytical framework of policy architectures. Martínez Franzoni and Sánchez-Ancochea (2016b) define the policy architecture as the interplay of five policy instruments, namely eligibility criteria, funding, benefits, delivery, and regulation of outside market-based options, which together, ´[…] define who has access to what benefits, and how` (p. 4). The authors claim the policy architecture as the first driver of social policy outputs and state that there is no single model of architecture to reach universalism, but unification is crucial to favour it whilst fragmentation is a major obstacle to achieving universal outputs. Accordingly, a unified architecture ´[…] 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` (p. 19).

The policy architectures framework has been used to unpack the linkages between policy outputs and different configurations of policy instruments. In doing so, this framework has considered the current architecture as well as the foundational architecture and historical trajectory of the policies in countries of the global south (Martínez Franzoni and Sánchez-Ancochea, 2016b). It has been drawn upon by an increasing number of studies on social policies in Latin America (see Deneulin and Sánchez-Ancochea, 2018; Blofield, 2019; Bernales-Baksai, 2020; Cruz-Martínez, 2020; Bernales-Baksai and Velázquez Leyer, 2021).

1.2.2) Scope and main conclusions of the thesis

Building on the above review, I argue that the three approaches presented are not mutually exclusive and can contribute to each other to create a more profound understanding of the social and institutional processes behind policy outputs of health care, whether these be closer to universalism or segmentation. This requires integrating into the quest both the institutional conditions (i.e. the policy architecture and its historical trajectory) and the participation of the middle-classes within the institutional arrangements that lead the policy.

In addition, it would appear to be of paramount significance to engage in a contextually-embedded perspective to analyse the linkages between the policy outputs, policy architectures and the middle-classes. The welfare literature has extensively argued the significance of welfare regimes, namely the arrangements that define the role of the state, market and families in producing social welfare and facing social risks, to shape the countries´ social policy (Esping-Andersen, 1990) and feed back the power balance and resource distribution in society (Korpi and Palme, 1998). In Latin America, several typologies have grouped countries according to their welfare regimes taking into account the regional specificities (Filgueira, F., 1998; Mesa-Lago, 2000; Barrientos, 2004; Huber and Stephens, 2005; Martínez Franzoni, 2008; Cecchini, Robles and Filgueira, 2014), revealing that, despite sharing certain characteristics, the region is not homogeneous. Consequently, this research takes into consideration the type of welfare regime where health care policies are embedded as a relevant contextual variable. To this end, as I will explain in detail in the following two chapters, this research draws upon the typology of Latin American welfare regimes by Martínez Franzoni (2007). Accordingly, I have selected countries that belong to the different clusters identified at the regional level, namely state-productivist, state-protectionist and non-state familist, to develop the case studies.

On this basis, this thesis seeks **to explain both the conditionings of the policy architectures of health care on middle-classes[7] practices for meeting their health care needs; and also the mechanisms through which these policy architectures and practices contribute to the reproduction of segmented health care or promoting universalism in Latin American countries**.

In particular, this research presents a cross-national study with a **comparative case analysis design** aimed at analysing empirically the conditions for universalism from the perspective of how the policy designs integrate the middle-classes. The analysis covers three countries of Latin America with different types of welfare regimes, namely Chile (State productivist), Ecuador (Non-state familist) and Uruguay (State protectionist), thus encompassing the various arrangements for the production of social welfare where the analysed policies of health care are embedded.

[7] Throughout the document, I frequently use the term ´middle-classes` (i.e. in the plural), because of the heterogeneity, both within countries and between countries, of the population considered within this group. On some occasions, I keep the expression ´middle-class`, because I am quoting authors who use the term in the singular. For a more detailed discussion on this see Chapter III Section 3.4.

The purpose is not to evaluate or measure the degree of universalism in health care achieved by the countries. Moreover, the research focuses specifically on the consolidated middle-classes, namely not those groups that remain vulnerable to falling into poverty against any shock, in urban areas. Chapter III discusses extensively the heterogeneity of the middle-classes and the importance of limiting the reference group addressed. However, it is relevant here to point out that the decision to focus on this specific segment of the middle-classes relies on the intention of studying groups that, taking into account the fragmentation of health systems in Latin America, have the possibility of deploying different practices for health care. That is, they are not restricted to just one access route due to their previous background or limited availability of resources, which might be common among more vulnerable sectors of the so-called middle-classes.

To achieve the aims of the thesis, I develop an analytical framework (presented in Chapter III) that builds upon critical realism´s ontological, epistemological, and conceptual foundation, which allows for an integrated approach to the participation of both policy design and social agents within a given context. Succinctly, critical realism understands society and people as two distinct, but interrelated and ontologically dependent strata, with independent properties and powers (Collier, 1994; Archer, 2000; Bhaskar, 2015). Society is composed of *structures* and a latticework of relations between them (Bhaskar, 2008). Social structures entail *generative mechanisms*, which are described as trans-empirical but real existing entities that explain why observable events occur (Blom and Morén, 2011). In society, generative mechanisms exert causal powers that, along with other such powers, co-determine social processes (Bhaskar, 2008). According to Archer (2015), ´[These mechanisms provide] the real basis of causal laws [...] regardless of the presence or absence of statistical associations with outcomes at the level of events` (p.3). They explain how social phenomena work, supplying the real basis for causal laws. The role played by social structures has a counterpart in human agency (Bhaskar, 2011), which supposes the voluntary or involuntary articulation of the interests of social collectivities (Archer, 2000). Agency is intrinsic to human beings and involves real actions by people sharing the same life chances owing to their occupying a similar position in terms of society´s distribution of resources (Archer, 1995).

Consequently, from the critical realist´s perspective, the explanation of social phenomena demands consideration of the interplay between the powers propelled by both society and social agents. Society, with its structures, is the condition and the context for people's action and, in turn, is continuously produced by human agency. The interactions between the powers exerted by the latticework of social structures, on the one hand, and the conditioned actions of social agents, on the other, drive social processes that can either preserve or transform the form and organisation of social structures (i.e. morphostatic or morphogenetic processes) (Archer, 1995, 2010).

Grounded on this understanding of social processes, this thesis addresses the following research questions:

- ***How does the policy architecture of health care contribute to universal or segmented health care?***
- ***What kind of practices for health care of the middle-classes are conditioned by the policy architecture?***
- ***What are the generative mechanisms which connect policy architectures, middle-classes practices and outputs of health care policy in Chile, Ecuador, and Uruguay?***

Briefly, from the research, it is concluded that the three studied countries have made progress in universalism, especially regarding coverage. However, segmentation persists in Chile, fundamentally referring to equity gaps in generosity and financial protection; in Ecuador, regarding the sufficiency and equity of generosity and financial protection; whilst Uruguay shows significant advances in all the dimensions of universalism, despite still having pending challenges. In Chile and Ecuador, the segmented policy outputs are shored up by middle-classes´ practices that strongly rely on private market-based options, while in Uruguay, a virtuous circle seems to be operating between policy architecture, the middle-classes´ practices and the advance of universal policy outputs of health care.

The comparative analysis of the case studies unveils three generative mechanisms that connect the policy architectures, the middle-classes practices, and the outputs of health care policy. The first is that, whilst segmented health care can result from different configurations of policy architecture, the conspicuous, i.e. extended and insufficiently regulated, entry of the market is a sufficient condition for segmentation to be spurred. Moreover, it is asserted that segmentation can be promoted both directly by the policy architecture through the system's fragmentation and by the conditioning of practices that maintain or intensify it.

The second generative mechanism relates to the importance of having available a non-commodified alternative capable of providing sufficiently generous health services for the middle-classes, as necessary condition for advancing universal health care. Finally, the third generative mechanism identified is that policy trajectories have effects on the chances of advancing universal health care through both the conditioning of their legacies on subsequent policy designs and by conditioning the perceptions and day-to-day practices for health care, which, in turn, reinforces the effect of policy legacies on the policy design.

1.2.3) <u>Contribution of the thesis</u>

This research seeks to contribute to filling significant gaps in knowledge. Indeed, to the best of my knowledge, the health systems tradition of research has not undertaken comparative studies on the drivers that underpin the policy outputs and, more specifically, the cross-cutting historical segmentation of health care in Latin America. Most of the extant studies have been focused on analysing the outputs of coverage, quality of services, levels of financial protection or on the

examination of the arrangements that govern health systems as well as the reforms and programmes deployed to advance universalism (e.g. Atun et al., 2015; Cotlear, Gómez-Dantés, et al., 2015; Cotlear, Nagpal, et al., 2015; Heredia et al., 2015; Monteiro de Andrade et al., 2015). Nor has social policy scholarship sufficiently addressed the drivers of segmented health care in Latin America. In particular, the role of the middle-classes, looked at in tandem with other variables considered decisive for explaining universal policy outputs (or the lack of), such as the policy designs and their legacies, has received scant attention. This is despite the significance of the middle-classes in pushing forward quality welfare provision and higher degrees of universalism being broadly agreed upon.

From the health system research perspective, a review published by Cotlear, Nagpal, et al. (2015) identified 6,500 studies that have evaluated the impact of UHC programmes on access to services, financial protection, and health outcomes. It was found that the results were inconclusive regarding the impact of these programmes. Moreover, the review concluded that studies do not sufficiently account for the design of the programmes and do not explain why some make progress in UHC and others do not. To overcome these limitations, the authors analysed programmes for UHC in 24 developing countries, adopting a similar methodology for all of them. This investigation entailed the history and institutional architecture of the programmes and addressed the outputs on the basis of the three dimensions of the UHC framework, namely population coverage, service coverage and financial coverage. The analysis showed that countries use a diversity of policy designs and that most programmes continue to segment the population. Nevertheless, the explanatory capacity of the study is limited to linking the policy outputs with the characteristics of the programmes and remains without integrating the analysis or clarifying the impact on the outputs of the contextual characteristics of the countries or the role of social agents.

As for Latin America, Cotlear, Gómez-Dantés, et al. (2015) reviewed the phases of health systems development from their foundation and the latest health reforms conducted to advance UHC. The study described four phases and showed that segmentation of health care by social class and employment status arose with the foundation of health systems and persisted in the first three phases. In contrast, the fourth phase would have involved direct efforts to expand coverage and tackle segmentation. Despite each country having transitioned through these phases at its own pace, the authors identified some temporal convergence, such as the fact that most entered the fourth phase in the 2000s. Moreover, they point out the role of several factors in the transition from one phase to another, such as economic growth, epidemiological changes, democracy and political shifts, ideological factors, and especially, health-policy diffusion across countries. However, this study did not account for the mechanisms, the specific contribution, or the direction of change pushed by these factors. Moreover, as the authors themselves recognise, they did not address the role of the private sector, which is of paramount importance in grasping the dynamics of health care provision in the region.

From a social policy stance, Mesa-Lago (2008) presented a comprehensive and insightful study that analysed pensions and health reforms across all Latin American and several Caribbean countries. The author developed a taxonomy differentiating ten types of health systems, which relies on population coverage, the integration-coordination of the systems, and the separation

of functions. Moreover, the study assessed health reforms based on several social security principles: universal coverage, equal treatment, solidarity and income distribution, comprehensiveness and sufficiency of benefits, unity or integration of the system, the role of the state and social participation, financial sustainability and efficacy. Nevertheless, despite its enormous contribution, Mesa-Lago (2008), as with several others addressing cross-country comparisons (see for instance Pribble, 2011; Huber and Stephens, 2012; Ocampo and Gómez-Arteaga, 2016), focused on health care coverage and financing overall. Therefore, it does not allow us to know and explain the variability in the quality and comprehensiveness of the services accessed across segments of the population.

More recently, analysis conducted by Sojo (2017) contributed to overcoming this limitation with a detailed examination of health coverage over 2002-2013 according to variables of social stratification, such as sex, income, level of education, and employment conditions, unveiling the endurance of segmentation throughout the region. The study presents an exhaustive analysis of the OOP spending and examines the architectures of health care in Brazil, Chile and Colombia. The author points out that, despite its formal unification, the Brazilian health system creates segmentation; the dual public-private Chilean health system constrains equity and promotes the individualisation of risks; and the fragmentation in service delivery in Colombia impacts negatively on quality and equity. However, this study does not address the mechanisms that lead to the endurance of segmented health care, thus limiting the advance of universalism.

A study carried out by Martínez Franzoni and Sánchez-Ancochea (2016b) goes further and makes relevant linkages between universal policy outputs in health care and pensions and the features of the policy architectures in four southern countries, including two in Latin America (Costa Rica and Uruguay). The authors show that policy architectures, at present and in their historical development, largely explain the policy outputs achieved in a specific policy area. Subsequently, they explored cross-national variations in health care policy outputs in 2000 and 2013 to assess the impact of the social policy expansion started by Latin America in the early 2000s. Policy outputs were evaluated based on a three-dimensional model of universalism/segmentation that considered coverage, generosity, and equity (Martínez Franzoni and Sánchez-Ancochea, 2016b). For the two years studied, the analysis involved grouping the countries in clusters and ranking them on a continuum of universalism and segmentation, according to their performance in the three dimensions (Martínez Franzoni and Sánchez-Ancochea, 2018). Nonetheless, the latter study did not establish linkages between the policy outputs and the characteristics of the health policies. Indeed, the authors explicitly asserted that further research is needed to both improve the measurement of the policy outputs in health care and to identify the drivers of the countries´ performance in this regard.

Lastly, regarding the role of the middle-classes and their connection with universal/segmented policy outputs of health care in Latin American countries, a study by Vera-Rojas and Budowski (2017) compares the relationship between the production of social welfare, the main features of the health system and the experiences and practices of middle-income strata for dealing with health problems in Chile and Costa Rica. Nonetheless, the study does not investigate the health care policy design in depth and only addresses households that remain vulnerable, from an income perspective, excluding the consolidated middle-classes. Also, the research conducted by

Daude et al. (2017) analyses the practices and perceptions of health care among the middle-classes in Latin American countries, but does not address the linkages between these practices and perceptions, on the one hand, and the policy designs and policy outputs of health care, on the other.

As it can be seen in this brief overview, despite the fact that there are studies that address the different variables of interest, there is a notable lack of studies that look at them as a whole and are capable of identifying how they are linked to each other to explain the endurance of health care segmentation in the region.

Considering these gaps in knowledge, this thesis aims to make an analytical and empirical contribution by advancing and applying a framework to address the mechanisms that lead to universal/segmented health care from the integrated view of the main drivers indicated by the specialised literature in Latin American countries. In particular, this involves addressing, in tandem, the role played by the policy architectures, the middle-classes and welfare regimes in the production of universal/segmented health care in Chile, Ecuador and Uruguay.

1.3.- Structure of the rest of the thesis

This thesis is divided into three parts comprising eight chapters in total. Part I (Chapters I, II, and III) presents the background and research approach. After this introduction, Chapter II reviews the relevant literature on the main variables addressed by this work, starting with the concept of universalism and especially universal health care. Then, it examines the contributions of the welfare literature regarding the drivers of universalism, focusing on the theorisations about welfare regimes, policy trajectories, policy architectures and the middle-classes.

Subsequently, Chapter III starts with an examination of the principles of the critical realist approach. This is followed by a presentation of the analytical framework for addressing the generative mechanisms that drive universal/segmented health care in Chile, Ecuador and Uruguay, with a focus on the relationship between the policy architecture and the middle-classes´ practices for health care within the context of a given welfare regime. This chapter also contains discussion of the main elements of the theoretical and methodological debates about the middle-classes and ends by presenting the methodological design.

Part II is devoted to the empirical work and encompasses Chapters IV, V and VI preceded by a brief introduction that explains the aims and organisation of the country case studies. Each of these three chapters examines the type of welfare regime that predominates in the country, the trajectory of the health care policy, the contemporary policy architecture and outputs of health care as well as the perceptions and practices of the middle-classes regarding health care. The case studies are concluded by presenting an integrated analysis of the different domains addressed.

Part III provides comparative analysis and the conclusions of this research. Chapter VII focuses on the cross-country comparison of the analysed subjects. It discusses the welfare regimes, policy architectures, policy outputs as well as middle-classes´ perceptions and practices and their reciprocal interactions. Three generative mechanisms are identified that connect the policy architectures, the middle-classes practices, and the policy outputs of health care in the studied countries. Finally, Chapter VIII reviews the research questions, setting out the main findings and conclusions of the thesis. It also reflects on the relevance of the adopted research approach, explains the major contributions that this study brings to current knowledge, and future avenues for research are proposed.

CHAPTER II LITERATURE REVIEW: DELINEATING UNIVERSALISM AND ITS DRIVERS

2.1.- Introduction

In order to address the main research questions of this research, this chapter examines the relevant literature to frame universalism, in general and in health care, in particular. The chapter entails three main sections besides this introduction. Next, Section 2.2 focuses on the concept of universalism, seeking to identify approaches that are suitable to address this issue in the health care realm, particularly in Latin America. The section starts by reviewing the main debates from a social policy perspective regarding universalism and some related concepts, such as inequality reduction, redistribution and solidarity. Then, the most recent contributions made by the health systems literature are examined, discussing the concept of UHC. Building on these two traditions, I present a multidimensional definition of universal health care, which states that it involves sufficient and equitable population coverage, generosity (the extent and quality of services covered), and financial protection to obtain health services.

Section 2.3 reviews the main approaches and explanations regarding the drivers of universal policy outputs. It concentrates on four areas, namely the theorisations about welfare regimes both in the developed world and in Latin America, the significance of policy trajectories, the role played by policy architectures, and the role attributed to the middle-classes. I argue that the notion of welfare regime enables understanding the rationale behind the policy architectures and contextualise the policy outputs within the broader constellation of practices that determine the role assigned to the state, the market and families. And, therefore, the extent of decommodification and defamilisation of social welfare in a given society as well as the type of (re)stratification that the policies rise. The conceptualisation of welfare regimes also contributes to illuminating the feedback between institutional designs for providing social welfare and the predominating social structure and the power distribution in society. In this regard, policy designs aimed at universalism would result from a social balance of power that allows the state to decommodify and defamilialise access to social welfare and redistribute resources throughout society, thereby reducing inequalities.

In the case of Latin America, typologies of welfare regimes have contributed to explaining the commonalities and differences within the region. Researchers concur about the significance of families and other informal mechanisms for achieving welfare owing to the weakness of most welfare systems (Barrientos, 2004; Filgueira, F., 2011) and the failures of the labour market to provide high quality jobs (Martínez Franzoni, 2007).

This section also stresses the contributions made by the Power Constellation Theory (PCT), which brings together different domains in a comprehensive conceptual framework to analyse the trajectory and outputs of social policies in Latin America, paying particular attention to the regional specificities. This framework downplays the role of the labour movement and highlights the importance of other social sectors in the construction of welfare systems in Latin America. Moreover, the PCT, as well as the historical institutionalist scholarship, reveals the conditioning brought about by earlier policy arrangements on subsequent policy designs as a paramount variable for explaining the current features and outputs of social policies. Most of the extant studies claim that the original policy designs, strongly fragmented and stratified, have had a lasting negative impact on universalism throughout the region.

A third theoretical contribution discussed relates to the role played by policy architectures in the path towards universalism. Specifically, the framework proposed by Martínez Franzoni and Sánchez-Ancochea (2016b) is reviewed. This framework states that the degree of unification, or fragmentation, of the policy architecture is the most crucial variable to understanding the advances of universal policy outputs, or the lack thereof. According to the framework, unified policy designs would contribute to delivering generous services in an equitable fashion, thereby suppressing differences in the services accessed across social groups and advancing universalism.

Subsequently, I delve into the role that social welfare theorisations have assigned to the middle-classes for the achievement of universalism. Specifically, this subsection highlights the arguments regarding the significance of keeping the middle-classes within the same schemes as the rest of the population for enabling higher generosity and the redistributive impact of social policies. The middle-classes can foster the demand and social legitimacy of generous social welfare provision, which if it is delivered by an encompassing model, namely through a scheme that provides services to the whole or the majority of the population, enables the expansion of solidaristic models and social welfare for the entire society.

Finally, Section 2.4 presents the main conclusions of the chapter. I argue that the literature has clearly supported the significance of social welfare arrangements being expressed in the configurations of welfare regimes, the policy designs, and the role of social agents, the middle-classes in particular, for universalism. Nonetheless, the empirical research has not incorporated these three approaches with the same strength, and there is a lack of cross-country research that integrates these different domains. Against this background, I highlight the importance of further empirical research about the implications of the policy design for the middle-classes and the role they can play within the continuously unfolding social processes that give rise to universal or segmented policy outputs.

2.2.- Delineating the concept of universalism

2.2.1) Universalism from a social policy perspective

The most traditional and broadly diffused conceptualisation of universalism is that which associates it with social programmes led by the state, funded by general revenues, providing similar benefits to all residents of a country, as a right (Béland, 2010). This view dominated in the first decades after the second world war and had its maximum expression in the Scandinavian countries. Nevertheless, subsequently, other stances emerged that use the concept more narrowly to refer to programmes intended to reach the entire population, independently of how generous the benefits are and whether they are equal for everyone or not (Martínez Franzoni and Sánchez-Ancochea, 2016b).

In the framework of these different understandings of universalism, Korpi and Palme (1998) make a fundamental contribution, stressing the linkages between universalism and inequality reduction. Specifically, they draw attention to the higher redistributive effects and capacity to decrease poverty and advance universal outputs of models that include all social groups and strata in the same programmes and institutional arrangements. Whilst social programmes that seek to reach the whole or the majority of the population by relying on the aggregation of multiple schemes with uneven benefits might deepen inequalities and be contested as not genuinely universal. Béland et al. (2014) make another significant contribution to advancing a more refined conceptualisation of universalism by stating the importance of discerning universal entitlements from the universal utilisation of the entitlements as well as the relevance of identifying the degree, rather than the presence or absence, of universalism. For instance, they argue that, when a significant share of the population relies on private options instead of on the publicly provided services, this constitutes a low degree of universalism, even if everyone is formally entitled to public services. Thus, both the above conceptualisations emphasise that (formal) massive coverage is a necessary, but insufficient, condition for universalism and hence, other requirements related to the distribution and access to benefits are essential for it to come into being.

Focusing on Latin America, Cecchini, Robles and Filgueira (2014) and Filgueira, F. (2014) identify three main approaches in the contemporary discussion on universalism: the ILO´s Social Protection Floor (SPF), Basic Universalism, and Efficient Universalism. The SPF promotes universal basic income and essential social services complemented by contributory and/or voluntary schemes of insurance. Basic Universalism advocates publicly-funded basic universal social benefits that should gradually increase in generosity for everyone, without the need of relying on contributory complements. Finally, Efficient Universalism proposes social benefits for all workers (i.e. either formal or informal) funded by consumption taxes.

The two first-mentioned approaches concur with the classical stance that advocates publicly-funded welfare provision for everyone. However, unlike the traditional paradigm of tax-based flat universalism, with these approaches benefits are basic, at least initially. Moreover, both the SPF and the Basic Universalism perspectives advocate integrating targeting and universalistic strategies to reach universal outputs. Skocpol (1991) describes this as targeting within universalism, arguing that targeting benefits can work as a halfway method to achieving universalism as the final goal. The rationale for this is that, albeit targeting should not be the central pillar of universally-oriented social policy, it can be a first step for the progressive expansion of economic and social rights (Cecchini and Martínez, 2011), thereby helping to tackle inequalities in the starting conditions across the population (Cecchini et al., 2015).

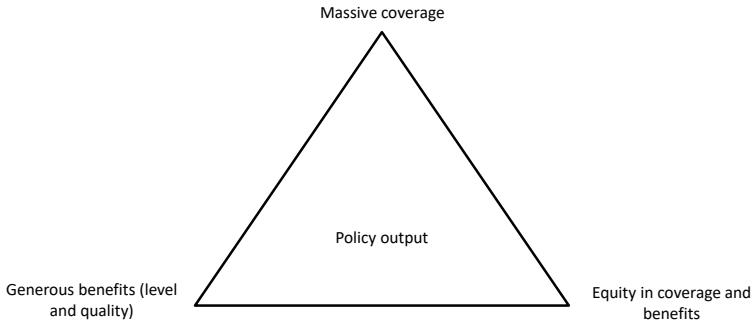
Strategies like starting with basic benefits and targeting within universalism may sound pertinent to dealing with fiscal constraints, especially in countries of the Global South. Nevertheless, both approaches risk keeping segmentation by providing unequal levels of social welfare throughout the population. By proposing to complement the basic services through contributory/voluntary schemes, the SPF approach supports that the level of services accessed depends on inclusion in the labour market or the household´s economic capacity. This is problematic in the Latin American context due to high informality of jobs and income inequality. In turn, the Basic

Universalism addresses this limitation by considering a single scheme, but risks the withdrawal of better-off citizens and the middle-classes from the public towards private options looking for better-quality services (Martínez-Franzoni and Sánchez-Ancochea, 2014), which hinders the chances for bringing the necessary resources to finance the transit towards higher levels of benefits. Finally, by targeting the working population, Efficient Universalism may hardly be considered a genuinely universalist proposal, as it is restricted to the population that is actively participating in the labour market. Moreover, social benefits relying on consumption taxes may become regressive instead of contributing to reducing social welfare inequalities.

Also referring to Latin America, Pribble (2013) conceptualises universalism as the presence of social policies that guarantee essential social services for everyone and a minimum income during and after working life. The opposite output is segmented access, meaning that only small sectors of the population receive the benefits or the benefits are uneven. Similar to Basic Universalism, Pribble recognises the importance of both state-provided social benefits and the coverage of groups traditionally excluded. However, she adds generosity of benefits and fiscal sustainability as conditions for universalism. Moreover, the author proposes some dimensions for evaluating and clustering the results of the different possible paths of reforms by their input either towards advancing universalism, maintaining segmentation or moving in a regressive direction. These dimensions are universal coverage; transparency in the administration of the policies; the ability of policies to provide quality public services or reduce the segmentation in the size of income transfers; and the degree of equity and sustainability allowed by the funding mechanisms. On this basis, she ranks social policy reforms as ´pure universalism`, ´advanced universalism`, ´moderate universalism`, ´weak universalism`, ´neutral`, ´regressive`, or ´failed reform`. Also, the author makes a significant point of distinguishing universalism from the policy instruments used to achieve it.

In the same line as Pribble (2013), Martínez Franzoni and Sánchez-Ancochea (2016b) propose a definition of universalism that overcomes the underplaying of the generosity of benefits that is usual among narrow approaches to the concept. They conceptualise universalism as a continuous variable made-up of three equally necessary dimensions: coverage, namely the proportion of people that access benefits or services; generosity, that is, the comprehensiveness and quality of the benefits or services; and equity, meaning the evenness of access and generosity throughout the population (Figure 2.1). By adding generosity and equity as explicit and constitutive dimensions, this definition refutes the universal character of programmes that do not provide sufficient benefits or quality of services to meet the welfare needs of the entire population and that end in creating segmentation across social groups. In this way, the authors provide a conceptualisation that considers that universalism is more than coverage at the time that offer dimensions that are easier to operationalise than those included in the proposal previously developed by Pribble. Moreover, they raised the alert about the usual conflation of universalism with the policy instruments used to produce it, arguing that policy instruments can promote or hinder universalism, but do not constitute universalism by themselves. Hence, unlike the more classic definition of universalism that predominated after the second world war, the authors decouple universalism, i.e. the output of the policy, from the financing mechanisms of social programmes.

Figure 2.1: Universal outputs as a triangle of coverage, generosity, and equity



Source: Martínez Franzoni and Sánchez-Ancochea, 2016 p. 7

In a later work, Martínez Franzoni and Sánchez-Ancochea (2018) define universalism and segmentation as the two ends of a continuous and multidimensional variable. Fully universal policy outputs, at the one end, comprise the coverage of the entire population with generous benefits or services and without the necessity of relying on the market (Martínez Franzoni and Sánchez-Ancochea, 2016b). Segmentation, at the other, takes place when a significant proportion of the population lack adequate protection from the market forces or when different groups hold uneven coverage or access to unequally generous benefits or services (Martínez Franzoni and Sánchez-Ancochea, 2018). Building on these ideas, the authors also argue that policy interventions that prioritise coverage without sufficiently caring about the quality or deliver services in a fragmented fashion tend to incite segmentation instead of universalism (see Martínez Franzoni and Sánchez-Ancochea, 2014; Martínez Franzoni and Sánchez-Ancochea, 2016b; UNDP, 2019). Thus, it is made explicit that achieving good results in one or two dimensions is insufficient and that all three dimensions are required. Universal outputs do not occur without sufficient coverage (although benefits are generous and equitable among those who are covered), without sufficient generosity (although benefits reach everyone in the same way), nor without being equitable in coverage and generosity. This argument allows us to understand that, despite the expansion of health coverage in many Latin American countries, universalism continues to be elusive, because this expansion has not gone hand in hand with generosity and equity.

2.2.2) <u>Contributions from the health care literature</u>

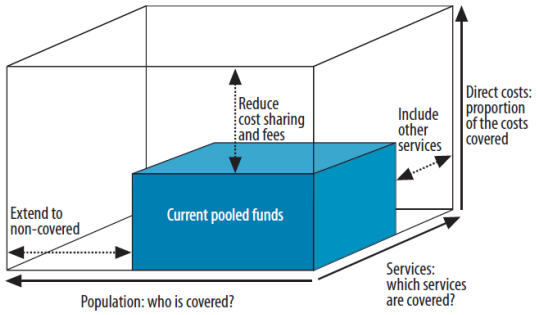
In the 2019 UN Political Declaration of the High-level Meeting on UHC, the representatives of states and governments declared:

> ´Universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial

hardship, with a special emphasis on the poor, vulnerable, and marginalised segments of the population` (UN, 2019).

This declaration concurs with the WHO (2010), which states that UHC means ensuring that everyone can access good quality health services without suffering financial hardship. This definition entails three dimensions, namely population coverage (i.e. who is covered), service coverage (i.e. which services are included), and financial coverage (i.e. how much is covered), which are depicted through the ´UHC cube`, in which the more people and services are included and financially covered more the system is filling the cube (Figure 2.2).

Figure 2.2. Universal Health Coverage Cube



Source: WHO (2010)

This three-dimensional definition involves access to health services – all people in need of health services should be able to receive care, independent of socio-economic characteristics, location, wealth or any other vulnerability – ; financial protection – all people should be safe from financial risk when incurring health care expenses. Therefore, service affordability and mechanisms that facilitate access to care should be prioritised –; and quality – services should be at a standard where it is effective in providing care and improving outcomes, while also being cost-effective and sustainable – (OECD/WB, 2020).

Nonetheless, the approach proposed by the cube has not always been easy to translate into implementation. It is recognised that countries frequently face the dilemma of prioritising resources for one or two dimensions over the others and have to choose, for instance, between covering more people with fewer benefits and less financial coverage or vice versa (Cotlear, Nagpal, et al., 2015). This relates to the lack of a consistent conceptual and operational framework to support policymaking (O'Connell, Rasanathan and Chopra, 2014). In this context, the discussion on universalism delivered by the social policy scholarship (Subsection 2.2.1) may contribute to achieving greater clarity regarding the implications associated with the different ways to approach universalism. As discussed in Chapter I, several reforms developed in Latin America have succeeded in extending formal coverage without similar improvements to defeat the systems´ fragmentation and thus, provide quality services and financial coverage in an equitable fashion. This has revealed the imbalance between efforts made to address the different dimensions involved in universal health care, because of a conceptualisation of universalism that continues to underplay quality and equity vis-à-vis formal coverage.

Another aspect of the approach proposed by the UHC cube that must not be overlooked, is that, despite the WHO's continuous claims regarding equitable coverage, equity is not included as a dimension, as happens to be the case in other approaches to universalism (e.g. Sojo, 1990; Sen, 1992; Martínez Franzoni and Sánchez-Ancochea, 2016b). These perspectives emphasise the generally low quality of services created for the poor vis-à-vis universal arrangements that allow solidarity and political resources for providing quality services for all (Korpi and Palme, 1998; Filgueira, F., 2013; Sojo, 2017). This omission is more striking considering that health care equity is recognised as imperative for coping with avoidable differences in health outcomes across population groups (CSDH, 2008) and, thus it should be a central consideration when assessing the advances towards universal healthcare.

Some authors argue that this omission relates to the utilisation of the term ´coverage`, instead of ´care`, which would have backed a greater focus on financial protection and financial sustainability (Saksena, Hsu and Evans, 2014) in the debate on the quality of health care and the contribution of UHC to social justice and equity (Prince, 2020). Nevertheless, the significance attributed to financial protection is a remarkable asset of this model since takes into account the barriers to access that result from the lack of adequate financial mechanisms to cover the costs of service delivery. This can seriously hamper equity in access and expose households to financial hardship. Hence, whilst the omission of equity could be seen as being problematic, the explicit inclusion of financial coverage is a strong contribution of this model. Moreover, there is significant evidence of the negative impact of insufficient financial coverage for universal access to health services (Kutzin, J., 2013; Kutzin, J, Yip and Cashin, 2016). Also, the inclusion of financial coverage brings the discussion on the links between universalism and commodification/decommodification of health care to the fore.

It was Bambra (2005b) who firstly extended Esping-Andersen´s conceptualisation by referring to health care decommodification as '[…] the extent to which an individual's access to health care is dependent upon their market position and the extent to which a country's provision of health is independent of the market' (p. 33). She proposed an index of health care decommodification that attempted to capture the public/private mix of health provision as well as the level of ease and coverage of public provision (Bambra, 2005a, b).

The consideration of health care access from the perspective of (de)commodification is especially meaningful for analysing universalism in the Latin American context, where authors agree that it has been insufficiently decommodified, thus hindering universalism (Dmytraczenko and Almeida, 2015; OPS, 2017). Indeed, it is common that health care access varies depending on the households´ purchasing capacity, either because of an ´explicit` or ´implicit commodification`. According to Bernales-Baksai and Velázquez Leyer (2021), an explicit commodification refers to the direct incorporation of market mechanisms into the policy architecture of health care. Whilst implicit commodification results from the states´ lack of capacity to provide a sufficient range of quality public services, which pushes people into meeting their care needs through the market, although it is not formally part of the health care system. Either of these two is the reason for commodification of health care, the consequence is that a significant proportion of people in the region has to cope with the market. This is evidenced in the vast levels of OOP spending (OECD/WB, 2020) and the high proportion of households facing catastrophic health spending (WHO, 2020b). Hence, the significant role

played by the market across the region is likely to be one of the conditions contributing to understanding the segmentation, or the shortcomings of universalism regarding health care.

2.2.3) Towards a multidimensional approach to universalism in health care

The previous pages illuminated the need for a nuanced definition to approaching universalism in health care. In Latin American countries, large parts of the population have been excluded from quality health services (Filgueira, F., 2001; Filgueira, C. and Filgueira, 2002; Barrientos, 2004; Filgueira, F., 2011). Therefore, it is fundamental to rely on a definition of universalism that goes beyond the rough formal coverage. Moreover, the unevenness in the range and quality of services across groups of the population according to their position in society makes it essential to consider how equitable is health care access, including both horizontal and vertical equity[8]. The three-dimensional definition proposed by Martinez Franzoni and Sánchez-Ancochea (2016b, 2018) can make a valuable contribution by explicitly addressing coverage, generosity and equity. However, I argue that, rather than considering equity as a homologous dimension to the other two, it should be seen in relation to them. That is to say that, if, as Franzoni and Ancochea contend, equity refers to the distribution of coverage and generosity of services across social groups, then it should rather be seen as cross sectional to the definition of universalism. In turn, as previously discussed, the approach of the UHC contributes by adding financial coverage as a dimension for reaching universal health care. I argue that financial coverage should be part of the conceptualisation of universalism in health care as it is needed to ensure real access to services and as such, it should be, like coverage and generosity, sufficient and equitable.

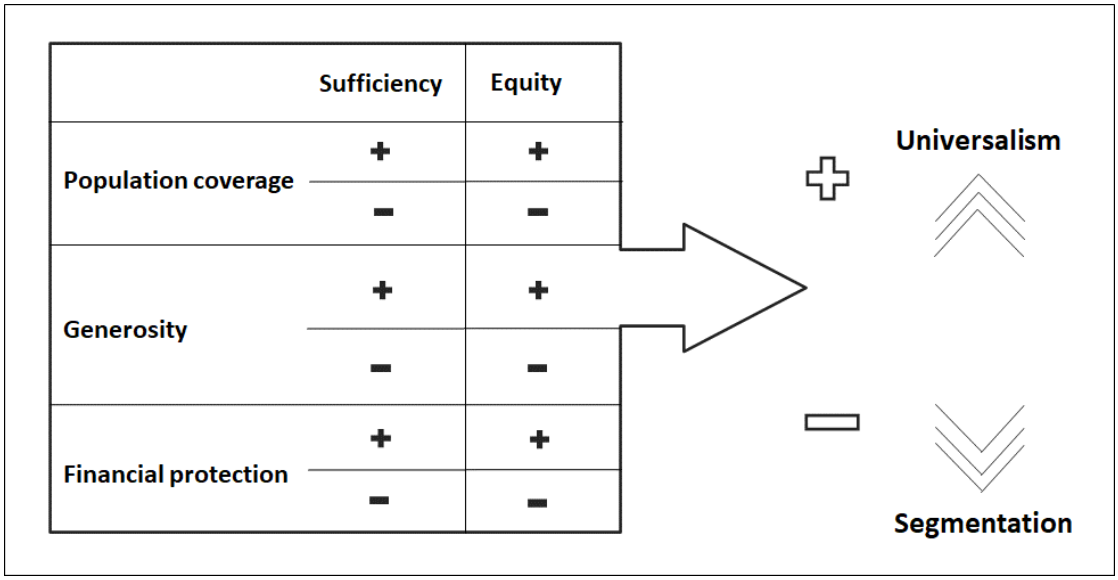
Starting from these two conceptualisations, in this thesis I claim that a health care policy that does not involve equitable access to the entire population to sufficiently comprehensive quality health services without incurring financial risks can hardly be considered universal. There is more than one example of unsuccessful attempts at universal health care in Latin America, because despite it being formally guaranteed, the deficiencies of generosity have maintained segmentation (i.e. only those with no other option rely on public provision), thereby spurring the middle-classes towards private options and discouraging the contribution to better public services (Ferreira et al., 2013; WB, 2017). In other words, universal health care cannot be limited to formal coverage without the actual possibility of utilisation of services when needed; nor to coverage with limited or low-quality services; nor uneven extent or quality of services across the population; nor to access by the addition of targeted benefits for the poor and lower-middle classes and individual´s resources for the middle and upper-middle classes because of the commodification of health care.

Figure 2.3 illustrates the proposed understanding of universal health care, that is, a variable made up of five dimensions, two of which, i.e. sufficiency and equity, being cross sectional as

[8] Horizontal health care equity refers to the absence of differences against similar needs, whilst vertical health care equity pertains to the upgrade of healthcare provision for greater needs (Starfield, 2001).

they take place in relation to the other three, i.e. coverage, generosity and financial protection. In this view, the two cross sectional dimensions are crucial since it is not enough for services to be the same for all, if they are not sufficient, nor it is enough for them to be generous, if they do not meet what is required by each social group. This conceptualisation explicitly demands that the services be sufficiently extended, generous and with financial coverage to allow access to satisfy the need for health care and that they are provided equitably. That is, they need to be provided according to the needs of the different groups in such a way as to allow everyone to have the same chances of satisfying their needs. Together, these five dimensions shape a continuum in which universalism occurs, where coverage, generosity, and financial protection are sufficient as well as equitable, whilst segmentation is at the opposite end of the continuum.

Figure 2.3. Dimensions of Universal Health Care



Source: Own elaboration

2.3.- Conceptual contributions for explaining the drivers of universalism

2.3.1) Universalism and welfare regimes

2.3.1.1. The working class and the emergence of welfare states

When examining how universalism is produced, it is essential to discuss the seminal contributions made by the proponents of the Power Resources Theory (PRT). This approach gained renown by theorising about the conjunctures that allowed for the emergence and initial expansion of the most universalist welfare states, arguing that they reflected a change in the balance of class power in society. In turn, under this lens, it is held that the variability among welfare states pertains to the differences in the degree of organisation of the working class and their capacity to reach political representation through the development of coalitions with

political parties. These ideas importantly rely on the analyses carried out by Korpi (1978, 1983, 2008), who associates the emergence of the Swedish welfare state with the increase of the labour movement's capacity for collective action and political bargaining as well as the development of a robust coalition with the Social Democratic Party.

Nonetheless, the initial PRT's ideas raised some criticism concerning its excessive emphasis on the labour movement and the Social Democratic Party, as these principles may result difficult to apply in other than Scandinavian countries. Hence, in the study of Latin America, supporters of this approach stress that the original statements need adaptations, as the economic development and class structure have historically differed from that exhibited by Western European countries. Huber and Stephens (2012) make this point, arguing that the late and limited industrialisation across Latin America led to a class structure (i.e. large groups of poor peasants, rural workers and urban informal workers, and a smaller urban working class) that weakened the potential for labour organisation, the density of civil society and therefore, the capacity for political mobilisation and influence of the lower-classes.

Also, Mesa-Lago (1978), in a pivotal study, pointed out that welfare policies throughout Latin America responded to the pressures of more powerful and well-organised sectors, such as the military and civil servants. They then continued to expand to other groups of the middle-classes and only later, to groups of workers with a higher capacity for collective action. Thus, other conditions, rather than the organised demands of labour movements, played a decisive role in the emergence and variability of the universalist potential of social policy regimes[9] in this region. In this regard, Huber and Stephens (2012) claim that the leadership assumed by left-of-centre political parties was essential for the launch of welfare policies, either supported by the formation of alliances with organised labour, social movements and civil society organisations, or merely appealing to the voters.

2.3.1.2. Regimes of welfare states

Building upon the PRT´s ideas, Esping-Andersen (1987b) defined the welfare state as the state's responses to coping with the market forces towards the commodification of the whole social spectrum. Welfare states entail the function of decommodification of social welfare, which '[…] occurs when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market` (1990, pp.21-22). By decommodifying, the state counterbalances the commodification effect of the market in those areas that society defines as crucial for welfare.

Esping-Andersen (1990) also claimed that welfare states are systems of stratification through both the redistribution of income and the arrangements to deliver social benefits. This means that through the policies the states reallocate resources and thus, can reduce inequalities, although it is also possible that the policies have a design that leads to a regressive redistribution

[9] The use of the expression ´social policy regimes` is widespread in the social policy literature of Latin America. It emphasises the production of social welfare through social policies (regardless of their degree of success) rather than the role played by the labour market, families or the community.

and increasing inequality (Hills, 2003; Martínez Franzoni, 2005). Welfare states' functions of decommodification and stratification were subsequently complemented by the capacity of defamilisation as the third cornerstone of their performance, which refers to the possibilities to achieve welfare without the need for family support and irrespective of the family's resources or previous performance (Orloff, 1996; Martínez Franzoni, 2005).

Furthermore, Esping-Andersen (1987a) argued that modern welfare states could arise in nations with more or less organised labour movements, in the context of diverse political regimes, and relying on different rationales for providing social welfare. Variations in these dimensions express in the welfare states´ capacity for decommodification, defamilisation, type of (re)stratification and the outcomes that they produce. The author broadened the focus from working class mobilisation and bargaining capacity to the formation of alliances between the middle and working classes. These alliances can change the social balance of power resources, thereby driving the development of diverse types of welfare states (1990), which are known as welfare regimes. This is the basis of the well-known typology that groups western developed countries into three regimes of welfare states[10].

In short, the Esping-Andersen's (1990, 2002) typology differentiates: the ´liberal regime` of the Anglo-Saxon countries of Northern Europe and North America, where the allocation of resources is strongly dependent on the market, with the state being subsidiary and usually targeting benefits at those with demonstrable needs, with families having a marginal role. Then, there is the ´conservative or corporatist regime` of the continental European countries, which basis social welfare on compulsory public social insurance to provide occupational-related benefits and relies to a significant extent on families. Finally, comes the ´social-democratic regime` of the Scandinavian countries, where the state assumes the primary responsibility for social welfare, and benefits reach to everyone in a similar fashion. Most welfare scholarship associates the social-democratic welfare regime with higher universalism, solidarity, and greater potential for decommodification and redistribution (Del Valle, 2010). However, Esping-Andersen himself asserts that the decommodifying capacity depends not only on universal coverage, but also, on the state's ability to offer benefits of sufficient standard to constitute a genuine alternative to working (1990).

From a different stance, Baldwin addressed the conditions for solidarity-based[11] welfare regimes, concluding that neither the economic factors nor the working-classes' ability to demand resource redistribution is enough to explain the conditions for their formation and expansion. Instead, he contends that the crucial explanatory variable is the middle-classes' interest in risk redistribution owing to the realisation of being exposed to risks that exceed self-reliance capacity and recognising the gains from risk-sharing in a system that provides sufficiently generous benefits.

[10] This kind of distinction between welfare regimes had already been inaugurated by Titmuss (1958) by differentiating residual and institutional welfare states. The former being defined as having a commitment limited to the circumstances when the family and the market fail, whereas the latter is aimed at the entire population in all areas of social welfare.

[11] For Baldwin (1990), policies are guided by the principles of solidarity and citizenship when all citizens are included in the same pool as beneficiaries of the same programmes, which are financed by general revenues.

Accordingly, the higher the capacity of institutionalising generous and universal social benefits, the higher the middle-class support for a solidarity-based model (1990). Nevertheless, these ideas have been criticised for limiting solidarity to the redistribution of risks (e.g. from healthy to sick or from young to old) and dismissing vertical solidarity, which involves the redistribution of resources across social classes (Korpi, 1983) and, therefore, the welfare state´s function of stratification (Esping-Andersen, 1990).

2.3.1.3. Welfare regimes beyond state action

Some noticeable criticism of Esping-Andersen's typology, has contributed to advancing a more comprehensive and dynamic conceptualisation of welfare regimes. For instance, Gough (1999) stressed the need of capturing welfare regime changes over time, whilst Papadopoulos (2005) drew attention to the artificiality of the conceptual separation of the economy from society and Orloff (1993, 2005) and Martínez Franzoni (2007) stressed that the Esping-Andersen´s classification draws most attention to the role of the state, whereas that of families, gender, and the sexual division of work is underplayed. Concurring with these ideas, Papadopoulos and Roumpakis (2013) showed how the three regimes proposed by Esping-Andersen exclude the many countries where both the production of social welfare and the reproduction of the socio-economic and political model fundamentally rely on families; what they call familistic welfare capitalism.

These debates pushed subsequent elaborations to address the interplay of the state, market, and families, thus acknowledging that the production of social welfare encompasses a dynamic and diverse constellation of practices of reallocation of resources and collective management of social risks, independently of whether these practices are state-led, or not (Gough and Wood, 2004; Martínez Franzoni, 2007, 2008). In other words, what is at stake are the social arrangements that define whether to opt for the individual confrontation of social risks through the market, and failing that through family support. This would leave the state in a subsidiary role or, on the contrary, prioritise the state´s responsibility for protecting the vast majority of the population in a line of action that is closer to universalism.

Thereby, there is widespread recognition that the degree of universalism of social policy outputs relies upon the policy design embedded within the socio-political context of the countries' welfare regime, in which social welfare results from the interplay between the state, the market and families through processes that express the balance of power resources in society. Hence, policy designs aimed at universal outputs express a kind of balance of power in society, where cross-class alliances between the middle and lower classes counterbalance the power of the market. This allows for the state to intervene to decommodify and defamilise key areas of social welfare as well as (re)stratify, because these policies redistribute resources, thus reducing inequalities.

2.3.1.4. Welfare regimes in Latin America

The study of welfare regimes in Latin America also sheds light on understanding the degree to which universalism has been reached in social welfare. Carmelo Mesa-Lago was the pioneer in the late 1980s in the attempts to identify different welfare regimes, proposing a classification that considered the moment of beginning and level of coverage reached by social security systems across the region (Mesa-Lago, 2000; Alabarce, 2015). Later, Filgueira, F. (1998) proposed a more comprehensive approach that adapted Esping-Andersen's model. It considered the level of public social spending, coverage, distribution of resources by policy sector, criteria for providing benefits, and some political-economy features during the Import-Substitution Industrialisation (ISI) period (1930s – 1970s). He concluded that, even those countries with the highest coverage in the region were featured by significant stratification in the quality of benefits and services. This means that these were unevenly distributed throughout the social strata, because of their position in the labour market or other social realms and hence, they were far from offering universal social welfare. Also, Huber and Stephens (2005) developed a typology that importantly relied on the levels of coverage, public social spending, criteria for benefit provision, and the political economy of countries. This study analysed the period 1970-2001 and concurred with Filgueira by stating that access to social welfare was markedly dependent on the people's participation in the formal labour market and therefore, stratified.

Barrientos (2004) broadened the analytical focus to consider explicitly the interplay between the state, the market, and families. The enquiry elicited that after the neoliberal turn pushed by the Washington Consensus[12], 'the emerging model of welfare production in Latin America relies to an increasing extent on individuals and households making provision for themselves, through saving and insurance instruments managed by private providers. Service provision has been opened up to competition between decentralised providers, both public and private` (p. 146). The author concluded by classifying all countries in Latin America (excluding the Caribbean) as liberal-informal welfare regimes, because of the market orientation and the states' compensatory approach that excludes a large proportion of the population. These arguments have, therefore, come to shed light to the linkages between the lack of universalism in social welfare, with the presence and predominance of the market in these matters.

Continuing this path of a more comprehensive understanding of welfare provision, Martínez Franzoni (2007, 2008) proposed a typology that groups 18 countries using four dimensions: commodification in the labour market, decommodification of welfare, defamilisation of welfare, and outcomes. By adding the dimension of commodification in the labour market, she recognises

[12] The term ´Washington Consensus` coined in 1989 by Williamson, refers to a set of ten principles for economic policy applied in Chile from the early eighties and then, promoted by the international financial institutions to orient policy reforms in the rest of Latin America. The principles are summarised in the following statements: 1) Fiscal discipline to control inflation and stop government budget deficit; 2) Reordering public expenditure priorities in a pro-growth and pro-poor fashion; 3) Tax reform combining a broad tax base with moderate marginal tax rates; 4) Liberalising interest rates (i.e. financial liberalisation); 5) A competitive exchange rate to facilitate export growth; 6) Trade liberalisation; 7) Liberalisation of Inward Foreign Direct Investment; 8) Privatisation of state enterprises; 9) Deregulation to ease entry and exit barriers; and 10) Advance property rights, especially for the informal sector (Williamson, 2009).

that in developing countries, the states need to complement their functions of decommodification and defamilisation of welfare with efforts to foster the labour market's capacity to absorb the labour force and offer quality jobs. This is to say that advancing universal social welfare may also require improvements in the labour market, rather than just the expansion of social policy. Furthermore, this typology empirically recognises the role of families in resource reallocation and, the inclusion of outcomes as a fourth dimension allows for considering the countries´ welfare achievements.

Like Barrientos (2004), the author concludes that all welfare regimes in the region are, to some extent, informal, but differentiates three welfare regimes: State-productivist, State-protectionist and Non-state familist, which includes the Familist and the Highly familist sub-clusters (Martínez Franzoni, 2008).

Lastly, more recently, Cecchini, Robles and Filgueira (2014) proposed a classification that groups 18 countries, focusing on two main dimensions: the labour market´s capacity to generate adequate jobs and the countries´ ability and fiscal effort to protect those who cannot achieve it through their participation in the labour market. According to the authors, these dimensions, in tandem, shape the welfare gap faced by countries. With this line of argument, the limitations for universal welfare in the countries of the region would be given both by the shortcomings of the labour markets and by the lack of capacity of the state to stand in for the labour market and take care of the population in need.

In sum, these typologies of welfare regimes have contributed conceptual devices for grasping the arrangements for social welfare and the outcomes achieved by countries across the Latin American region and over time. The understanding of the welfare regime in a country gives clues for a more comprehensive policy analysis and explains the policy outputs within the broader social context. In other words, it allows for capturing the rationale behind specific social policies as the expression of the historical trajectory and contemporary conditions. In this regard, the dynamic nature of welfare regimes and the social policies that they shape also demands shedding light on the drivers of the directions followed by those trajectories. This is the focus of the next subsection.

2.3.2) Social policy trajectories

Departing from the PRT's ideas on the origin of the welfare state, first Esping-Andersen (1990) and then, Korpi and Palme (1998), moved the focus of attention towards the role of institutions and cross-class alliances as explanatory variables for the differences in the welfare states' trajectories, levels of generosity, and impact on redistribution. Esping-Andersen (1990) emphasises that welfare states reproduce themselves through welfare institutions. He argues that, through social policies, welfare states create specific systems of stratification in such a way that social policies themselves are both an expression of the ordering of social relations and an active force in the production and reproduction of social relations. Likewise, Korpi and Palme (1998) stress that welfare institutions work as intervening variables ´[…] on one hand reflecting

causal factors such as actions by coalitions of interest groups, and on the other hand potentially having feedback effects on distributive processes via their effects on the formation of interests, preferences and coalitions among citizens` (Korpi and Palme, 1998, p.664).

In the so-called ´Paradox of redistribution`, Korpi and Palme (1998) demonstrate the crucial role of welfare institutions in the redistributive processes and therefore, in the consolidation or transforming of the prevailing social ordering that, in turn, gives rise to a specific kind of such institutions. The paradox of redistribution holds that, despite it being expected that policies targeted at the poor would have a higher redistributive impact, the result is the opposite, as countries that importantly rely on targeting also spend less on social policies and therefore, attain less redistribution. The reason for this is that targeting segments the population, hinders the formation of cross-class alliances and limits the middle-class disposition to pay higher taxes for benefits that are restricted to the poor, instead of reaching the whole population. Conversely, institutional arrangements that provide universal benefits enhance the formation of cross-class alliances and create virtuous circuits, as social agents participating in the alliances can reinforce the redistributive capacity of institutions, thus contributing to poverty reduction and a more egalitarian social structure. Thereby, in both Esping-Anderson and Korpi and Palme´s perspectives, welfare institutions, alliances between social agents, and the interaction between them over time are fundamental determinants of social policy's trajectories that are expressed in the transit towards higher or lower levels of universalism.

In regard to the particularities of Latin America, Huber and Stephens (2012) proposed the Power Constellation Theory (PCT), in which they developed a comprehensive theoretical framework to explain the trajectory and outputs of social policy regimes, adapting the core principles of the PRT to make them relevant to the region. The PCT integrates three clusters of power that, according to the authors, together explain the changes in social policy directions towards more or less universalism, poverty reduction, and redistribution observed across the region. These three clusters are i) the dynamics of power distribution within countries; ii) the institutional development of social policies, the structure of the state, and the state-society relations; and iii) the transnational structures of power, the relations in the international economy and systems of states.

Concerning the first cluster of power, several scholars claim a positive association between democracy and progressive political leadership, on the one hand, and universalism, on the other (see Rudra, 2007; Segura-Ubiergo, 2007; Haggard and Kaufman, 2008; Martínez Franzoni and Sánchez-Ancochea, 2016b). In this regard, Huber and Stephens (2012) argue that, in this region, the social structure has not have been favourable to democracy nor the formation of a robust political left. Hence, democracy should be taken as a variable that, along with the left political strength, significantly influenced the development and features of social policy in Latin America.

Nonetheless, some research has put into question such associations. For instance, Martínez Franzoni and Sánchez-Ancochea (2016b) point out that, despite programmes with universal coverage being more frequent during periods of democracy, there have also been some extended social programmes created under authoritarian regimes. Moreover, Altman and Castiglioni

(2019) have argued that electoral pressures are more determinant than the ideology of the government to explain the move towards universal policy outputs.

A second conclusion reached by Huber and Stephens (2012) concerning the first cluster of power, which has aroused greater agreement than the previous one, is the more prominent role played by gender movements and other forms of civil organisations in shaping social policy vis-à-vis the weak role performed by labour unions. Pezzini (2012), Silva, E. (2015), and Altman and Castiglioni (2019) reached similar conclusions, drawing attention to the increasing role of the middle-classes in demanding quality public services; the potential influence of social movements and protests at different stages of the policymaking; and the impact of diverse organised groups in pushing more equitable social policy. Along the same lines, Sojo (2017) argues that, for Latin America to advance redistributive reforms and to tackle stratification and exclusion from social protection systems, the formation of new social alliances based on shared risk and capable of counterbalancing the power of economic interests is fundamental, especially in those policy areas with a strong presence of private actors.

Regarding the second cluster of power, like Korpi and Palme (1998), Huber and Stephens (2012) identify in Latin America feedback effects between the institutional arrangements, the formation of cross-class alliances, and the balance of power resources. Specifically, they show that the lasting fragmentation of welfare systems (i.e. systems composed by different schemes that offer uneven benefits throughout the population) has fostered the interest of more privileged groups for maintaining their advantages, rather than supporting the expansion of benefits to the rest of the population, thus contributing to reproducing segmented access to social services and social inequalities. Thus, frequently, vetoing and policy legacies have limited the advance of universal policies, which in some cases has been further hampered by the lack of state capacity to develop a sound welfare system.

These ideas rely upon a vast tradition of studies that lay out the relevance of policy legacies for policy trajectories and outcomes (see Pierson, 1996, 2000; Arce, 2001; Haggard and Kaufman, 2008; Ewig and Kay, 2011) and concur with other analyses of the region. For instance, Pribble (2013) argues that the chances of universalist reforms in Latin America have been conditioned by two main mechanisms, namely, the setting of the problems that enter the policy agenda and the shaping of the distribution of power that defines the reformers' ability to lead policy changes. Policy legacies have also been analysed in detail by Filgueira (2011, 2013, 2015), who has concluded that the institutional arrangements shaped in Latin America throughout the period of the ISI (1930s – 1970s) gave rise to a sharply stratified model that, hence forth, hindered the unification of the provision and generosity of services and benefits. Accordingly, stratification is one of the main limitations that has hampered the progress towards universalism in that it has inhibited the construction of broad alliances of the middle and lower sectors around collective goods provided by the state (Filgueira, F., 2013).

Moreover, several scholars have identified a significant regional turn in the 1980s-1990s, where the introduction of market forces in areas formerly managed publicly, pushed forward a subsidiary state and the withdrawal of the middle-classes towards market-based options, thus further segmenting social welfare (Barrientos, 2004; Draibe and Riesco, 2009; Cecchini and

Martínez, 2011; Filgueira, F., 2011, 2013, 2015). Indeed, the promotion of the market into the welfare mix throughout the region is broadly recognised as creating policy legacies with an intense impact on subsequent policy trajectories, because it implied the empowerment of private actors as veto players. Those countries where commodification was more accentuated have faced stiff opposition from private corporations that have applied political pressure against universalist reforms, because they affect their interests (Arce, 2001; Pribble, 2008; Ewig and Kay, 2011; Pribble, 2011, 2013; Pribble and Huber, 2013; Pribble, 2017).

In this regard, the universalist turn claimed by Huber and Stephens (2012) and others in the early 2000s would be explained by shifts in coalitions and power balance, thus activating a reversal of path dependence (e.g. Mahoney, 2000; Mahoney and Thelen, 2010). In turn, the variations in the depth of universalist initiatives across countries express the type of compromise made under the first-generation reforms (i.e. the role and veto capacity reached by different actors) and the nature of policymaking (i.e. how policymaking arrangements determine the ability of actors to have their preferences represented in the final policy design) (see Brooks, 2009; Baba, 2015).

Coming back to the PCT, regarding the third cluster of power (i.e. the transnational structures of power), Huber and Stephens (2012) found that countries of Latin America faced more international anti-universalist pressures than European countries during the 1980s and 1990s. The location of Latin America in the international system of power and the sharp influence of the U.S. in the region resulted in the greater influence of agencies, such as USAID and transnational structures of power, such as the International Monetary Fund (IMF) and the World Bank (WB) that pushed for structural adjustment of the economies and neoliberal social policy reforms. Likewise, Madrid (2003) and Weyland (2005) show how neoliberal ideas diffused across the region and pushed for policy reforms through the influence of economists and technocrats involved in the governments. Also, there is consensus on the 21st century radical shift linked to a pro-universal international scenario (e.g. Garay, 2016; Martínez Franzoni and Sánchez-Ancochea, 2016b) that has favoured reforms in this direction throughout Latin America (Huber and Stephens, 2012; Cecchini, Robles and Filgueira, 2014; Cecchini et al., 2015).

What has been presented so far illuminates the wide range of variables that have been considered when studying the determinants of universal outputs. Some of them stand out for the robustness with which they have been developed throughout the social policy discussion globally or in the Latin American context. In this regard, there are at least four points to stress. First, that the type of welfare regime where social policy unfolds is important to understand the rationale and implications of the policy. Second, the feedback effects between the institutional arrangements for welfare provision driven by social policies, cross-class alliances and the power distribution in a society are essential for comprehending the potential of policies for advancing universal outputs and tackling social inequalities. Third, policy legacies are crucial to understanding the policy trajectory over time. In particular, it is widely recognised that the extended involvement of the market into the welfare mix in Latin America created policy legacies that have obstructed universalist reforms. Lastly, there is a consensus that the pro-universal international scenario has favoured the turn towards universalism in recent decades. However, the mechanisms that link these conditions with the policy outputs remain insufficiently clear. In this regard, Martínez Franzoni and Sánchez-Ancochea (2016b) recently drew attention to policy

architectures as a variable that could contribute to the missing explanations to link political preconditions with social policy outputs.

2.3.3) The analytical framework of policy architectures

Martínez Franzoni and Sánchez-Ancochea (2016b) argue that policy architectures are decisive determinants of the degree of universalism that the policy reaches. They conceptualise these as being the combination of five instruments, namely eligibility, funding, benefits, delivery, and outside options along with their reciprocal interactions, that define who is entitled to receive the benefits/services, what benefits/services are included, and how they are provided. Moreover, the authors claim the relevance of considering both the current and the foundational policy architectures. The latter refer to the blueprint or initial arrangements defined by the states to organise welfare provision, which have influenced the entire trajectory of the policy by empowering some actors over others and determining the available alternatives that stakeholders could pursue in the policymaking process.

In this analytical framework, *Eligibility* pertains to the criteria that define who can receive the benefits or services that the policy or programme is supposed to supply (Martínez Franzoni and Sánchez-Ancochea, 2016b, p.56). Usually, countries rely on some kind of combination of three criteria: need, payroll contributions, and citizenship or residency. Different to the tradition that associates universalism with the criterion of citizenship, Martínez Franzoni and Sánchez-Ancochea do not rule out that a policy can advance universal outputs relying on a combination of these three criteria as long as it does not imply differences concerning the generosity of the benefits and services received by groups included under the different criteria.

Funding refers to the sources and mechanisms for financing the benefits and services, namely how resources are raised, pooled and distributed (p. 57). In this regard, the authors point out that most countries in the Global South face fiscal constraints that prevent the possibility of following the Scandinavian model, which funds social programmes through general revenues. They argue that social policies can rely on multiple revenue sources (e.g. general revenues, earmarked taxes, payroll contributions, and co-payments) to expand coverage and improve the generosity of services. In doing so, however, governments would need to ensure that households´ contributions are progressive and affordable, all revenues are pooled into a single fund to facilitate solidarity and equity in resource allocation, and confidentiality regarding the contribution of different groups. Also, the authors assert that systems that predominantly rely on co-payments tend to produce inequities between groups with differing payment capacity, thus impairing the generosity of services.

Regarding *Benefits*, Martínez Franzoni and Sánchez-Ancochea point out that it is essential to consider both what is included (i.e. the extent and type of benefits or services) and the mechanisms to define these (p.57). This implies identifying whether benefits included are similar for all and defined by the government or a public agency according to social welfare principles or whether, on the contrary, they depend on other criteria (e.g. contributing to social security,

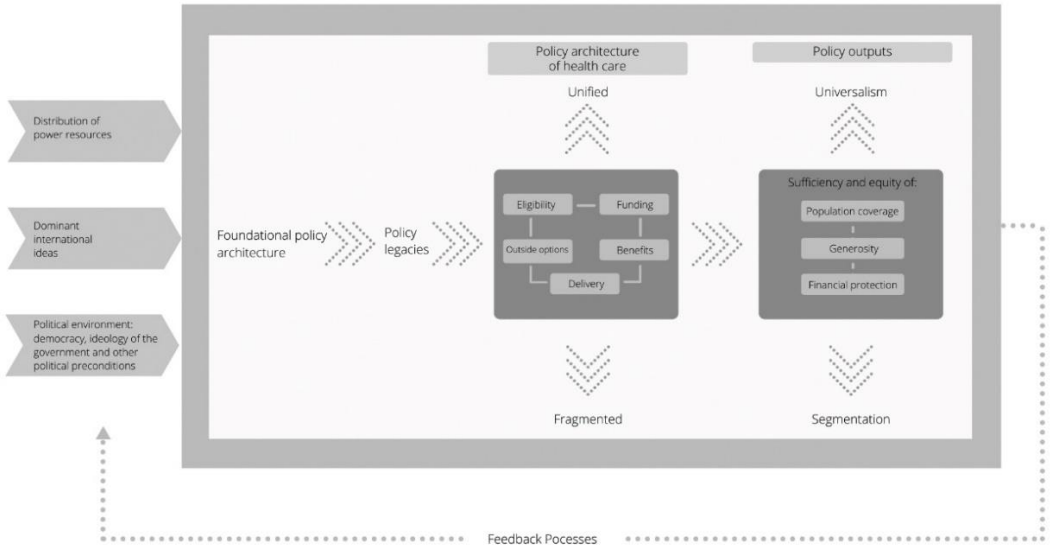
individual insurance, job benefits) and therefore, vary across social groups. Another aspect highlighted is that the comprehensiveness of benefits and services is critical for promoting equitable access. Otherwise, only those who can afford additional payments can adequately meet their needs and the rest will have to settle for basic services. Moreover, it is important to consider the gaps between the package promised and that actually available (Cotlear, Nagpal, et al., 2015).

Delivery has to do with the provision of services and benefits. It is necessary to establish whether it is unified or managed in a fragmented fashion (i.e. split between different providers, such as public, private not-for-profit, and private for-profit suppliers) (p. 57). If delivery is not unified, then it is essential to identify who supplies services to whom and potential differences in quality or efficiency, as they may seriously hamper universal outputs.

Finally, *Outside Options* refer to the size, significance, and regulation of non-public alternatives (p. 57). The authors argue that large and unregulated external options usually segment access to services by pushing the exit of better-off citizens from public options, thus draining resources from the public sector, impairing the quality of services, and limiting the move towards universal outputs.

Each of these policy instruments, alone and by interacting with the others, shapes the degree of unification of the policy. A unified policy architecture is defined as one capable of providing the benefits or services to everyone in the same manner, with a central role for the state and proper regulation of market-based options. Conversely, fragmentation entails differing criteria for eligibility, financing arrangements, benefits or services, delivery, and/or unregulated outside options. Fragmentation can be driven by corporativist policy arrangements or led by the extended participation of the private sector in welfare provision. Thus, whereas unified policy architectures promote universal policy outputs, fragmented ones shape multi-tiered systems and are more likely to promote segmentation (Martínez Franzoni and Sánchez-Ancochea, 2016a). Figure 2.4 presents graphically the instruments that, according to these authors, make up the policy architecture and its relationship with policy outputs, as defined in Subsection 2.2.3.

Figure 2.4. Policy architectures as drivers of policy output



Source: Own elaboration partially based on Martínez Franzoni and Sánchez-Ancochea (2016b)

Focusing on health care, the health systems literature extensively agrees regarding the negative effects of fragmentation in the path towards universalism all over Latin America (e.g. Bossert et al., 2014; Kaplan and Levy, 2014; Laurell and Giovanella, 2018; Donato Göttems and Rollemberg Mollo, 2020). Most of this discussion has referred to fragmentation as the coexistence of different stratified schemes by occupational groups (e.g. one for private employees, another for civil servants and some others smaller for employees of specific enterprises) and a poor quality social assistance scheme for the poor and workers with informal jobs. Against this background, Martínez Franzoni and Sánchez-Ancochea (2016b) have contributed a relevant insight by stressing the significance of the outside option as a condition that can strongly push towards fragmentation. Accordingly, the poor regulation of the outside option can erode the unification of the whole policy architecture by draining resources from the public sector and tipping the balance of power in favour of private actors. Hence, this framework adds new elements to explain fragmentation, which relate to the participation of the private sector. This is an extremely salient feature in Latin America considering the penetration of the market in welfare provision, in general and in health care, in particular (see discussion in the previous sections), being particularly meaningful for the issues discussed in this thesis.

In addition, by paying attention to the constraints of developing countries in applying the model traditionally associated with universal outputs (i.e. similar generous benefits and services for everyone funded by general revenues), Martínez Franzoni and Sánchez-Ancochea advocate a strategy that goes from the middle-classes to the rest of the population. They assert that, for countries where fiscal constraints and inequality are commonplace, what seems to enhance higher universalism is to start providing relatively generous services for the middle-classes and gradually extending them, using a unified scheme, to other income sectors. Services of sufficient quality may potentially attract the better-off to join the middle-classes and this, in turn, facilitates the availability of resources to fund the expansion of benefits to the poor (UNDP,

2019). These ideas appear consistent with several of the key aspects emphasised by the welfare literature. Such a strategy would have the potential to promote institutional arrangements that favour cross-class alliances and hence, virtuous cycles that may end up generating policy legacies helpful to universalism. It also fits well with the comprehensive definition of universalism discussed earlier in this chapter. Following this argumentative line, as well as the recognition that the different approaches discussed make regarding the middle-classes, the next subsection focuses on the analysis of the significance of this social group for the development of universal social policies.

2.3.4) The significance of the middle-classes for advancing universalism

Several of the most renowned theorisations on social welfare in both industrialised countries and the developing world include social agents, particularly the middle-classes, as playing a relevant role concerning the variations of generosity and redistributive impact of social policies. For instance, Baldwin (1990) argues that advanced welfare states would have turned solidarity into a right due to the interest of the middle-class in risk redistribution as its members evaluated that social benefits were sufficiently generous to compensate for their contributions to the system. Esping-Andersen (1990) claims the relevance of alliances between the middle and working classes and the garner of the former's support for the expansion of social benefits as a matter of rights. Accordingly, the engagement of the middle-class with social services and benefits being publicly provided in line with those received by the lower social classes, promotes the formation of alliances between them. It has the potential to alter the balance of power and foster the demand and social legitimacy of generous social welfare provision. In turn, this promotes institutional designs that enhance the involvement of the middle-class and their willingness to stay within.

Likewise, the examination of the Korpi and Palme (1998) ´Paradox of redistribution` stresses that welfare institutions, on the one hand, express the pressure of interest groups and, on the other, feedback the formation of interests, preferences, and coalitions among citizens. For instance, social policies developed in social-democratic welfare regimes illustrate iterations in which long-term alliances between the working and the middle-classes have allowed for the consolidation of welfare systems capable of offering benefits and services of sufficient standard for upper-middle and middle-income groups to support them, thereby enabling the expansion of solidaristic models. Hence, the historical consolidation of the most advanced and universal welfare states has gone hand in hand with broad political coalitions that included the elites, the middle-class and industrial workers. It was when the middle-class came into play that social policy transcended the political and economic functional minima (Sojo, 2017). In contrast, in the absence of such coalitions, like in the USA, private insurance proliferated, and public protection was restricted to assistance for the poor (Porter, 1999).

Also, other authors have highlighted the benefits of including the middle-classes in the same programmes and schemes as the rest of the population (i.e. an encompassing model) for poverty reduction and inclusive development (Deacon and Cohen, 2011), overcoming stigma and generating a stronger sense of solidarity (Ulriksen and Plagerson, 2014; Plagerson and Ulriksen,

2016). From a historical perspective, Pierson (1996) highlights how the middle-classes have been crucial in stopping the retrenchment of welfare states. He also stresses that the middle-classes' support for welfare policies importantly relies on the quality of public services, which, in turn, expresses the past success of the middle-class in stopping the reduction of welfare states. Likewise, the World Bank´s World Development Report (2017) highlights the historical importance of the middle-classes in pressuring governments to deliver better public services.

Building upon the analysis of developing countries, Birdsall (2010) makes another interesting point. The author draws attention to the definition of the middle-class to discuss its implications for social policy. She shows that when developing countries are analysed, there are important misconceptions that rely on a loose definition of the middle-class that accept within this category a significant proportion of households that are far from being a consolidated middle-class by Western standards. This is an issue that I will come back to in Chapter III.

As for Latin America, the proponents of the PCT highlight that the historical exclusionary hallmark of social policies, the political instability as well as the limited industrialisation and economic wealth hindered improvements in living standards, thereby curbing the formation of extended and robust middle-classes (Huber and Stephens, 2012). The feedback loops generated between social policies and the processes of class formation restricted both the movement toward higher degrees of universalism and the expansion of the middle-classes that, in turn, may have pushed higher universalism. With this perspective, the shortcomings of universalism are, at least partially, explained by the lack of an extended and robust middle-class. At the same time, these shortcomings of social policy also operated as an obstacle to the expansion of the middle-classes in the region.

Recent studies have pointed to a more favourable environment that has opened the possibilities for positive feedback between middle-class expansion and universal policies (e.g. Huber and Stephens, 2012; Garay, 2016; Martínez Franzoni and Sánchez-Ancochea, 2016a; Sojo, 2017). That is, favoured by years of economic growth and poverty reduction, the last two decades have witnessed the unprecedented rise of the middle-classes, who have started to demand more generous policies (Daude et al., 2017; WB, 2017). Hence, they have been contributing to compensating for the historical weaknesses of the labour organisations and their ties with centre-left parties (Huber and Stephens, 2012), and would have the historical chance of becoming actors that may be capable of turning social policy towards a universal direction.

Nevertheless, other studies are more sceptical. They point out that, despite the low levels of taxation, the middle-classes contribute more than they receive. The poor quality of public services has pushed them outside of public provision, which has undermined the chances to continue to expand and improve social services (Ferreira et al., 2013; Filgueira, F., 2013; UNDP, 2019). According to these authors, this has led to the creation a vicious circle that reinforces the lack of service quality and hampers the regional path towards universalism. Specifically, as discussed earlier, in the health care domain, policy designs continue to be fragmented, leading segmented access of different groups of the population, either through explicit eligibility criteria or, implicitly, because of the low quality of the public health care offer (Bernales-Baksai and Velázquez Leyer, 2021).

The above discussion would seem to reinforce the view that without an encompassing model of sufficiently generous health care provision that includes the middle-classes in the same schemes as the lower classes, genuinely universalist access to health care in Latin America is unlikely to become a reality, because the middle-classes will continue to turn towards outside options and hence, not see it in their interest to demand better public service provision. Nevertheless, the role of the middle-classes and more specifically, the linkages between their practices and perceptions and the policy designs of health care, have been notably overlooked in empirical studies addressing universalism in health care from a comparative perspective in Latin America (see discussion in Chapter I). These are some of the issues that the analysis presented in the following chapters will focus on, with the aim of illuminating how the current designs of health care policy, with higher or lesser levels of unification/fragmentation, relate to the middle-classes, in producing policy outputs with different degrees and shades of universalism.

2.4.- Conclusions

This chapter has presented the most influential conceptualisations of universalism and those that have dominated the Latin American debate. Moreover, the review has made clear that the understanding of universalism demands considering its linkages with discussions regarding inequality reduction (Korpi and Palme, 1998), redistribution (Esping-Andersen, 1990; Huber and Stephens, 2012) and the principles of solidarity (Baldwin, 1990; Sojo, 2017), among others. Also, there were evident the contributions of conceptualisations that address universalism from a multidimensional perspective, standing out the proposal by Martínez Franzoni and Sánchez-Ancochea (2016b), which considers the coverage, generosity and equity of services provided. As for health care, the definition of UHC has been examined, with its limitations and strengths being considered. Among the latter, the explicit inclusion of financial coverage as a dimension related to the policy ability to deliver financial protection when people are in need of health services stood out. Building on these contributions, adopting a multidimensional conceptualisation of universal health care was proposed, which considers it as a continuous variable in which universalism and segmentation are at the two opposite ends. The positioning of health care on this spectrum requires consideration of sufficiency and equity of coverage, generosity and financial protection.

Regarding the drivers for universalism to thrive, it has been shown that diverse theorisations have shaped the body of knowledge on the conditions involved in the production, or the lack of, universal social policy outputs. The specialised literature has identified a number of variables that range from macropolitical conditions to the specific features of the policy instruments that shape the policy architecture in a specific social policy area.

The review has illuminated that the corpus of knowledge globally and in Latin America is robust regarding the analysis of welfare regimes. Several typologies have analysed the social arrangements that regulate the relations between the state, the market and families for the

production of social welfare and their expression in social policies with dissimilarities in both their aims and universalist potentials. The analysis has made clear that the welfare regime in which social policies unfold shape the key context for understanding the rationale of the policy as well as their outputs and implications (e.g. two similar policies may have different outcomes depending on whether they happen in a less or more commodified welfare regime).

The literature is also forceful about the significance of considering both the policy trajectory, with its legacies, and the current policy architecture to explain the higher or lower potential of a given policy producing universal outputs. Policies that reach higher unification facilitate the advance of universalism, whereas those underpinned by fragmentation tend to create segmented access. In this regard, I have argued that the analytical framework of policy architectures proposed by Martínez Franzoni and Sánchez-Ancochea (2016b) is helpful as it allows for consideration of the historical dimension and a nuanced depiction of the policy in the present by examining it through five policy instruments: eligibility, financing, benefits, delivery and outside options.

Another area highlighted throughout the chapter has been the iterations between welfare institutions and social agents. In particular, different theoretical approaches acknowledge the middle-classes as key agents for the advancement of policy designs capable of delivering universal policy outputs. Moreover, either explicitly or implicitly, they indicate that the relationship between welfare policies and the middle-classes is in two directions. On the one hand, welfare policies express how power resources are distributed in society and the role that the state, the market, and families have within the broader welfare regime. On the other hand, welfare policies, with their effects on stratification, contribute to the formation, features and size of the middle-classes and the other social classes and, therefore to the power resources distribution that determine the social arrangements for welfare production. Nonetheless, as discussed in Chapter I, more research is needed to identify the mechanisms that connect the institutional (i.e. the policy design) and contextual (i.e. welfare regimes) components, with the role played by social agents, and the middle-classes in particular.

I argue that the explanation of the processes that sustain, intensify, or allow transformations of the policy outputs of health care needs to be sought in these interconnecting mechanisms, rather than in the isolated parts. Specifically, this perspective foregrounds the significance of considering the iterations between the welfare regime in which the health care policy takes place, the development and features of the policy -expressed in the policy trajectory and the policy architecture, respectively- and the implications for the middle-classes in terms of both how their access to health care is conditioned and how it gives feedback the policy design. These considerations give meaning to the questions I have raised for this research:

- ***How does the policy architecture of health care contribute to universal or segmented health care?***
- ***What kind of practices for health care of the middle-classes are conditioned by the policy architecture? and***
- ***What are the generative mechanisms which connect policy architectures, middle-classes practices and outputs of health care policy in Chile, Ecuador, and Uruguay?***

In the next chapter, I develop an analytical framework to respond to these questions considering the iterations between the four areas of analysis (i.e. the welfare regime, policy architecture of health care, middle-classes and policy outputs) and a suitable conceptual backup based on the critical realist approach. Moreover, the chapter discusses the concept of middle-classes and develops the methodological proposal to build the picture of the advances and limitations of universalism in health care from the perspective of the middle-classes in three countries of Latin America.

CHAPTER III ANALYTICAL FRAMEWORK AND METHODOLOGY

3.1.- Introduction

Chapters I and II showed that, whilst the significance of welfare regimes, policy designs and the middle-classes have been highlighted by theorisations about universalism and social welfare, there remains a gap in studies addressing these variables together. This chapter is aimed at contributing to filling this gap by identifying a suitable theoretical approach and developing an analytical framework and methodological strategy to study empirically the outputs of health care encompassing these variables and their reciprocal interactions.

The chapter begins (Section 3.2) with a review of the critical realist approach, with it being argued that it provides an appropriate lens for examining both the conditioning exerted by social structures and institutions as well as the role played by social agents; focusing on the relationships without conflating them. This approach highlights the existence of generative mechanisms in society and individuals that are independent, but interrelated in the unfolding of social processes. Accordingly, it is by applying a diachronic perspective that it is possible to investigate these interactions. I rely on the critical realist´s statements to build up an analytical framework (Section 3.3) in which I consider the conditioning of the policy architecture of health care, embedded in a given welfare regime, over the middle-classes´ practices and the contributions of these to maintaining or transforming the policy outputs of health care. I consider all of this bearing in mind that the relationship between the variables is not linear, but rather, a process with multiple feedbacks, as proposed by critical realist principles.

Having presented the analytical framework, the chapter then reviews the main elements of the theoretical and methodological discussion about the middle-classes (Section 3.4). The discussion highlights that the concept of middle-classes continues to be subject to debate, with there being a number of approaches defining these that rely on economic, occupational or subjective variables or a combination of them. However, there is consensus regarding the heterogeneity of the middle-classes within and across countries, which seems to require a contextually embedded perspective for its study. Drawing on this discussion, I aim at being as accurate as possible when referring to and using the term middle-classes throughout the thesis and hence, lay the foundations for a sound operationalisation of this social group.

The chapter ends by presenting the methodology (Section 3.5) that builds upon the critical realist ontological and epistemological principles. It is argued that a cross-national comparative case analysis best enables the uncovering of explanations for the generative mechanisms that drive universal/segmented health care, with a particular focus on the relationship between the policy architecture and the middle-classes´ practices for health care within the context of a given welfare regime. This design involves an intensive process of gathering information through document analysis and interviews, with the utilisation of abductive and retroductive logic.

3.2.- The critical realist approach to social processes

As outlined in Chapter I, critical realism is a comprehensive approach that offers an ontological, epistemological and conceptual framework for unfolding social processes from a relational, non-linear, perspective. Ontologically, this approach claims the existence of the world independently of our knowledge of it (Sayer, 2000) and distinguishes three stratified domains: *the real*, *the actual* and *the empirical* (Bhaskar, 1997). *The real* comprehends objects or structures with generative mechanisms, which cause events in the other domains by the operation of causal powers. *The actual* is shaped by the events produced by the actions of the generative mechanisms and causal powers in a contingent context. Finally, *the empirical* corresponds to what is experienced by individuals (Collier, 1994; Parr, 2015; Fletcher, 2016).

Roy Bhaskar pioneered the applications of critical realism to the social sciences by proposing the Transformational Model of Social Action (TMSA). Here, society is conceptualised as an open system, an emergent stratum, composed of structures and the latticework of relations between them (Bhaskar, 2008), which are governed by social laws, rather than by natural ones (Collier, 1994). Social structures belong to the domain of the real and have *generative mechanisms* that shape social phenomena (i.e. the actual) by the contingent operation of their *causal powers* (Collier, 1994; Sayer, 2000; Bhaskar, 2008; Scott, 2014). According to Bhaskar (2008), generative mechanisms are as real as social structures and are not reducible to the exercise of their causal powers, as they occur only when suitably triggered by the contextual conditions (Collier, 1994; Sayer, 2000).

In open systems, like society, the operation of generative mechanisms is by no means mechanical or deterministic, but rather, defines *tendencies*[13] (Bhaskar, 2008, 2011). Causation does not imply regularities or fixed patterns of events, as social phenomena are the result of the interplay of multiple co-existing structures, each with its generative mechanisms and causal powers that can reinforce, modify or hinder each other (Bhaskar, 2008). Hence, the operation of the same mechanism can produce different outcomes as different mechanisms can produce similar results, depending on their reciprocal interactions in a specific context. Hence, explaining social phenomena is about identifying structures, mechanisms, and the conditions under which they operate (Sayer, 2000).

The role played by structures, with their generative mechanisms, in the processes of social reproduction/elaboration, has a counterpart in human *agency*. People perceive and give meaning to social phenomena in such a way that their actions are influenced by the social world. In turn, through their actions, human beings participate, whether intentionally or not, in reproducing or transforming society. Thus, people's perceptions and practices are rooted in both the conceptual and material dimensions (Bhaskar, 2011).

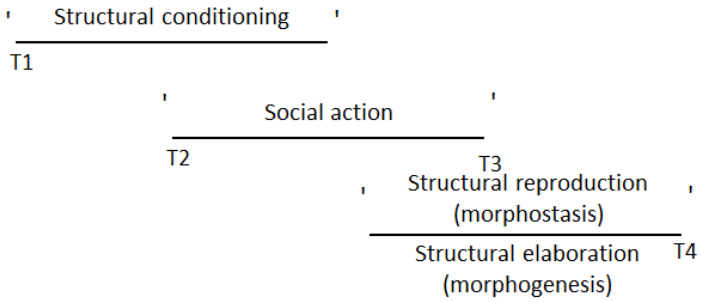
[13] For Bhaskar, the concept of tendency captures the idea of continuing activity, rather than enduring powers: ´It is by reference not just to the enduring powers but the unrealized activities or unmanifest (or incompletely manifest) actions of things that the phenomena of the world are explained` (2008, p. 50).

According to Archer (1995, 2000), agency is the indefectible product of the people´s interactions, which is always plural and intrinsically social. She argues that agency is the human generative mechanism and as such, encompasses causal powers that, like the generative mechanisms of social structures, impact on social processes. Social agency expresses the articulation of interests of collectivities with shared life chances. In this sense, everyone is necessarily an agent as, since birth, everyone occupies a position in society´s distribution of resources that is similar to the position of others within society. Those whose agency is involuntary, namely, are not organised for pressing for their shared interests and needs, are *primary agents*. This includes every individual in society, as their actions in concomitance with others´ actions are contributing to shaping social processes regardless of this happening intentionally or not. Meanwhile, organised interest groups become *corporate agents*, who develop coordinated actions to influence (Archer, 1995).

These two strata, society and people, are ontologically connected. Society is the ever-present condition of people's actions that, in turn, participate in the conscious or unconscious production and reproduction of society (Bhaskar, 2015). The links between society and agency are addressed by Archer (1995, 2000, 2010), who in the so-called morphogenetic approach states that a diachronic perspective allows for addressing the classical problems of structure and agency avoiding their conflation.

Archer´s diachronic analysis makes visible that: i) human actions are involved in reproduction or transformation of social structures; ii) these actions presuppose an already existing set of enabling or constraining structures; and iii) these structures were reproduced or transformed by people´ actions in an earlier time (t-1), which in turn, were constrained or enabled by earlier structures (t-2) (Archer, 1995). Figure 3.1 summarises this approach, dividing social evolution into three continuous and overlapped stages. The first one is *structural conditioning*, which derives from structures that, whilst being the result of past actions, are taken as given in the analysis, because of their influence on the following stages. The second stage is *social action*, in which agents (always in the plural) perform their actions conditioned, but not determined by, pre-existent social structures. Finally, *structural reproduction/elaboration* is the outcome of the previous stages that, once again, sets structures that will produce further processes of reproduction or elaborations in an endless cycle of structural conditioning → social action → structural reproduction/elaboration. Thus defined, the social system is always the product of historical interactions of social agents, but once it emerged, it has its own properties. Social structure is a human product that, having emerged, escapes to its makers to act back upon them (Archer, 1995, 2010).

Figure 3.1. Sequential cycle of social reproduction and elaboration



Source: Based on Archer (2010)

The interplay between structure and agency triggers either morphostatic (i.e. reproduction) or morphogenetic (i.e. elaboration) processes (Archer, 2010). The outcome depends on the interaction of the different structural demands (i.e. the tendencies produced by the multiple co-existent social structures involved) (Bhaskar, 2008) as well as the conditioning of these structures empowering some agents over others, with all this being within a given and contingent socio-historical setting (Collier, 1994).

The points of contact between social structures and human agency are the *positions* that individuals occupy within society and the *practices* they engage in by virtue of such positions (Bhaskar, 2015). Agents´ positions lead to different vested interests and influence pre-dispositions for allying with others and the nature of the resources that can be drawn upon, thus giving rise differential bargaining powers amongst the parties concerned. Meanwhile, through practices, human beings remain embedded in the world as a whole (Archer, 2000). Thus, practices can be conceptualised as recurrent actions deployed by people according to their positions within society and to their relationships with other agents, whose product is agency.

Thus understood, both structural conditioning and agency are the fundamental drivers behind social processes. The social system sets the scene for agents´ practices and in doing so, draws the limits of what can be reproduced or transformed, which, in turn, changes over time, because of the social agents´ actions. Hence, agency can reproduce the previous social structures or lead to structural elaboration, whilst at the time social agents also are transformed throughout the process. All of this takes place in the sequential cycles of social reproduction/elaboration and needs to be analytically differentiated to identify the generative mechanisms operating in a given (contingent) context to produce the observed outcomes (Bhaskar, 2014). Once the analytical dissection allows for understanding the mechanisms and the powers under which that these mechanisms operate, it is possible to reconstruct explanations capable of capturing the interplay between society, agency, and the socio-historical setting.

Despite critical realism, and the Archer´s morphogenetic approach, in particular, having not been extensively used in policy analysis, it can make a valuable contribution from the perspective of the subject matter that motivates this research. I argue that adopting this approach sets the ground to understand universal/segmented policy outputs as the result of

dynamic social processes shaped by society and social agents. In particular, and paying attention to the main explanatory variables highlighted by the welfare literature, critical realism provides an observational model that allows for looking beyond isolated variables to explain health care policy outputs, by addressing the relations between the welfare regime with its power relations (i.e. social structures) that contextualises the policy, the policy architecture of health care (i.e. social institutions) and middle-classes´ practices regarding health care (i.e. agency). Next, in Section 3.3., the critical realist principles are applied to set out the analytical framework for the development of this research.

3.3.- Analytical framework

The analytical framework discussed below builds upon three main pillars: first, the principles of the critical realist approach that, as explained, provides observational devices to link the policy of health care and middle-classes´ practices within the context of a given welfare regime. Second, the conceptual and empirical contributions made by the PRT and its successors that highlight the links and feedback effect between policy institutions and the role of social agents and in particular, of the middle-classes for shaping policy outputs (e.g. Esping-Andersen, 1990; Korpi and Palme, 1998). Third, the policy architectures framework, which allows for delving into the links between the policy design and universal outputs.

Figure 3.2 presents a diagram of this analytical framework. From left to right, the first square shows that society´s distribution of power resources is expressed in a welfare regime that represents the social arrangements regarding the role of the state, the market and families for producing welfare and dealing with social risks. This square also shows that welfare regimes operate institutionally through social policies and other welfare institutions, among them the policy of health care. Whilst it is expected that there will be consistency between the type of welfare regime and the policy architecture of health care, this is not always the case[14] (see Wendt, Frisina and Rothgang, 2009).

The policy architectures produce policy outputs allocated at some point on the continuum of universalism and segmentation (second square) and condition the middle-classes´ practices for health care (third square) directly and indirectly (i.e. through the policy outputs that they produce). All this together shapes the process of structural conditioning (T1 – T2).

Structural conditioning enables the middle-classes, according to their position within society, some practices for health care, whereas other practices are constrained. In turn, the conditioned middle-classes´ practices for health care can contribute to the reproduction of the current policy outputs or can trigger the elaboration of the structural setting to transform it into something different (T2 - T3), which again is expressed in the policy architecture and impacts on the policy

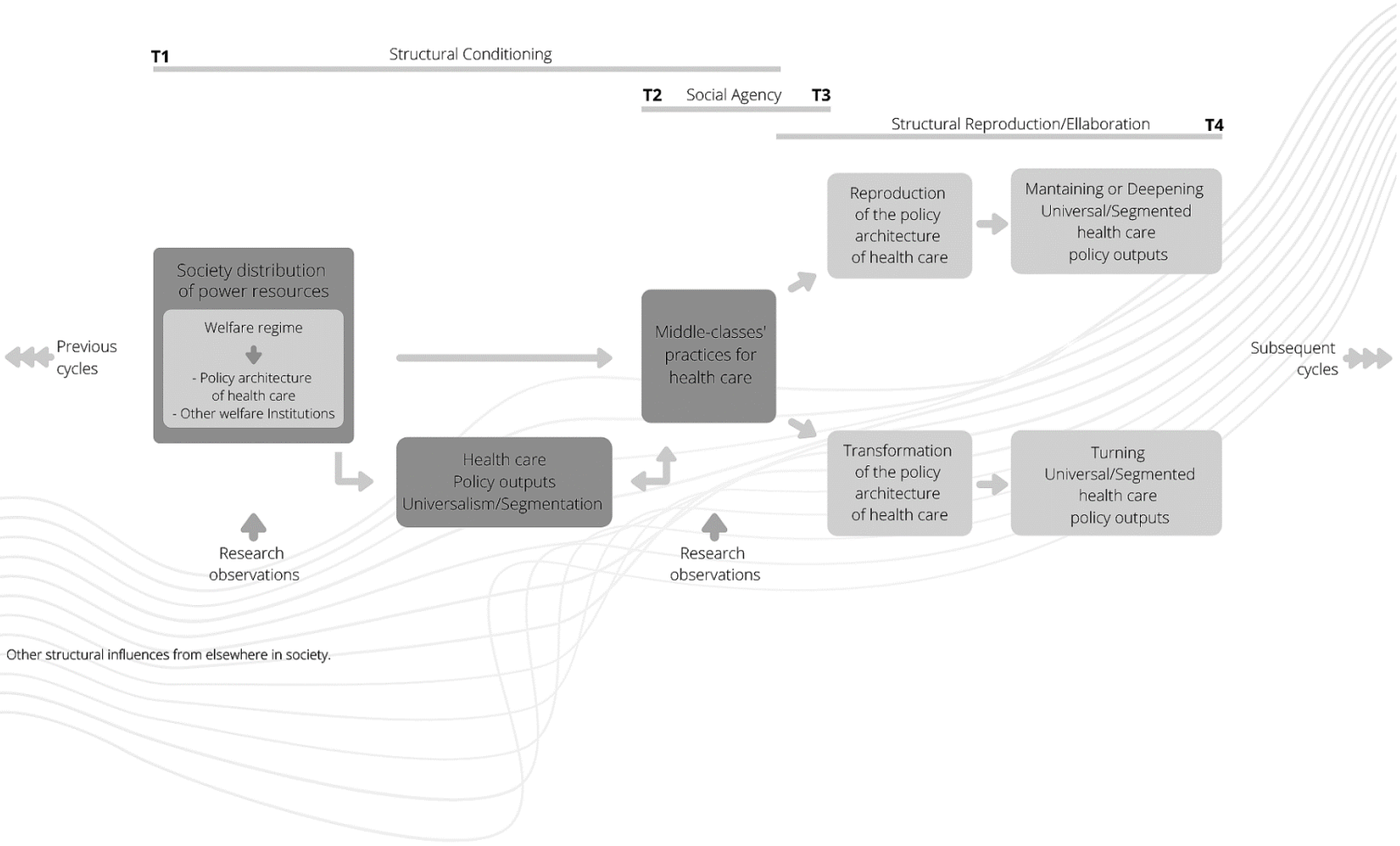
[14] An iconic example of possible divergence is the NHS of the United Kingdom, which may be a perfect illustration of a social democratic policy design but it exists within the context of a welfare regime qualified as liberal in the Esping-Anderson typology.

outputs (T3 - T4), thereby constituting the starting point (T+1) of subsequent cycles. The reproduced or elaborated structures will condition subsequent practices, which will produce new elaborations, or reproduce the old structures, in an endless cycle of Structural-conditioning → Social-action → Structural reproduction/elaboration.

According to this analytical framework, the segmented policy outputs of health care observed in most Latin America respond to the design of the policy, whilst also being maintained through the practices of social agents conditioned by the policy architectures and by the outputs themselves. These practices can contribute either to the reproduction of segmentation or to policy attempts to advance universalism.

Figure 3.2 also shows that the observations in the field focus on both the policy architecture and the middle-classes´ practices for health care. This double focus holds the purpose of addressing the relations between them and thus, disclosing the generative mechanisms that explain the segmented/universal outputs of health care. In other words, this obeys the intention to be coherent with the critical realist claims, by considering the processes that happen between the policy of health care and the middle-classes to explain the observed outputs.

Figure 3.2. Analytical framework: Relational approach to study the policy architectures, middle-classes´ practices and policy outputs of health care in three countries of Latin America with different welfare regimes



Source: Own elaboration based on the critical realist (Bhaskar, 2011) and morphogenetic (Archer, 1995, 2010) approaches

Moreover, considering the literature review conducted in the previous chapter, this research pays special attention to some aspects and relationships that, according to the existent knowledge, may play a crucial role in the observed policy outputs in the Latin American context. A first area, related to the policy architecture, is to investigate whether there is any feature of this that is a necessary condition to promote universal outputs and whether there is any configuration of the policy instruments that is a sufficient condition for this. Also, in the context of the lasting commodification of health care in Latin America, it is important to identify the nuances and mechanisms of the public-private dynamics, such as the different forms in which the market can be involved in health care provision and how it takes shape through the architecture and in people´s practices.

A second consideration, closely related to the previous one, is the importance of looking at the influence of the policy architecture, not in isolation, but also observing the influence of the context, or to be more precise, the welfare regime where the policy and practices of health care take place. This involves considering, for example, whether similarities in some policy instruments or in the whole policy architecture spur similar middle-classes´ practices independently of the welfare regime of the country. Moreover, it is essential to ascertain the influence of past policy outputs. This refers, for example, to the effect that historical quality differences between different schemes may have over the middle-classes´ perceptions and practices.

Finally, it is worth noting that, following the conceptualisation proposed by Archer (2000), I consider the middle-classes as social agents, that is, in regard to the collective social beings of people of this social class and not to as individual human beings nor individual social beings. In turn, as stated by both the TMSA of Bhaskar (2011, 2015) and the morphogenetic approach of Archer (2010), social structures and institutions, represented by the first square of Figure 3.2, are conceived as irreducible to human behaviour. Applying these ideas to the conceptualisations proposed by Esping-Andersen and several scholars who built on his work for Latin America, such as Filgueira (1998) and Martínez Franzoni (2008), in this analytical framework, I define welfare regimes as a latticework of relations between the state, the market and families to address social risks and produce social welfare, which is shaped consistently according to the distribution of power resources in society. In turn, the policy architecture of health care, as defined by Martínez Franzoni and Sánchez-Ancochea (2016b) (i.e. the combination of policy instruments that encompass the criteria for eligibility, funding, benefits, delivery and regulation of outside options), is understood as one of the institutional expressions of the prevailing welfare regime. As an institution, it involves rules, norms and values that orientate people´s practices by defining the positions that social agents can occupy and the actions associated with these positions. Thus, the policy architecture, embedded in the welfare regime, condition the middle-classes´ practices (i.e. recurrent actions performed by virtue of their position within society). However, the practices performed by these social agents also have the power to reproduce/transform the social structures and institutions. This is why it is important to look at the whole process, focusing on the relationships, rather than the isolated elements.

All in all, this analytical framework sets the groundwork for the elucidation of the generative mechanisms that shape these relationships within this social process. Building on this, I intend

to contribute to explaining how the policy architecture conditions the middle-classes´ access to health care, on the one hand, and the contributions of their positioned practices to the reproduction or transformation of segmentation in health care described by the previous research in most of Latin America. Finally, it is important to recognise that by focusing on social structures and institutions related to the production of social welfare and, more specifically, those directly involved in health care provision and on the practices of the middle-classes in this realm does not mean to deny the existence of other structures and social agents, as well as cultural and personal conditioning simultaneously influencing. Hence, for this research, recognising and dealing with the limitation of leaving out other structural and non-structural influences that could also be part of the explanation for the observed outputs is essential.

3.4.- Excursus: Debates and considerations regarding the concept of middle-classes

3.4.1) Main perspectives for the conceptualisation and operationalisation of the middle-classes

From the 1970s onwards, sociological analyses of social class and stratification were notoriously grounded on occupational positions. Such an approach, markedly influenced by the Weberian tradition[15], found in Goldthorpe´s class schema (Goldthorpe, Llewellyn and Payne, 1980; Erikson and Goldthorpe, 1992; Goldthorpe, 2000) the most influential and best-known expression, having dominated the study of social classes in the United Kingdom, Europe and Latin America. However, in the latter Marxist-based ideas have also occupied a relevant position, particularly in Portes and Hoffman´s (2003) model of social class structure, which considers both market assets (i.e. Weberian criteria) and production relations (i.e. Marxist criteria). Both class schemas distinguish manual and non-manual occupations, which has been the basis for differentiating the middle-class, either in the singular or plural (Carbajal and Rovner, 2014).

The merits of occupational-based approaches are broadly recognised. The contributions of Portes and Hoffman (2003) model to the study of social classes in Latin America is highly valued owing to its consideration of the salient features of labour markets (i.e. high labour informality). Nonetheless, critics have pointed out that these deductive schemas theoretically divide society into classes, without interrogating the social and cultural conditions that determine the formation of a specific class in a particular socio-historical context. Under this lens, these schemas limit to deductively associating the middle-class with occupational groups or categories of employment rather than providing a sociologically meaningful depiction of this social class grounded on the observation of the modes of existence (Adamovsky, 2014).

[15] ´Weber identified a social class as a group of occupations within which intragenerational and intergenerational mobility was easy and typical. These social classes are identifiable social groups (and not just classifications created by social scientist) and arguably the basis for collective social action` (Huber and Stephens, 2012 p. 60-61).

In recent years, bottom-up perspectives have gained influence. Perceptual approaches, for instance, advocate a class division built on the people´s perceptions of their capacity to retain or attain a specific status in society (Vaughan-Whitehead, Vasquez-Alvarez and Maître, 2016). However, detractors argue that individuals´ self-perceptions are not sufficient for building a concept of class with explicative and predictive validity (Portes and Hoffman, 2003; Jorrat, 2014). Other bottom-up perspectives emphasise social agency as a critical element to differentiate class positions, claiming that social identities emerge through collective action in the political and social arenas (Oliven, 2014).

The French tradition has also drawn significant attention within the sociological debate, with Bourdieu as the most-influential proponent. In short, the Bourdieusian theory explains social class formation and reproduction as dynamic processes of interactions between social structures, culture, and peoples´ subjectivity. Social class does not merely indicate people´s positions in the labour market, but rather, arises from the volume and structure of different types of resources or capitals that people hold (Bourdieu, 2016). Accordingly, the overall amount and the proportion of economic (i.e. income and ownership), cultural (i.e. educational credentials, informal education, and cultural objects), and social (i.e. social connections) capitals that individuals hold in the multiple social fields (e.g. political field and economic field) set the social divisions, class positions, and relations within the society (Riley, 2017). Individuals, in turn, internalise social structures (i.e. social divisions and relations), translating them into habitus (i.e. matrixes of perceptions and dispositions for actions) (Bourdieu, 1977) that engender social action, thus completing the circuit in which social classes are dynamic, and individuals´ class positions vary over time. Thus understood, Bourdieusian social classes express different objective conditions of existence, raised from differing endowments of power or capital, that condition the perceptions, dispositions, and practices that are shared by a social class in particular socio-historic contexts (Brubaker, 1985).

Drawing upon Bourdieu´s distinction of interplaying types of capital, Savage et al. (2013) proposed a multidimensional and bottom-up model that distinguishes seven class groups in Great Britain. According to the authors, this model contributes to overcoming the ´too homogenous description of the salaried middle class` (p.222) of the standard sociological models. The class groups identified are: i) Elite, ii) Established middle-class, iii) Technical middle-class, iv) New affluent workers, v) Traditional working-class, vi) Emergent service workers, and vii) Precariat. Among them, groups ii, iii and iv may be roughly considered as shaping the category of middle-class, which the authors profile as currently featured by fragmentation and increasingly blurring boundaries with the working class.

By not limiting the definition of class groups to the endowment of economic resources nor the individuals´ positions in the labour market, Savage et al.´s (2013) model facilitates a more comprehensive and dynamic standpoint that may be beneficial in advancing a sociologically meaningful definition of the middle-class, especially in contexts with higher heterogeneity of the labour market and income inequality, than those that gave rise to the traditional class schemas. Nevertheless, this model faces the limitation of requiring reliable data to measure each type of capital, which may be challenging to obtain in developing countries, where there are usually

more constraints regarding the obtaining of information (Vaughan-Whitehead, Vasquez-Alvarez and Maître, 2016).

Feminist literature and historical studies further contribute to a more comprehensive understanding of social classes. The former, by claiming for the need to consider the symbolic and cultural paths through which social class operates shaping social values and practices (Skeggs, 2004; Crompton, 2008). Meanwhile, the latter makes a case for the historically embedded (i.e. non-abstract) existence of any social class, asserting that the specific expression of the material conditions of existence in people´s practices and attitudes only can be understood in consideration of the social context (Adamovsky, 2014). These contributions also bring implications for comparative aims, as they demand acknowledgement of the dynamic character of social classes and thus, the deployment of definitions that are both theoretically meaningful and contextually grounded.

The lack of conceptual consensus, along with the measurement difficulties, has led several researchers to write middle-class with quotation marks, thereby drawing attention to the challenges of clearly demarcating its boundaries (Adamovsky, 2014). As a way to dealing these challenges, studies that adopt an economic standpoint and define the middle-class in terms of relative[16] or absolute[17] income or consumption patterns have proliferated.

Income-based inquiries have the advantage of providing clear operationalisation and the possibility of easily distinguishing sub-groups (e.g. lower-middle-class, core middle-class and upper-middle classes) (Daza and Cortes, 2013; Vaughan-Whitehead, Vasquez-Alvarez and Maître, 2016), but also involve limitations. On the one hand, relative measures do not necessarily ensure that the so-called middle-class access wealth and services that are different from vulnerable or even poor groups (Carbajal and Rovner, 2014). Moreover, these measures hardly allow adequate standards for cross-country comparisons, especially in the developing world, as the group considered middle-class in one country may not be so under the parameters of other countries (Birdsall, 2010). On the other hand, whilst absolute measures enhance cross-country comparisons by determining specific levels of income or consumption (PPP-adjusted), there is still the matter of the arbitrariness of the thresholds. Furthermore, critics have contended that income-based measures fail to consider other conditions (e.g. income stability and the variability of employment conditions in a given income segment) that might hamper the endurance of the middle-class position as well as their lack of a definition built upon sociologically distinctive features (Adamovsky, 2014).

[16] Relative measures locate individuals in a defined income (or consume) section within the country income distribution. For instance, Birdsall *et al.* (2000) consider within the middle-class a range of between 0.75 and 1.25 the median income; and Solimano *et al.* (2008), working on Latin America, include from decile 3 to 8.

[17] Absolute measures establish specific thresholds (e.g. PPP dollars). For instance, Banerjee and Duflo (2008) include in the middle-class individuals living with per capita expenditure 2-10 dollars (PPP) a day. For developing countries, Ravallion (2010) consider within the middle-class a consume per capita between the median poverty line of 70 developing countries ($2 a day) and the USA poverty line ($13 a day), whilst for Latin America, López-Calva and Ortiz-Juárez (2014) include in the middle-class non-vulnerable people (i.e. less than 10% probability of falling into poverty).

As an alternative to deal with these controversies, some authors have used an integrated approach, trying to capture both the size and perceptions (e.g. sense of belonging, experiences of security/insecurity) of the middle-class. For example, Vaughan-Whitehead, Vasquez-Alvarez and Maître (2016) incorporate two economically-oriented measures (i.e. job-based income and augmented-income[18]), one sociologically-led measure (i.e. categories of occupation), and one perceptual measure (i.e. self-definition) to identify the middle-class. Nonetheless, these eclectic proposals also fail in offering a clear definition of what is the defining condition of being middle-class and risk grouping together groups that have very little in common.

3.4.2) Evolution of the middle-classes in Latin America

In addition to the difficulties in conceptually and operationally framing the middle-classes, the Latin American region presents certain peculiarities that need to be considered. The previous chapters discussed how the processes of class structuration in this region differ from those observed in the developed world. Indeed, the expansion and consolidation of the middle-classes remained restricted for most of the 20th century, because of the features of the labour market (i.e. the large size of the informal economy and the agricultural sector), the high levels of inequality, and the predominance of exclusionary social policy systems that did very little for social redistribution (Huber and Stephens, 2012). Even near the end of the past century, the middle-classes barely exceeded 20% of the regional population, either from an income-based perspective (UNDP, 2016) or when applying an employment-based schema (Portes and Hoffman, 2003)[19].

Nonetheless, in recent years the situation seems to be changing, with an increasing number of studies pointing out the growing presence of middle-classes that has accompanied poverty reduction in the region. For instance, an inquiry conducted by Franco, Hopenhayn and León (2011), which considered occupational categories and income, shows that between 1990 and 2007, the number of middle-class households increased by 56 million[20], reaching around 50% of households in Argentina, Brazil, Chile, Costa Rica, Mexico, and Panama. Also, a regional study by López-Calva et al. (2014), using absolute income measures and income vulnerability (i.e. probability of falling into poverty), states that the group rose from 21.9% in 2000 to 34.3% in 2012. Moreover, the Regional Human Development Report for Latin America and the Caribbean indicated 34.6% of middle-class population circa 2013 (UNDP, 2016), thus surpassing for the first time the percentage of people living in poverty. Scholars such as López-Calva et al. (2014) and Daude et al. (2017), claim, however, that Latin America is not yet a middle-class society. The former point out that two-thirds of the regional population remain poor or vulnerable to poverty

[18] The households´ wealth or capital.

[19] Since the schema developed by Portes and Hoffman does not distinguish a middle-class as such, this calculation considers as middle-class the group of professionals, petty bourgeoisie and non-manual employees. By 2000, these groups represented 2.8%, 8.5%, and 12.4%, respectively, for eight countries of the region, totalling 23.7%.

[20] The study comprised 10 countries that represent 80% of the Latin America´s population.

and the latter emphasise that the recorded increase in the emerging middle-class hides their fragility.

Another recent study that involved applying an adaptation of the Goldthorpe class schema to nine Latin American countries questions the expansion of the middle-class, arguing that it is hindered by the slow pace of non-manual classes´ enlargement and the persistence of massive inequalities between formal and informal manual classes (Solís, Chavéz Molina and Conbos, 2019). Also, the study shows a strong association between (occupational) class, access to social protection, and monetary income. The authors argue that, because of the high inequality in the region, class positions are significantly associated with access to social welfare and income level.

3.4.3) Middle-classes´ heterogeneity and fragmentation

Aside from the discussion regarding its size, recent studies indicate that instead of a single group, the contemporary middle-class is enormously diverse and fragmented (UNDP, 2019). Consistently, most studies in Latin America have shown significant variability within this broad category, stressing that a large proportion of the so-called middle-class is not yet consolidated, but rather, fragile against economic and life-course shocks (e.g. Franco, Hopenhayn and León, 2011; Torche and Lopez-Calva, 2013; Castellani, Parent and Zentero, 2014; Penfold and Rodríguez Guzmán, 2014; Stampini et al., 2015). Franco, Hopenhayn and León (2011), for instance, argue that, despite shared patterns of consumption, the differences between the various middle-class segments are remarkable in terms of categories of occupation, lifestyles, and place of residency. They differentiate three segments based on income (i.e. the consistent middle-class, the inconsistent middle-class, and the precarious middle-class), two hierarchical substrata based on occupation and sector or category of employment (i.e. upper and lower), and horizontal segments based on the sector of employment (i.e. public- and private-sector employment) and status of the job (i.e. wage and own-account employment). Consequently, it is feasible to expect broad heterogeneity regarding their possibilities of access, preferences, practices and ways of relating to the public and the private for achieving social welfare.

The consensus regarding the heterogeneity of the middle-class, but not its size nor distinctive features, has led to the examination of further dimensions, such as the values, expectations, preferences, involvement in social mobilisation, and patterns of consumption at both the regional level and within countries (see López-Calva, Rigolini and Torche, 2012; Carbajal and Rovner, 2014; Penfold and Rodríguez Guzmán, 2014; PNUD, 2017; Colafranceschi, Leites and Salas, 2018). At the regional level, a study carried out in six Latin American countries by López-Calva, Rigolini and Torche (2012) examines middle-class(es)´ values and political orientations, establishing a significant association between income, on the one hand, and political values and social orientations, on the other. The relation found is monotonic, namely that middle-classes´ values are placed in between the those of the better-off and the poor, such that they tend towards moderation. The inquiry also reveals a positive association between higher education and left-wing ideology as well as between higher income and more conservative orientations. Moreover, values notoriously differ across countries, thus suggesting that each society

importantly bounds them. The authors also acknowledge that other conditions, not-included in the statistical models, may be intervening and hence, the need for further research to determine the drivers of middle-classes´ values.

Also, analysis conducted by Penfold and Rodríguez Guzmán (2014) shows controversies throughout the middle-classes regarding expectations of social protection, with more favourable positions for the state responsibility in lower-income groups, whereas higher-income earners exhibit more willingness for individual responsibility. The study also identifies differences between countries, with the Uruguayan and the Chilean middle-classes being more reliant on state-provided social protection, whereas in El Salvador and Peru, the middle-classes favour more individual responsibility. Regarding social mobilisation, the authors point out that the increasing number of civil society demonstrations in the region reveals the disposition of the middle-classes to adopt an active role in social change. The World Development Report 2017 supports this view, underlining that the growing middle-classes in Latin America are demanding better-quality services and better governance (WB, 2017).

More recently, Daude et al. (2017) empirically explored people´s self-reports on the use and satisfaction with public health care and education, testing the widely accepted idea of the tendency of the middle-classes to opting-out from public services. The findings showed that dissatisfaction with public services grows with income. Nevertheless, the authors did not find a clear association between perceptions of low-quality and practices of opting-out.

Despite these studies not representing all the research conducted at the regional level on the middle-classes, they are among the most relevant and illustrate the main lines of research undertaken so far. The evidence supports that the middle-classes have grown all across the region, whilst also uncovering their heterogeneity and the fragility of some groups that remain highly vulnerable. Cross-country comparisons have shed light on some elements but also, such as López-Calva, Rigolini and Torche (2012), stress that there is a need for continuing delving into these groups to understand better the processes of class-formation and evolution, their composition, expectations, orientations and practices, as well as the role that they can play in the future of the region.

Concerning the relationship between the middle-classes and social welfare, even in the European context, authors identify the need for further comparative analysis of the practices that these social groups perform to meet their welfare needs in different areas (see Deacon and Cohen, 2011). In Latin America and the health care domain, this lack of knowledge is even more accentuated. Very little has been investigated regarding both the middle-classes´ practices for achieving social welfare and their role in the development and sustainability of welfare policies. As mentioned in the introductory chapter, only one recently published comparative study (i.e. Vera-Rojas and Budowski, 2017) focuses on the middle-income strata´s experiences and practices for dealing with their health care needs, in this case, regarding two Latin American countries. Hence, this study is pioneering an area of research largely neglected. Yet, it does not delve into the relationship between those experiences and practices, on the one hand, and the policy architectures of health care, and the structure of the welfare regimes of the studied countries, on the other.

Last but not least, the unsolved controversies about the key features that define the middle-classes, along with the agreement on its increasing heterogeneity, indicate that an approach embedded in the context may result in overcoming the mentioned gaps of knowledge. Consequently, for this thesis, the existing approaches are used as a starting point to be complemented by re-definitions grounded on the contextualised findings. Such an approach is not new for studies relying on qualitative comparative methodologies that work on structuring context-sensitive strategies to facilitate meaningful comparisons without losing methodological accuracy (see Carmel, 1999). This is also why it seems more relevant to use the expression ´middle-classes` in the plural rather than referring to the ´middle-class` as a single and homogeneous category. Moreover, in consideration of the issues addressed by this research, it seems sensible to pay attention to Birdsall's (2010) warning, mentioned in the previous chapter, regarding the loose definition of the middle-classes that is usually adopted in the developing world, including groups that are highly fragile and exposed to fall into poverty and, therefore, far from the standards that developed countries require to grant this category. Hence, as explained in the next section, this research is aimed at being more demanding when defining the target group that will be considered middle-class.

3.5.- Methodology

According to critical realism, methodological strategies for developing social research must have solid and coherent linkages with the ontological and epistemological premises on which the social inquiry is founded (Archer, 1995). Therefore, to better understand and evaluate the methodology proposed by this research, it is helpful to bear in mind the ontological and epistemological principles that guide it. Regarding the former, Section 3.2 presented the key critical realist ontological assumptions, such as that reality exists independently of the knowledge about it; the differentiation of the real, actual and empirical domains; the conceptualisation of society as composed by structures with generative mechanisms and causal powers that interact with each other to produce tendencies that actualise according to contingent conditions of the context; and the role played by human beings through social agency in the unfolding of social processes.

As for the epistemological principles, they stand up over the idea of the irreducibility of the real to our knowledge about it and therefore, the irreducibility of ontology to epistemology. That is one of the most significant differences between critical realism, on the one hand, and constructivism and positivism, on the other (Fletcher, 2016). Then, critical realists propose a fallibilist epistemology, according to which there is no unmediated access to reality (Archer, 1995), as our knowledge of the world depends on our standpoint, which arises from the available descriptions and discourses (Sayer, 2000).

For critical realism, explanations are about processes and tendencies, rather than patterns or regularities. These explanations can be uncovered by articulating empirically observable outcomes to the structures from which generative mechanisms emerge in a particular context.

With this perspective, researchers must follow a two-fold strategy, that is, identifying the generative mechanism and determining the conditions framing the observed outcomes (Scott, 2014).

Critical realist research can rely on various methodological strategies (Ackroyd and Karlsson, 2014; Fletcher, 2016), but the selected one must be strongly theory-led. Under this premise, the following subsection describes the research design utilised to respond to the central questions of this thesis.

3.5.1) Research design

3.5.1.1. Type of design

Critical realist researchers have followed some recurrent research designs, the hallmark of which is the utilisation of *abductive* and *retroductive* logics which go beyond inductive and deductive processes (Ackroyd and Karlsson, 2014; Bhaskar, 2014) by adding theory to the empirical observation. Abduction and retroduction have the potential of developing explanations on mechanisms that cannot be directly observed (Ackroyd and Karlsson, 2014; O´Mahoney and Vincent, 2014).

Abduction, also known as re-description, is the theoretically-guided enquiry of data. This involves going to data (the empiric) and re-describing observable events using theoretical concepts in order to give an account of a mechanism or a process that explains such events (Bhaskar, 2014). It involves combining observations and linking them to the existent theoretical body to achieve the most plausible explanation of the mechanisms behind the observed events (O´Mahoney and Vincent, 2014). Retroduction, in turn, involves attempting to identify the necessary contextual conditions for a particular mechanism to operate, so that it results in the observed empirical effects (Fletcher, 2016). In other words, it means clarifying the conditions for the studied social event to take place.

Social researchers can undertake abduction and retroduction in different degrees depending on whether the priority is unveiling generative mechanisms or giving a detailed account of the context in which mechanisms that are already known operate. In the first case, the research needs to follow a more intensive strategy, whereas when the focus is on the context, the strategy should be more extensive (Ackroyd and Karlsson, 2014). Based on this premise, for this thesis, a **comparative case analysis design** is adopted. Case studies prioritise an intensive strategy that allows for higher sensitivity for identifying generative mechanisms (Ackroyd and Karlsson, 2014). Moreover, comparative studies enable consideration of the interaction of such mechanisms with contextual circumstances (Sayer, 2000; Parr, 2015).

Case analysis, also known as case studies, is characterised by an in-depth exploration of programmes, events, activities, processes or individuals through various data collection procedures (Stake, 1995). A comparative design based on a small number of cases allows for in-

depth analysis and a focus on causation (Kessler and Bach, 2014), that is, it ´[…] helps to clarify both the nature of a mechanism and the range of variation in both process and outcome that can occur` (Ackroyd and Karlsson, 2014, p.31). Thus, comparative studies are suitable for a deeper understanding of social reality and to achieve explanations and theoretical generalisations from the cases studied (Hantrais and Mangen, 1996).

In particular, for this thesis, **cross-national comparative research** is undertaken, relying on the same framework of analysis and procedures to study different countries which, as Marmor, Freeman and Okma (2015) stress, enables the achievement of generalisation. In such a way, albeit the proposed framework recognises the particularities of each case studied, this does not mean that the research is only limited to the particular cases under study. Rather, to the extent that generative mechanisms are illuminated, they allow analysing other cases, always considering that the actual operation of those mechanisms is inevitably subjected to the contingent contextual conditions.

3.5.1.2. Selection of cases

The selection of cases is a critical issue for developing comparative research. In order to follow the critical realist principles, the cases for this investigation were selected based on theoretical considerations. I selected three countries, namely Chile, Uruguay and Ecuador, which belong to the three clusters of the Martínez Franzoni (2007) typology of welfare regimes examined in Subsection 2.3.1. I decided to rely on this typology, because it is the most recent that integrates different dimensions beyond the action of the state (see discussion in Chapter II, Subsection 2.3.1). Table 3.1. summarises the main features of the three clusters of welfare regimes identified by Martínez Franzoni, according to the four analytical dimensions considered by this typology.

Table 3.1. Martínez Franzoni's (2007, 2008) typology of Latin American welfare regimes by dimensions of commodification, decommodification, defamilisation and outcomes.

	Cluster 1: State-productivist welfare regimes (Argentina and Chile)	**Cluster 2: State-protectionist welfare regimes (Brazil, Costa Rica, Mexico, Panama and Uruguay)**	**Cluster 3: Non-state familist welfare regimes (Familist sub-cluster: Colombia, Ecuador, El Salvador, Guatemala, Peru, Dominic Republic and Venezuela; Highly familist sub-cluster: Bolivia, Honduras, Nicaragua and Paraguay)**
Commodification in the labour market	Labour force formalisation is higher, but self-employed represent 16%-20% of the labour force. Higher income levels and lower share of poverty. Predominantly urban population.	Labour force formalisation is higher, but self-employed represent 16%-20% of the labour force. Medium income levels. Share of poverty slightly above cluster 1. Predominantly urban population.	Lower formalisation of the labour force. Self-employed workers represent most of the labour force. Lower income levels and higher share of poverty. Predominantly rural population.
Decommodification of welfare	Public spending higher than in the other two clusters, but the fiscal priority of social policies is slightly lower than in cluster 2. Proportion of salaried workers with social insurance lower than in cluster 2. Proportion of the EAP in the public sector higher than the other two clusters. Proportion of enrolment in private education higher than for the other two clusters. Social protection predominantly individual, labour-related and pro-poor. Subsidiary state.	Public spending lower than cluster 1 and higher than cluster 3. Higher fiscal priority of social policies. Proportion of salaried workers with social insurance higher than in the other two clusters. Proportion of the EAP in the public sector lower than cluster 1 and higher than cluster 3. Proportion of enrolment in private education lower than the other two clusters. Social protection predominantly stratified and pro-formal labour. Relatively interventionist state.	Public spending consistently lower than in the other two clusters. Proportion of salaried workers with social insurance very low. Proportion of the EAP in the public sector lower than the other two clusters. Proportion of enrolment in private education lower than cluster 1 and higher than cluster 2. Social protection predominantly individual and limited to small sectors of the population. Subsidiary state.

Defamilisation of welfare	Demographic transition is advanced, and the demand for unpaid work is lower than in cluster 3. Overall welfare defamilisation is low, and the sexual division of work is still prominent. However, families have more support from the state and labour market than in cluster 3.	Demographic transition is less advanced than in cluster 1, but the demand for unpaid work is similar to that cluster. Overall welfare defamilisation is low, and the sexual division of work is still prominent. However, families have more support from the state and labour market than for cluster 3.	Demographic transition is incipient. There is a higher demand for unpaid work than in clusters 1 and 2. Overall welfare defamilisation is very low, and the sexual division of work is still quite prominent. Families cannot rely on the state and labour market.
Outcomes of quality of life and wellbeing	Similar performance in terms of quality of life and wellbeing outcomes as in cluster 2, but greater than in cluster 3.	Similar performance in terms of quality of life and wellbeing outcomes as in cluster 1, but greater than in cluster 3.	Lower performance in terms of quality of life and wellbeing outcomes than in clusters 1 and 2.

Own elaboration based on Martínez Franzoni (2007, 2008).

Using a design of most contrasting cases in terms of their welfare regime allows for identifying what are the conditionings generated by different contexts on the relationship between policy architectures of health care and the middle-classes. This involves not only examining the type of policy architecture or the type of middle-classes´ practices for health care that are generated but also, how the context of the welfare regime leads to the production of certain outputs from the relationship between them. This, in turn, contributes to the relevance and generalisability of the findings as it identifies generative mechanisms, whilst also specifying what outputs they produce in the focal context of operation.

Chile and Argentina belong to the cluster of ***State-productivist welfare regimes***. The reason for selecting Chile is that, when compared with Argentina, this country reveals a higher prominence of those features attributed to such regimes. This, especially considering that, from 2001 onwards, Argentina progressively increased the participation of the central state in social protection, addressing universal policies through a combination of contributory and non-contributory instruments (Repetto and Potenza Dal Masetto, 2012). Chile, in contrast, has retained a significant participation of private actors in welfare provision, which is a legacy of the reforms applied by the military dictatorship (1973-1990). The scarce decommodification of welfare might be considered as one of the most determining points in the Chilean model, illustrated by the significant presence of private insurance for health care (ISAPRES) (Cid et al., 2014), private education (OECD, 2014), and the control of the old-age pension system by private institutions (AFPs) (SSA, 2016), among others.

Uruguay, together with Brazil, Costa Rica, Mexico and Panama, is considered a ***State-protectionist welfare regime***. The decision to study Uruguay within this cluster is because, unlike what has happened in countries, such as Mexico and Costa Rica, it has maintained the state at the centre of welfare provision, and the market option has remained limited. In fact, this country has been identified as one of the most generous social states in the region (Huber and Stephens, 2012; Martínez Franzoni and Sánchez-Ancochea, 2014) and since 2005, governments have promoted a number of important reforms aimed at expanding social protection to the whole population as a social right (Filgueira, F. and Hernández, 2012). In turn, Panama was not selected, because this would imply considering variables that are beyond the scope of this study due to the strong influence that the USA has had on the republican history of this country. Finally, the prioritisation of Uruguay over Brazil was because the size, the socio-territorial heterogeneity and the different language of the latter, represent complexities not easy to overcome.

Finally, **Ecuador** is part of the ***Non-state familist welfare regimes***. This is the biggest cluster in the typology and encompasses two qualitatively similar, but quantitatively different sub-clusters: familist (Colombia, Ecuador, El Salvador, Guatemala, Peru, Dominic Republic and Venezuela) and a highly familist (Bolivia, Honduras, Nicaragua and Paraguay), both featured by the limited scope of social policies (Martínez Franzoni, 2007).

Within this cluster, I considered Ecuador as a case of great interest, since, with the turn to the left begun in 2007, the country started a process of profound reforms in different social policy areas, seeking to leave behind the exclusionary character that historically characterised its

welfare regime and transit towards a more protective model (see Minteguiaga and Ubasart-González, 2014; Naranjo Bonilla, 2014; Ubasart-González and Minteguiaga, 2021). In particular, I considered it informative to analyse access to health care framed by the transformations undertaken towards universalism in the context of a familist welfare regime.

In addition, there are four main reasons that I considered for not selecting any of the other countries of this cluster. Firstly, I dismissed countries belonging to the highly familist sub-cluster as the extremely precarious development of their welfare systems virtually eliminates the households´ possibility of actually relying on social policies. Secondly, within the familist sub-cluster, I decided not to select Colombia, El Salvador and Guatemala due to the high levels of street violence and criminality they exhibit, which made it difficult to carry out fieldwork there, especially for foreigners. Thirdly, Venezuela was not selected because of the political crisis the country has been facing for several years. Finally, the option of Ecuador over Peru fitted with the intention of not limiting the research exclusively to Southern Cone countries.

In sum, the countries selected represent welfare regimes with notoriously different realities, namely two of them characterised by extended and well-institutionalised social policies (i.e. Chile and Uruguay), although with significant differences regarding the role adopted by the state and the market, and another, by a not yet extended nor well institutionalised welfare system, where social welfare still depends importantly on families (i.e. Ecuador). Grounded on these differences, it is possible to capture the distinctive conditionings over the policy architecture / middle-classes relationship arising from welfare regimes with uneven degrees of decommodification, commodification in the labour market and defamilisation.

3.5.1.3. Research stages

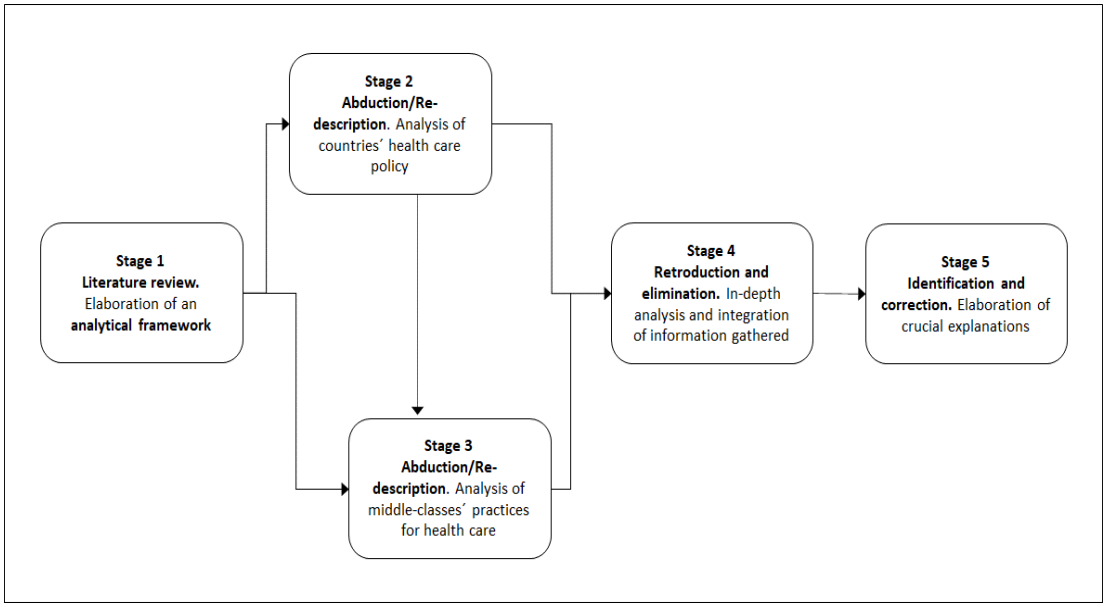
The methodology for developing this research encompassed **five stages**, as summarised in figure 3.3, which were carried out consecutively, although not in a strictly linear way. These stages integrate the contributions of different authors who have conducted social research following the critical realist approach, which are briefly compared in Table 3.2.

Table 3.2. Stages of social research based on a critical realist approach

DREIC Model (Bhaskar, 2015)	**Critical realist method** (Fletcher, 2016)	**Critical realist method** (Scott, 2014)	**Iterative abstraction** (Yeung, 1997)
		Reasoning and analysing causal laws as expressions of the tendencies of natural and social objects	***Literature review***: identification of possible causal mechanisms
	Identification of demi-regularities: when it is possible to make identification of previous trends	***Resolving*** a concrete event occurring in a context into its components	Development of an **analytical framework** with the main interactions being considered
Description of patterns of events or phenomena	***Abduction*** (also known as theoretical ***re-description***): Empirical data are re-described using theoretical concepts	***Re-describing*** the components in theoretically significant ways	***Empirical validation***: by means of intensive and/or extensive methods. ***Iterative abstractions***: re-reading of the initial propositions based on the empirical findings
Retroduction of possible explanatory mechanisms or structures, involving a disjunctive plurality of alternatives	***Retroduction*** to identify the necessary contextual conditions for a particular causal mechanism to take effect and to result in the empirical trends observed	***Retroductive*** moving from describing the components of an event to proposing explanations about what produces or are the conditions for the event.	Identification and differentiation of ***causal mechanisms*** and ***contextual contingencies***
Elimination of competing alternatives		***Eliminating*** alternative possible explanations	
Identification of the causally efficacious generative mechanism(s) or structure.		***Identifying*** crucial explanations	
Correction of earlier findings in the light of the previous identification		***Correcting*** earlier proposed explanations in the light of the temporarily completed analysis	
		Explaining the parameters of these subsequent explanations and how they relate to the ontology and epistemology of the world	

Own elaboration

Figure 3.3. Methodological stages for this research



Source: Own elaboration

Hereafter, each stage is explained in more detail.

Stage 1 Literature review, elaboration of an analytical framework and methodological design

This stage involved the review of relevant literature in order to achieve an adequate definition of the research problem and to identify the theories and concepts required to address it. In critical realist terminology, this pertains to unpacking the concrete event to be studied into its components, linking these in theoretically significant ways (Yeung, 1997; Scott, 2014) and identifying previous trends where possible, (Fletcher, 2016). Most of this stage was undertaken when elaborating the research proposal. However, additional revisions and reformulations were made throughout the whole process of research, especially at the beginning of the empirical work.

Stage 2 Analysis of countries´ health care policy

This stage was aimed at responding to the first research question, namely ´how does the policy architecture of health care contribute to universal or segmented health care?`. In critical realist language, this stage corresponded to the *abductive* process (also known as *re-description*), which involves gathering empirical information followed by analysing and re-describing these findings using theoretical concepts (Fletcher, 2016). For this procedure, I also returned to the analytical framework to re-read the initial propositions (Yeung, 1997) and generate more refined tentative propositions.

The analysis conducted in this stage started by reviewing the welfare regime prevailing in each country, in which health policy is embedded. I built an up-to-date examination of the countries´ welfare regimes relying on the four dimensions and indicators used by Martínez Franzoni (2007), which corresponded to data from the early 21st century. Nonetheless, some indicators shifted due to availability issues and to maintain comparability between the three analysed countries. Appendix 1 presents the list of indicators used in the original typology and those I used to update each dimension.

The second step was to examine, for each country, the trajectory of health care policy and the architecture and outputs of the current one. For this purpose, I used document analysis of secondary sources, including governments´ reports, public accounts elaborated by governments and international organisations, and scientific publications. I complimented the analysis of policy architectures with interviews with six policy-makers (two per country), including former vice ministers and other high-level decision-makers as well as nine scholars (see the list of interviewees in Appendix 2). I relied on these interviews to fill gaps in information and to clarify grey areas (Pierce, 2008), but did not use them to analyse politicians or experts' views of the policy.

The analysis of policy architectures was based on the model developed by Martínez Franzoni and Sánchez-Ancochea (2016b), paying particular attention to the implications of the arrangements of the architecture for middle-classes´ access to health care. According to this framework, the examination encompassed five policy instruments and their interactions:

- *Entry*: the definition of who, and under what criteria, is entitled to be covered and receive the service in each co-existing scheme;
- *Funding*: considers the existence of state subsidies, identifying funding sources and the relationship between them, the pooling of resources as well as the progressivity of revenue collection and allocation;
- *Benefits*: who defines benefits and what is included;
- *Delivery*: who provides services for whom, purchasing private services by the public sector, vouchers and co-payments for private provision;
- *Outside option*: considers the regulation and size of the outside market-based options and the extent of integration into the health system.

The analysis of policy outputs involved coverage, generosity, financial protection, sufficiency and equity as the five dimensions that, according to the definition presented in Chapter II (Subsection 2.2.3), are involved in the production of universal health care. It is worth noting that for analysing universalism in health care, I relied upon the available information for each country (i.e. secondary sources), as I did not intend to develop my own assessment of universalism in health care. To do so would have necessitated building suitable and comparable indicators by conducting primary data analysis, which would have been beyond the scope of this research. Hence, I had to deal with the limitations and unevenness of the availability of information between the studied countries. This means that, whilst this research can distinguish which country has achieved greater universalism, it cannot determine exactly how much difference there is between them, since it is not measuring universalism, which is one of the limitations of this piece of work. In the analyses, I focused on building a picture of the

universalism/segmentation of health care access by determining not only the averages of sufficiency, but also, the evenness throughout the entire population, that is, to analyse whether access is equitable across groups. Moreover, whenever it was feasible, I analysed the particular situation of the middle-classes in this regard.

For coverage, I considered[21] overall population coverage; coverage by scheme or type of insurance; coverage by age, sex, education level, income level, and occupational category or level of welfare as proxies to social class. Regarding generosity, the analysis sought to approach the comprehensiveness and quality of services delivered. With this aim, I considered as proxies the total and public expenditure in health, resources per capita by scheme or type of insurance, human resources and waiting lists. Nevertheless, several of these indicators were not available, especially for Ecuador. As for financial protection, the analysis was focused on public subsidies, prepayments for private health insurance or other complementary benefits, co-payments and other OOP spending and service utilisation. Finally, the two cross-sectional dimensions, namely sufficiency and equity, were analysed in relation to each of the other three dimensions and their respective indicators (see Figure 2.3).

Stage 3 Analysis of middle-classes´ perceptions and practices for health care

Similar to the previous one, this stage contributed to the *abductive* process, which in this case was aimed at ascertaining how the middle-classes´ practices for health care have been conditioned by the policy architecture and the context (i.e. second research question). This also allowed for the subsequent identification of generative mechanisms that connect these practices with the policy architectures and policy outputs (i.e. third research question).

The first step of this stage was gathering information through **semi-structured interviews**. Interview patterns included open questions and vignettes, both based on the research´s analytical framework and on the analysis of the welfare regime, policy architectures and outputs carried out in the previous stages.

The utilisation of semi-structured interviews contributed to delving into interviewees´ perceptions of the health system and their practices to meet their health care needs. The interview structure allowed for enough flexibility and openness of questions, thus giving the possibility for the emergence of content that would not necessarily be anticipated. Additionally, the vignettes were intended to facilitate knowledge about the practices in specific hypothetical situations. As vignettes are less threatening than more 'direct' questioning techniques, they facilitate the exploration of potentially sensitive issues and systematic comparisons both within and between countries (Fitzpatrick and Stephens, 2014). They allowed for the stimulus to be held constant across a heterogeneous group of respondents (Soydan, 1996).

[21] Whenever it was possible, I included all these variables in the analysis. However, as can be seen in the development of the case studies, in some of them there were significant gaps in information.

Nonetheless, different to what I expected, the responses to the vignettes did not add new information, but rather, just corroborated what was already present in the interviewees´ narratives in response to the interview questions. The vignettes were presented in the middle of the interview, before asking evaluative questions, so that the judgments expressed by the interviewees did not interfere with their responses to the vignettes. It is possible that these contributed little or that they were not necessary, because the interviewees understood the reasons for their practices for health care and did not feel in conflict with them.

The dimensions considered during the interviews were:

- Perceptions about the overall health care system
- Perceptions of the different schemes/sectors of the health system
- Assessments about the health care system
- Experience of security/insecurity
- Expectations of the health system
- Practices of insurance
- Practices of health care seeking: relationship with public/private providers
- Need of family/community or other type of support

Questions and vignettes focused on households as a whole, and not on the individual members. Interviews were conducted with any ´competent` adult of middle-classes households, meaning adults who are aware of the household´s practices for health care and who participate in decision-making regarding such practices.

Operationally defining middle-classes households in the three countries studied was challenging. The understanding of the contemporary middle-classes in Latin America is limited (Hopenhayn, 2010) and, although there are some exceptions (see for example López-Calva, Rigolini and Torche, 2012; Daza and Cortes, 2013; Torche and Lopez-Calva, 2013; Lopez-Calva and Ortiz-Juarez, 2014), most studies have focused on quantifying the size of this group or its capacity for consumption, rather than on profiling its composition, income and educational levels, and/or cultural and political preferences.

Based on the discussion presented in Section 3.4, I opted to favour more demanding criteria to ensure exhaustiveness, rather than inclusivity. Hence, I used an integrated approach that requires income, occupation and self-definition to define someone as part of the middle-classes. I sought mainly to include households that may be considered as belonging to the consolidated middle-classes, as it could ensure that households included in the study actually belong to them and are not part of the so-called vulnerable groups or emergent middle-classes.

In view of these considerations, I used the following four criteria:

- Households whose main income is job-based;
- Households with an income level that allows them to opt for public or private insurance and/or services;
- Households in which the active members work in occupational categories traditionally associated with the middle-classes. I specifically included civil servants, professionals who were employed or self-employed (i.e. liberal professions) or ran small-businesses;
- Households whose members defined themselves as belonging to the middle-classes.

Additionally, in order to safeguard the heterogeneity of interviewees in terms of other characteristics than the belonging to the middle-classes, the sample was composed of individuals working in the public and private sectors, males and females, people of different ages, those occupying heterogeneous positions within the households as well as those participating or not in social movements. Moreover, scholars in Uruguay recommended considering the university where professionals studied as an additional criterion to access heterogeneous groups. Hence, for this country, the sample included both professionals who had studied in the public university and in private educational institutions. Appendix 2 presents a detailed account of the sample. The corollary of these methodological options is that, because of the small size of the sample, it does not enable the analysis of the role that sociodemographic characteristics, such as gender, age, employment status, education, among others, may have in explaining differences in the practices for health care identified within the sample in each country. This constitutes one of the limitations of this study, namely the prioritisation of in-depth analysis from a small sample.

Overall, I conducted 18 interviews with members of middle-classes households in each country, which is a total of 54. For the recruitment process, I used snowball sampling, but taking at least three different starting points in each country in order to ensure their heterogeneity. The initial contact for potential participants was an invitation in person, a telephone call or an email, depending on the case. In this first contact, I stated that there would be informed consent and offered information about the research aims and the general topic of discussion of the interview. The interview date and location were agreed with the participants.

In the three countries, I reached the point of saturation of information after around 14 – 15 interviews, which refers to the absence of narratives of practices that could not be classified into the categories that had already emerged and had been reiterated among interviewees. However, I decided to conduct a few extra interviews, up to the abovementioned 18 in total. All the interviews were conducted in the capital cities and hence, the findings and analyses presented are only applicable to urban areas. This methodological decision responded to the limitations in the availability of private services, and sometimes even public ones, in rural areas, which may influence the range of practices deployed to achieve health care.

It is important to point out that this sample was not aimed at being representative. Consistent with the critical realism principles, the sample should be suitable for contributing to the exploration and explanation of the generative mechanisms behind social processes. Hence, the fundamental criterion is not the number of interviews or the representation of the entire society, but rather, their usefulness for delving into the central inquiries of this research.

In the three countries I was hosted by social research centres, specifically in the offices of the Centro de Estudios de Conflicto y Cohesión Social (COES) in Santiago-Chile, the Facultad Latinoamericana de Ciencias Sociales (FLACSO) in Quito-Ecuador and the Faculty of Social Sciences at the Universidad de la República in Montevideo-Uruguay. Scholars of these institutions supported me in adapting the interview patterns as well as the initial identification

and gaining access to sites for conducting interviews, thus contributing to the relevance and feasibility of the fieldwork.

Regarding the procedures to register and analyse information, all interviews were recorded and transcribed verbatim. Moreover, I kept a diary to register my notes, experiences and reflections throughout the fieldwork. Transcriptions of interviews were coded and analysed in NVivo. Regarding the process of codification, I relied on a two-directional procedure. On the one hand, I started from the analytical framework to define codes and build up analytical categories and sub-categories, and on the other, new categories emerged from the interviewees´ narratives. Thus, analytic codes were reformulated during the process, adding new ones, eliminating some and merging others.

Stage 4 In-depth analysis and integration of information gathered

This stage was focused on the in-depth analysis of the information previously gathered and the integration of the different domains of analysis, namely the welfare regimes, policy architectures and middle-classes´ perceptions and practices. During this stage, I also elaborated upon initial explanations on generative mechanisms and contextual circumstances relevant for middle-class households´ perceptions and practices for health care in each country as well as embarking upon some initial comparisons. This corresponds to what critical realist researchers call the process of *retroduction* and *elimination* of alternative explanations.

Retroduction considers proposing possible explanations about the conditions for the event (Collier, 1994; Scott, 2014; Bhaskar, 2015). Thus, this stage involved the careful analysis of how the studied policy architectures and the practices for health care deployed by the middle-classes operate in a specific scenario in light of the main features of their welfare regimes.

As it was highlighted by Bhaskar (2014), ´[…] it will not in general possible to specify how a mechanism operates independently of its context. Hence we must not only relate mechanisms back to explanatory or grounding structures, but also to the context of operation […] we need always to think of a context mechanism couple, C+M, and thus of the triple, mechanism, context, outcome, CMO, or more fully the quartet composed of context, structure, mechanism and outcome, CSMO` (p. viii). Once I had some tentative explanations on the generative mechanisms and contextual circumstances for their operation, I started the process of elimination (see Table 3.2), in which I came back to the relevant literature and to the analytical framework to look at these tentative explanations in the light of previous knowledge.

Stage 5 Elaboration of crucial explanations

The last stage was devoted to correcting the explanations proposed earlier in the light of the completed analysis and explaining the parameters, i.e. the context, that frame these explanations. In the terminology of critical realism, this process corresponds to *identification* and *correction*. In this stage, I focused on the comparisons as the strategy to identify significant

generative mechanisms involved in the relationship between the policy architectures, the middle-classes´ practices, and the policy outputs of health care. I also revisited once again the theoretical and empirical information in order to refine and deepen the explanations developed in the previous stages.

The comparison was developed in stages that were additive in terms of complexity. Initially, it was by domain of analysis, that is, the welfare regime, the trajectories of health policies, the current policy architectures and the perceptions and practices of the middle-classes regarding health care. Subsequently, the comparisons were progressively integrating more areas. For example, comparing the policy architecture in relation to the welfare regime of each country and the historical trajectory that health policy has followed. In the final stage, that is, considering all the domains of analysis, the comparisons allowed me to identify generative mechanisms that, as I argue in Chapter VII, connect health policy, middle-classes' practices and the policy outputs of health care in the context of welfare regimes where occur.

3.5.2) Reflecting on research standards and limitations

Developing critical realist research involves many methodological challenges, as this type aims to address social phenomena by acknowledging their complexity and without isolating them from the context. This also implies criteria for evaluating its strength and rigour different to those used in positivist and constructivist/interpretivist traditions. Broadly speaking, positivist research usually aims to generate ´valid`, ´reliable` and ´generalisable` findings through deductive designs. Quantitative methods, such as questionnaires or scales, are its choice par excellence, as well as the study of large samples designed to represent the population under analysis and the isolation of variables to eliminate external ´interference`. Meanwhile, constructivist research aims to generate knowledge that is historically and culturally embedded, being mostly based on inductive designs and tends to prioritise qualitative methods for gathering information (Pierce, 2008).

The critical realist stance considers other criteria for rigorous research. It emphasises the need for a careful consistency between the ontological and epistemological principles, the theoretical approach and the chosen methodological design (Archer, 1995, 2010). Whilst it allows a variety of research designs and methods, it is key that those chosen explain social processes in terms of their complexity and context, which involves disclosing the generative mechanisms that shape the studied phenomena. Thus, generally, more intensive research designs are prioritised (Sayer, 2000) and it is recommended that the methodology should be based on abductive and retroductive logics (Yeung, 1997; Ackroyd and Karlsson, 2014; Bhaskar, 2014; Scott, 2014; Bhaskar, 2015; Fletcher, 2016). Finally, critical realist research seeks theoretical (transfactual) generalisations, rather than empirical ones (Bhaskar, 2014).

All these criteria were considered throughout this investigative process. The consistency between ontology, epistemology, the theoretical body and the methodological design was taken care of in the development of the analytical framework. It is deliberately concerned with

developing a standpoint coherent with the critical realist principles and useful to orientate the selection of an appropriate methodological design. Moreover, the methodological design is based on the extant scholarship that used a critical realist approach for social research, thus incorporating its central methodological recommendations, such as the utilisation of abduction and retroduction and the selection of an intensive design to disclose the generative mechanisms and their relation with the contexts in which they operate.

In relation to the possibility of making generalisations, as previously argued, this investigation is not designed to generalise on populations through the identification of regular patterns by the application of extensive methods of research. On the contrary, it is expected to achieve theoretical (transfactual) generalisations based on an intensive strategy that enables the identification of the generative mechanisms that drive the studied social processes in a contextually embedded perspective. Thereby, despite this study including only one country per type of welfare regime, the intensive and theoretically-led research design allows for relevant cross-country comparisons likely to be of interest to other countries within the region. However, due to the lack of previous comparative empirical research on the subject matter of this study in Latin America, it is not possible to contrast the findings with other similar studies, which is a limitation.

Regarding the process of interviews, the patterns and vignettes were discussed with other researchers from the host institutions in each country in order to ensure their suitability for each context. This facilitated the adequacy of language and clarity, according to the different studied realities, which implied more than just substituting one concept or word for another. In some instances, it was necessary to move or add questions to accommodate them to the main features of each health system, different features of middle-classes at the cross-national level and the recent history of the country, among others. The vignettes were also slightly adapted in their content and wording in order to avoid ´unrealistic` hypothetical situations for interviewees and maintaining the key issues that they were intended to address.

Whilst the described actions contributed to increasing the rigour of the research process, there were still some limitations. One of these was the small number of interviews (54), which is a relatively common restriction in qualitative research due to the nature of its methods. This was addressed by the rigorous conduct of interviews making all possible efforts to gain an in-depth understanding of the perceptions and practices regarding health care. Secondly, it is necessary to acknowledge that my understandings were inevitably mediated by my particular position in society and background. As it is recognised by the critical realist approach, knowledge is never complete, but it is always socially, culturally and historically located. The means of addressing potential researcher bias during the inquiry were engaging in reflexivity, discussing the findings with other researchers, and being keenly aware of my personal standpoint throughout the process.

Finally, a limitation that cannot be avoided in cross-national social studies is the presence of social and cultural dimensions difficult to capture for a foreign researcher. Whenever it was feasible, I dealt with this limitation by a previous careful revision of those issues that are central

according to the subject matter of this investigation before visiting each country. In addition, I was advised by local scholars who supported me throughout the research process.

3.5.3) Ethical Issues

This study was not aimed at particularly vulnerable groups or discussing especially sensitive topics. The ethics guidelines of the Department of Social and Policy Sciences of the University of Bath were followed and the research was approved by the Department Research Ethics Officer (DREO) on January 5th 2017. Briefly, to avoid deception in any moment of the research, I presented myself as a researcher developing my PhD thesis at the University of Bath and hosted during the fieldwork by the COES in Chile, FLACSO in Ecuador and Universidad de la República in Uruguay. I made clear that to be hosted by these institutions did not mean any compromise with them regarding the study's outcomes.

I discussed with the interviewees the conditions of collaboration verbally and through written informed consent. I stated that participation was on a voluntary basis, with the right of withdrawal at any moment during the conversation and that confidentiality would be assured. There were two copies of this document, one of them for the interviewee and the other was for my records. The informed consent was signed off before starting the interview and included:

- Name of the study
- Identification of the researcher, university and persons to contact in case of questions
- Identification of the sponsor institution
- Expected benefits for participants
- Guarantee of anonymity and confidentiality
- Acknowledgement of the right to refuse to participate or withdraw from the investigation at any time and not having to give a reason
- The promise of providing a copy of the research results, if requested

Moreover, I provided and explained to all interviewees a cover letter with information about the purpose of the study, the researcher, how the study was financed, the plan to disseminate and use the information gathered, and contact information in case participants required additional information. This letter was supported and signed by the host academic institution in each country.

Also, in the development of interview patterns and vignettes, I avoided any stimulus that might be psychologically distressing for the interviewees or someone else. I applied the same care in the circumstances of contact with the interviewees.

To ensure the privacy and confidentiality of the interviews, I took care to manage the setting of the conversation. Most interviews were conducted in the participants´ households and workplaces. They were recorded and confidentially transcribed verbatim, protecting the interviewees´ anonymity and ensuring the contents' accuracy. Interviews were recorded on my

recorder and files saved without using names. The audio files were kept in my personal computer protected by a password and, once transcribed and checked, were eliminated. The transcriptions files were saved with numbers and held on my laptop with a password. The transcriptions did not include the real names of interviewees, their family members, places or any other information that might lead to their identification by the readers except for interviews conducted with scholars and policymakers, who explicitly accepted their identification.

Lastly, I plan to share my final work with the host institutions and persons who participated as interviewees. This will be an opportunity to have their feedback to improve my work. Moreover, this will be a way to thank them for their help, suggestions and collaboration. For interviewees, I will prepare a debriefing document, in which I will include a summary of the study aims, methods, main results and conclusions. This document will also include my contact information for questions about the research and the offer to send them the complete results of the study. Finally, the contribution of institutions and participants will be recognised in future publications.

3.6.- Conclusions

This chapter has set out the analytical and methodological bases for the development of this thesis. The proposed analytical framework relies on the critical realist ontology and includes key conceptual contributions regarding universalism in health care coming from the social policy and health systems scholarship. Building on these traditions and focusing on the relationship between social structures, institutions and agents, rather than isolated variables, the aim was to investigate the connections between policy architectures (i.e. social institutions), middle-classes´ practices (i.e. agency) and outputs of health care in the context of different welfare regimes. Hence, a lens of analysis was adopted that captured the phenomenon as a continuously unfolding process in the production of which different strata participate with their respective generative mechanisms.

The diachronic perspective contributed by the Archers´ morphogenetic model is a fundamental piece of the proposed analytical framework. It allows for analytically differentiating social conditioning, social agency and structural reproduction/elaboration and then, reconstructing explanations capable of identifying the generative mechanisms operating to produce the observed outcomes.

This chapter has also reviewed the conceptual and methodological discussion around the concept of the middle-class in order to define the margins of what is included in this category in the three studied countries. In particular, of relevance to the issues addressed by this thesis is the general agreement regarding the growing presence of the middle-classes in the region, their fragmentation and the fragility of some of the sub-strata distinguished within the middle-classes. Based on this, I have argued for the need to adopt a perspective embedded in the context, with the criteria to include only those belonging to the consolidated middle-class (i.e. a more exhaustive than inclusive operational definition). This decision was aimed at ensuring that the study would effectively be about the middle-classes and not about groups whose belonging

to this category could be contested depending on the applied standard. This is especially important given that the possibilities and dynamics of the relationship of the middle-classes with the public and private health care sectors are central to the topics covered in this research.

Regarding methodology, I argued that it needs to be consistent with the principles of Critical Realism. Based on the review of the methodological strategy adopted by different researchers that followed a Critical Realist approach, I developed a proposal that adopts a comparative case study design and goes through different stages. The result is a theoretically-led strategy that starts from a number of variables identified as relevant by the literature (i.e. universalism, policy architectures, middle-classes, and welfare regimes) and develops an analytical framework that establishes significant relationships between these variables. Then it goes to the field and, based on the empirical findings, revisits the concepts and relationships initially established (i.e. abduction) to later differentiate the generative mechanisms and the contextual conditions in which these mechanisms operate (i.e. retroduction).

With these elements, this chapter wraps up the first part of the thesis to give way to the presentation of the empirical work. An introduction to the country case studies is presented below, specifying their structure and the main aspects to be considered in their elaboration. Subsequently, chapters IV, V and VI address the case studies of each country.

Each of these cases constitutes a study in itself while also being a part of overall research. According to the analytical and methodological proposal for each of the countries, the policy architecture of health care's contribution to universal or segmented health care (first research question) and the middle-classes' practices for health care (second research question) are identified establishing significant links between them and concerning the context in which they occur (i.e. the country's welfare regime). Regarding the generative mechanisms that drive the relationship between these variables (third research question), they are addressed based on the comparative analysis of the case studies as a whole, presented in Chapter VII.

INTRODUCTION TO THE COUNTRY CASE STUDIES

The previous chapters set out the problem to be addressed, defined the theoretical background and analytical framework as well as explaining and justifying the methodological approach to this research. Chapters IV, V and VI present the empirical findings of the country case studies of Chile, Ecuador and Uruguay, respectively.

The proposed analytical framework (see Figure 3.2) advocates for a multi-dimensional and multi-level approach to understanding the relationship between the policy architecture, the middle-classes practices and universalism/segmentation of health care, considering the context of each country. Hence, each case study is aimed at providing a comprehensive picture of the relationships between these domains. To this end, the three case studies are organised with the same structure, that is, examining in detail the different domains considered in the analytical framework and then, uncovering the relevant links between them.

Each chapter comprises a short introduction and five sections, with the three first addressing what was presented in the analytical framework as structural conditioning. That is, they examine how social structures and institutions create specific policy outputs and how they condition the perceptions and practices of social agents, which in this particular case correspond to the middle-classes perceptions and practices for health care. Specifically, Sections 4.2/5.2/6.2 examine the welfare regime that predominates in each country, which shapes the social policy context for the health care policy. The examination takes the Martínez Franzoni (2007) typology of welfare regimes as a starting point and analyses the evolution of the countries´ performance in four dimensions that together constitute the country´s welfare arrangements for social welfare. The dimensions are commodification in the labour market (the labour market's capacity to absorb the labour force and offer good-quality jobs), decommodification of social welfare (the welfare independence from the purchasing capacity), defamilisation of social welfare (the welfare´s independence from family support), and outcomes (the actual performance in wellbeing). The analysis of each dimension is based on relevant indicators covering two points on time, that is data used when the typology was developed (from the early 2000s) and the last available information (2020 or the nearest year) (see Appendix 1).

Subsequently, Sections 4.3/5.3/6.3 review the trajectory of the health care policy and the milestones in the welfare systems development since the early 20th century to the present. This provides a historical dimension to provide understanding as to how the contemporary policy architecture in each country was shaped, the position, power and interests of the different actors regarding the health systems as well as the incentives and constraints that are contributing to the endurance of segmentation or the advance of universal health care.

Sections 4.4/5.4/6.4 address the contemporary policy architecture and policy outputs of health care. They focus on the main schemes, insurance and providers involved in health care provision in each country, whilst excluding small schemes restricted to specific occupational categories (e.g. military and the police). The analysis of policy architectures encompasses the examination of the eligibility criteria, funding arrangements, benefits, provision and regulation of outside market-based options. Special attention is paid to the impact of each of these policy instruments on the middle-classes' access to health care and their contribution to the unity or fragmentation of the health system. In addition, due to its central role in understanding the segmentation and

the paths that the middle-classes follow to access health care, special attention is drawn to the participation of the private sector and its interactions with the whole health system. As for the outputs, the analysis involves the five dimensions stated in Chapters II (Section 2.2) and III (Section 3.5), namely coverage, generosity, financial protection, and sufficiency and equity, as cross-sectional dimensions.

The fifth section addresses what in the analytical framework corresponds to the social agency, namely the role that the middle-classes practices have regarding the reproduction or transformation of the policy architecture and policy outputs of health care. To do so, Sections 4.5/5.5/6.5 reveal the acceptability of the different options encompassed by each system and the sense of security that arises from the different policy configurations and their outputs. Regarding practices, these are grouped into alternative clusters that describe how the middle-classes manage to meet their health care needs in terms of the practices of insurance, care seeking and complementary strategies deployed to strengthen their chances to access high quality health care. Finally, building on the previous analyses, Sections 4.6/5.6/6.6 address how the conditioning exerted by the social context and the policy of health care, along with the middle-classes practices for health care, contribute to advancing universalism or reproducing segmented health care.

CHAPTER IV CHILE: WELFARE REGIME, POLICY ARCHITECTURES OF HEALTH CARE AND MIDDLE-CLASSES PRACTICES FOR HEALTH CARE

4.1.- Introduction

The case study of Chile begins by examining the welfare regime (Section 4.2) that shapes the scene for the health care policy. The up to date information unveils that social welfare in the country significantly depends on the households´ capacity to obtain it in the market, complemented by social policies that decouple social benefits and services from the purchasing capacity for those who fail to do so. Most social benefits and services are organised into two tiers: a commodified one for those who can afford private services and a public one for the rest. Section 4.3 completes the scene in which the current policy architecture of health care takes place by reviewing the health care policy´s historical trajectory. This examination indicates that after decades of fragmentation based on occupational categories, health reforms undertaken during the military dictatorship in the 1980s were crucial to tipping the balance in favour of the private sector. They empowered private actors and created a system that continued to be fragmented, but so forth providing services of different quality according to the payment capacity.

The analysis of the contemporary policy architecture and policy outputs of health care (Section 4.4) unveils the commodification-led fragmentation of the health system. Within the context of a dual public-private health care provision, the policy instruments involve institutional means for opting-out from the public towards the private sector. These means, along with some deficiencies in the outputs of the public sector, push the middle-classes into dealing with market-based options to meet their health needs and thus, reproduce inequities in health care between groups of the population according to their payment capacity. Against this background, Section 4.5. shows that the middle-classes perceive that no public or private options are acceptable enough, as none guarantees quality while protecting against financial hardship. They deploy various individualised practices for health care and mostly rely on private market-based options in care-seeking and insurance. Moreover, individualised strategies are widely used to strengthen access to quality care and cope with financial hardship. The chapter ends (Section 4.6) with an integrative analysis of the different domains addressed throughout the case study being presented. It is argued that the current welfare regime supports a coherent policy architecture that offers health care through multiple tiers in a kind of gradient of generosity and security according to the households' investment ability. In this context, the middle-classes are pushed towards market-based options by a state that, after four decades, continues to be subsidiary to the market. They respond through individualised practices that end up creating a vicious circle that reproduces segmented access to health care and results in their being trapped in the commodified form.

4.2.- The Chilean welfare regime in the 21st century: progress and limits in the achievement of social welfare.

According to the typology of welfare regimes proposed by Martínez Franzoni´s (2007, 2008), Chile belongs to the cluster of state-productivist welfare regimes, meaning that: *i.* People`s welfare primarily depends on their participation in the labour market; *ii.* The state has a

subsidiary role in supporting those who fail to enter the labour market; *iii.* Families play a significant role[22] in the production of social welfare; and *iv.* Outcomes of well-being are favourable in the regional context, but strongly dependent on the payment capacity. The next paragraphs briefly update the country's performance in these realms.

Beginning with the country´s *commodification in the labour market*, the updated review of indicators shows that Chile is continuing to perform better than the Latin American averages and has exhibited some improvements in the last two decades. Less than 30% of jobs are informal, the share of employees has slightly increased, the numbers of working children is low, and unemployment remains at under 10% (Table 5.1). Moreover, the minimum wage rose by 53% from 1990 to 2012 (Ruiz-Tagle and Sehnbruch, 2015), reaching about $USD 480 per month in 2020. Nevertheless, there are significant gaps in employment quality regarding atypical contracts, instability of jobs, and lack of guarantees in essential labour rights (Sehnbruch and Carranza, 2015).

The GNI per capita substantially increased, and the population living in poverty (below $5.50 a day) substantially decreased from 30.4% to 3.6% between 2000 and 2017. In 2010, Chile became an OECD member and in 2012 reached the category of a high-income economy (WB classification). This landscape, however, is undermined by income inequality, despite some decrease throughout the analysed period. Thus, the Human Development Index (HDI) for 2018 falls from 0.843 to 0.710 (a loss of 15.7%) when inequality-adjusted (IHDI) (UNDP, 2018).

Table 4.1. Indicators for the dimension commodification in the labour market for Chile years, 2000 and 2020 (or the nearest year)

Indicator	**Year**	
Economic participation rate (% of the working-age population) [i]	2000: 54.7%	2019: 62.8%
Employees (% of the total employed population) [ii]	2000: 69.4%	2019: 72.8%
Unemployment (Average annual rate) [i]	2000: 9.7%	2019: 7.2%
Women economic participation rate (% of the working-age women population) [i]	2003: 36.6%	2019: 52.5%
Children in employment, total (% of children ages 7-14) [iii]	2003: 4.1%	2012: 4.5%
Share of workers in informal employment (% of non-agricultural employment) [ii] [iV]	2000: 33.1%	2019: 29.2%
GNI per capita, PPP (Constant 2017 international $) [iii]	2000: 14,679	2019: 23,261
Poverty headcount ratio at $5.50 a day (2011 PPP) (% of population) [iii]	2000: 30.4%	2017: 3.6%
Gini coefficient [i]	2000: 0.514	2017: 0.454
Personal remittances received (% of GDP) [iii]	2000: 0.02%	2019: 0.02%
Rural population (% of total population) [i]	2000: 13.9%	2020: 10.3%

[i] ECLAC (2020), CEPALSTAT
[ii] ILO (2021), ILOSTAT
[iii] WB (2021), World Development Indicators
[iV] ILO (2015), KILM 9th ed. for the year 2000

[22] According to the analysis laid out by Martínez Franzoni (2005, 2007, 2008), overall, families still have a decisive role in supporting people against social risks in the three clusters of Latin American welfare regimes, although their involvement is greater in countries belonging to the non-state familist cluster, due to the limited scope of their social policies.

Regarding *decommodification of welfare*, Table 4.2 shows that, between 2000 and 2018, public investment as a percentage of the GDP increased in health, education and overall, but it decreased in social protection (7.7% to 5.7%). Despite the old-age contribution ratio being 55% in 2008, pensions reached near 75% of the population above the retirement age by 2012 owing to the expansion of non-contributory pensions (Bravo et al., 2015). Moreover, the multidimensional index of social protection developed by Ocampo and Gómez-Arteaga (2016) locates the country in the category of comprehensive social protection systems, occupying the second position within the region, only behind Uruguay, for the decade 2002-2012.

Nevertheless, market-based options have noticeable participation in the provision of fundamental social services, and families usually resort to their payment capacity. For example, in 2015, 62% of eligible pupils attended independent private or government-dependent private primary schools; in 2020, 34% of the current health expenditure (CHE) was OOP spending, and private institutions almost entirely manage old-age pensions through individual accounts (SSA, 2016).

Table 4.2. Indicators for the dimension decommodification of social welfare for Chile years, 2000 and 2020 (or the nearest year)

Indicator	Year	
Private health expenditure (% of total health expenditure) [i]	2000: 47%	2018: 40%
Out of pocket health expenditure (% of current health expenditure) [i] [ii]	2000: 43%	2020: 34%
School private enrolment, primary (% of total primary) [iii]	2002: 46.5%	2015: 62.0%
Households and NPISHs final consumption expenditure (% of GDP) [iV]	2000: 64.1%	2019: 63%
General government final consumption expenditure (% of GDP) [iV]	2000: 12.1%	2019: 14.6%
Public expenditure on health care (% of GDP) [V]	2000: 2.7%	2018: 4.9%
Public expenditure on education (% of GDP) [V]	2000: 3.6%	2018: 5.2%
Public expenditure on social protection (% of GDP) [V]	2000: 7.7%	2018: 5.7%
Overall social expenditure (as % of GDP) [V]	2000: 14.2%	2018: 16.4%
Old-age contribution ratio (% labour force) [Vi]	2000: 46.2%	2008: 55.3%
Old-age pensioners recipient ratio above retirement age [Vi]	--	2012: 74.5%

[i] WHO (2020), Global Health Expenditure Database
[ii] year 2020 OECD/WB (2020)
[iii] UNESCO (2021)
[iV] WB (2020), World Development Indicators
[V] ECLAC (2020) , CEPALSTAT
[Vi] ILO (2016), Social Security Inquiry

In the dimension *defamilisation of welfare* (Table 4.3), the share of women aged 15 and over in full-time household chores markedly declined, indicating a lower reliance on female reproductive work, although Ullmann, Maldonado and Rico (2014) point out prominent differences by income level. The proportion of female heads of households increased, the proportion of extended families remained roughly stable, and the ratio of demographic dependency fell due to the decline in fertility rates (WB, 2021).

Table 4.3. Indicators for the dimension defamilisation of social welfare for Chile, years 2000 and 2020 (or the nearest year)

Indicator	Year	
Extended and composite households (% of the total number of households) [i]	2000: 28%	2017: 25.5%
Domestic servants (as % of total employment) [i]	2000: 6%	2017: 3.5%
Women full-time to household chores (% of the population of women aged 15 and over) [i]	2000: 34.9%	2017: 18.5%
Female share of part-time employment (% of total employment) [ii]	2000: 53.9%	2014: 60.2%
Female heads of households (% of the total number of households) [i]	2000: 23.2%	2017: 42.4%
Demographic dependency ratio (children and older persons) [i]	2000: 53.8%	2020: 45.9%

[i] ECLAC, CEPALSTAT
[ii] ILO, KILM 9th ed.

Finally, the country exhibits favourable results in the *outcomes* for quality of life and well-being, considering indicators such as the under-five mortality rate, expected years of schooling, homicide rate, and use of TICs (Table 4.4). These results contribute to the high score of Human Development (HDI) that allocates the country in first place for Latin America (UNDP, 2018). Nonetheless, the Gender Development Index (GDI) is lower than the regional average (0.978 in 2019) and, compared with the OECD`s averages, Chile performs poorly in health status, jobs and earnings, social connections, work-life balance, housing, income and wealth, education and skills, and environmental quality (OECD, 2016a, b).

Table 4.4. Indicators for the dimension outcomes for Chile, years 2000 and 2020 (or the nearest year)

Indicator	Year	
Under-five mortality rate (Deaths per 1,000 live births) [i]	2000: 10.9	2019: 7.0
Expected years of schooling [ii]	2000: 13.3	2019: 16.4
Gender Development Index (GDI) [ii]	2000: 0.934	2019: 0.963
Homicide rate (per 100,000 people) [ii]	2005: 3.6	2018: 4.4
Individuals using the Internet (% of population) [i]	2000: 16.6%	2019: 82.3%

[i] WB (2021), World Development Indicators
[ii] UNDP (2021) , Human Development Data Center

In sum, the country profile has not changed dramatically since the early 2000s, when it was classified as a state-productivist welfare regime, but several indicators have improved. Nonetheless, the country exhibits an uneven performance: while indicators such as the GNI per capita, economic participation rates and public social expenditure may contribute to reaching higher social welfare, others reveal that jobs are of deficient quality and that social welfare is highly market-based, which prevents its decommodification. Table 4.5 summarises the updated features of the Chilean welfare regime by each of the dimensions examined above.

Table 4.5. Updated features of Chilean welfare regime by the dimensions of Martínez Franzoni's (2007) typology of Latin American welfare regimes

	CHILE
Type of welfare regime	**State-productivist welfare regime**
Commodification in the labour market	**High in the regional context, but uneven** Jobs quality is above the regional average, but stagnated from the early 2000s. Economic performance is high with significant decrease of poverty and inequality, but the latter remains high.
Decommodification of welfare	**Limited and dual** Well-developed public welfare system for social assistance. Strongly market-based system for the non-poor.
Defamilisation of welfare	**Moderate** Reliance on families slightly declined associated with decline of dependency ratio and progress in women´s entrance into the labour market.
Outcomes of wellbeing	**High performance** sustained over time

Source: Own elaboration based on Tables 4.1 to 4.4

This overview of the recent evolution and current state of the welfare regime sets the background to understanding the configuration and implications of the policy architecture of health care within the broader arrangements for social welfare. The next section describes the trajectory of the health care policy over time and some milestones in the macrosocial and institutional processes of the Chilean welfare system. This will provide the analysis with a historical dimension that, along with the contextual picture provided by the review of the welfare regime, is crucial to comprehending the contemporary policy architecture from a contextually-embedded perspective.

4.3.- Historical trajectory of the policy architecture of health care

In the second decade of the 20th century, Chile, together with Argentina, Brazil, Costa Rica, Cuba and Uruguay, pioneered the development of welfare systems in Latin America (Mesa-Lago, 1985). According to Illanes (2004-2005), the ´assistance state` emerged in the 1920s in the context of a deep economic crisis and the working class` demands for better living conditions. These demands resonated in the developmentalist project of the ruling governments that also had the financial support of the United States (US) seeking to invigorate the mining industry.

In 1924. the ´assistance state` created the Ministry of Hygiene, Assistance and Social Security as well as enacting the Mandatory Insurance Fund for blue-collar workers (Caja del Seguro Obrero Obligatorio [CSO]) and the legislation of labour and social security (Illanes, 2004-2005). Between the 1920s and mid-1960s, contributory-based health care and social security gradually

extended, reaching about two-thirds of the workforce. The CSO co-existed with several other schemes, such as the National Medical Service of Employees (Servicio Médico Nacional de Empleados [SERMENA]) for white-collar workers and civil servants created in 1942, and the schemes for the army and security forces, which shaped a fragmented and stratified system that delivered benefits and services according to workers´ pressure capacity (Larrañaga, 2010).

In 1952, the government split the CSO into two branches, leaving health services in the charge of the National Health Service (Servicio Nacional de Salud [SNS]) and social security benefits in the hands of the Social Insurance Service (Servicio de Seguro Social [SSS]). The SNS pioneered regional efforts for desegregating health care, allowing the equalisation of benefits for blue-collar workers, the inclusion of indigents on a non-contributory basis, the strengthening of the role of the state and the expansion of coverage (Cotlear, Gómez-Dantés, et al., 2015). In the following years, under the governments of the Christian Democratic President Frei Montalva (1964-1970) and the Socialist President Allende (1970-1973), the SNS expanded coverage and benefits, with health outcomes becoming substantially improved (e.g. infant mortality decreased by 69% from 1939 to the early 1970s) (Castillo-Laborde, Carla et al., 2019). Nevertheless, the endurance of separate schemes for public servants, army forces, and other groups of privileged workers prevented the unification of the system (Mesa-Lago, 1985, 1994; Barrientos, 2004) and the urban middle-classes continued to be favoured with more generous benefits than the rest of the population (Borzutzky, 2002).

In 1973, the expansionist trajectory was abruptly interrupted by the military coup and the dictatorship that lasted until 1990. This meant the application of massive neoliberal reforms, pushed by political and economic pressure of the USA and Britain (Williamson, 2009). Chile became the neoliberal model, later used by the World Bank and the IMF to prompt the Washington Consensus across the region (Huber and Stephens, 2012).

The military government applied macroeconomic adjustments and reoriented social policies in favour of market principles, turning the ´assistance state` into a ´residual state` (i.e. subsidiary to the market) targeted at the poor (Haagh, 2002; Barrientos, 2004; Larrañaga, 2010; Huber and Stephens, 2012). Such a dismantling of social policies in tandem with the precarisation of jobs not only affected the most vulnerable groups but also, the middle-classes, who became markedly unprotected (Draibe and Riesco, 2009).

The health system suffered significant setbacks by reforms that undermined the public sector and favoured the private sector (Cotlear, Gómez-Dantés, et al., 2015). Law 2.763 of 1979 replaced the SNS and SERMENA with the National System of Health Services (Sistema Nacional de Servicios de Salud [SNSS]) and set the National Health Fund (Fondo Nacional de Salud, FONASA-Chile) as the new public insurance. In 1980, primary health care was decentralised to the municipalities (MINSAL-Chile, 2012; Cid et al., 2014), and the new Political Constitution (Article 19, paragraph 9) established that the state has the duty of protecting equal and free access to health care either through public or private institutions, with there being the individual's right to choose between these two systems (Ministerio Secretaría General de la Presidencia, 1980).

The most radical pro-market social policy reforms took place in 1981. The publicly managed pay-as-you-go pension system was turned into individual accounts administrated by private for-profit financial firms (Administradoras de Fondos de Pensiones [AFPs]) (Junta de Gobierno de la República de Chile, 1980). Workers` compulsory contributions rose from 4% to 7%, and employers` contributions were eliminated (Castillo-Laborde, Carla et al., 2019). In the health sector, a public system and a parallel private option administrated by private for-profit institutions (Instituciones de Salud Previsional [ISAPREs]) replaced the former structure. Thus, by creating a public-private dual system where people could direct their contributions to public or private insurance (i.e. ´opt-out`) the policy architecture of health care was virtually re-founded.

The government granted special subsidies to favour enrolment in the ISAPREs and curtailed financial resources for the public sector from 2% to 0.8% of the GDP between 1980 and 1981 (Cid et al., 2014). The ISAPREs were allowed to charge additional premia, offer various health plans, and cream the population by selecting groups with low levels of health risk (Huber and Stephens, 2012; Pribble and Huber, 2013; Cid et al., 2014). Meanwhile, FONASA-Chile kept responsibility for covering non-contributing workers, the poor, and those with higher health risk (Barrientos and Lloyd-Sherlock, 2002). In 1985, FONASA-Chile grouped its holders by income level (Groups A, B, C and D) and allowed those in groups C and D (i.e. higher incomes) to seek attention either through public providers by the Institutional Care Modality (Modalidad de Atención Institucional [MAI]) or private practices and hospitals by the Free Choice Modality (i.e. Modalidad Libre Elección [MLE]) (Castillo-Laborde, Carla et al., 2019), meaning a new endorsement of the private sector.

In a way, the unification of previous schemes into FONASA-Chile enabled ending the historical fragmentation of the system by occupational categories. Nonetheless, the explicit and radical incorporation of private institutions created a new form of fragmentation and segmented the population by payment capacity. The health reform was not limited to establishing a dual system, for it also introduced and reinforced market mechanisms as a route for accessing health care. Such commodification hindered the access of the poor owing to the underfunding of the public sector, whilst also significantly affecting the middle-classes, as many who had previously not done so had to started dealing with the market to meet their health care needs (Bernales-Baksai and Velázquez Leyer, 2022).

In 1990, the return to democracy restored civil rights with governments starting to correct the underfunding of social policies[23], access to social services expanded, and poverty declined markedly (Larrañaga, 2010). Nonetheless, the state kept a subsidiary role in economic and social affairs (Barrientos, 2004; Illanes, 2004-2005; Martínez Franzoni, 2007; Draibe and Riesco, 2009). In the health sector, waiting lists were tackled, the comprehensiveness of services improved (Atun et al., 2015), and coverage rose to 95% in 1996, with 65% of the population covered by FONASA-Chile (Barrientos and Lloyd-Sherlock, 2002). Nevertheless, after the initial increase in public spending on health, it remained roughly 2.4% of the GDP (Barrientos and Lloyd-Sherlock, 2002), whilst private expenditure rose to over 50% of health expenditure (Huber and Stephens, 2012).

[23] Between 1989 and 1998, public social spending as percentage of the GDP grew by 86.4% (Moreno, 1999 cited by Illanes, 2004-2005).

In the 2000s, under the Socialist government led by President Lagos, the country began to boost a universal model of social policies (Cecchini and Martínez, 2011). The Ministry of Health included the reduction of inequities in the health goals for the decade 2000-2010 (MINSAL-Chile, 2002) and created a fund for catastrophic diseases (CAEC) (Cid et al., 2014) to cover ISAPREs holders, who despite belonging mostly to the upper-middle and upper classes were financially at risk, because of the lack of coverage by the ISAPREs` health plans. In 2004, there were significant changes in the health system´s governance, regulation of the private sector was strengthened, and the purchasing and provision functions, formerly conflated at FONASA-Chile, were split (MINSAL-Chile, 2012). The most salient reform was Law 19,966, which created the Universal Access Plan of Explicit Guarantees in Health (Plan de Garantías Explícitas en Salud [AUGE-GES]) that guarantees prompt access to quality and standardised health services and financial protection for a group of priority health problems that currently amounts to 85 (MINSAL-Chile, 2019).

Despite the broad support of the population, the original AUGE-GES´ proposal experienced significant curtailments pushed by the interests of private actors and economic concerns of the Ministry of Finance (Huber and Stephens, 2012; Garay, 2016). The most critical setback was the replacement of the solidarity single-fund by separate public and inter-ISAPREs funds, meaning the limitation of solidarity to horizontal solidarity and the endorsement of a dual system (Cuadrado, 2015). Moreover, it is argued that the AUGE-GES´ impact is limited by the dual character of the system that allows for disparities in the non-covered health problems (Frenz et al., 2018) to exist as well significant participation of private actors both in AUGE-GES´ provision and in the overall system (Bernales-Baksai, 2020).

In sum, the review of this historical trajectory makes it clear that the health care policy has constantly segmented the population. From the health system's foundation up until the late 1970s, segmentation mainly relied on a system fragmented by occupational category. Meanwhile, since the neoliberal reforms that created the dual public-private system in the early 1980s up to today, segmentation primarily relates to households´ payment capacity and health care commodification. The original architecture privileged the urban middle-classes, whilst the reforms in the 1980s fractured the previous architecture and the protection previously enjoyed by these privileged groups. Post-retrenchment reforms started in the 21st century did not involve a structural transformation, and Chile continues to have a dual system that, despite providing a public basis, involves a prominent market component. Currently, a social outbreak (´Estallido Social`) started in October 2019, and the COVID-19 pandemic keep the health system´s transformations on standby of a new Political Constitution expected in 2022. Against this background, Section 4.4 delves into the current policy architecture and outputs of health care, considering their implications for the middle-classes, followed, in Section 4.5, with analysis of the practices that they deploy to access health care.

4.4.- The contemporary policy of health care

4.4.1) Policy architecture of health care

4.4.1.1. Eligibility - Under what criteria do people benefit?

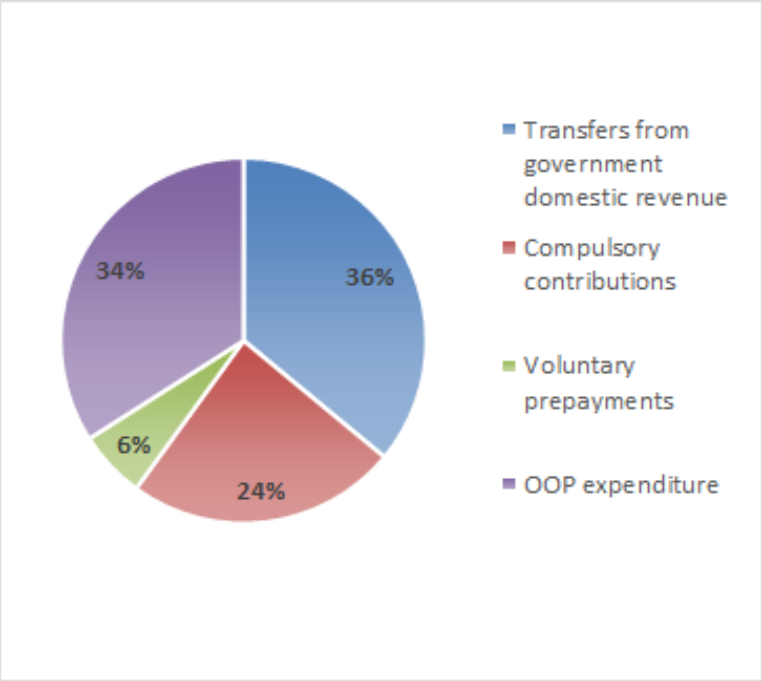
Payroll taxes are the primary criterion to be eligible for health coverage. Health care insurance is mandatory for all workers, formally entitling them and their economic dependents to get coverage through either public (FONASA-Chile) or private (ISAPREs) insurance (Bernales-Baksai, 2020). In this scenario, most middle-classes meet the formal criteria to opt between the two types of insurance. Nevertheless, despite receiving compulsory social security contributions, ISAPREs work as individual insurance and retain the possibility of demanding extra premia and creaming of the population according to health risk and level of income (Cid et al., 2014; Cid and Uthoff, 2017; Frenz et al., 2018). Therefore, in practice, the options taken by the middle-classes need to consider the extra costs and benefits of the ISAPRE´s health plan vs public insurance. Differently, FONASA-Chile defines need as a complementary criterion of eligibility, delinking health entitlements from performance in the labour market and payment capacity (Homedes and Ugalde, 2002; MINSAL-Chile, 2012). Nevertheless, some groups (e.g. non-poor workers of the informal economy) remain excluded by not meeting any of these criteria (Bernales-Baksai and Solar-Hormazábal, 2018).

4.4.1.2. Funding - Who pays and how?

Broadly speaking, health care can rely on three types of financing sources, namely general revenues (i.e. provided by the state), payroll taxes (i.e. provided through any combination of workers, employers and state contributions), and household spending (i.e. provided by the individuals or families). The lattermost can be direct payments to obtain services and health products (i.e. OOP spending) or prepayments (e.g. complementary private insurance) (WHO, 2019b). Currently, general revenues are the primary source of health financing in the country, representing 36% of total health expenditure (WHO, 2020a) and 3% of GDP (ECLAC, 2020), by 2018 (Graph 4.1). These funds permit exemption for households of the first income deciles from paying contributions and copayments in the public sector. Comparatively, public expenditure, that is, general revenues plus compulsory contributions, is high, reaching 5.4% of GDP in 2017, while the average for Latin America was 3.7% of GDP in the same year (OECD/WB, 2020). Nevertheless, it still is below the international recommendation of 6% of GDP (WHO, 2010; PAHO/WHO, 2014).

Payroll taxes represented 24% of the total health expenditure in 2018. These come entirely from workers` contributions (the 7% of their salaries) without employers` participation. The remaining 40% of the total health expenditure was private expenditure, mainly OOP expenditure (WHO, 2020a). This financing configuration with very high OOP, as I discuss later, seriously hampers financial protection (Kutzin, J., 2013) and, for the middle-classes, implies significant investments to access health care.

Graph 4.1. Health care expenditure distribution by source, Chile 2018



Source: Own elaboration based on the WHO Global Health Expenditure Database

In turn, financing arrangements enable people to ´opt-out` from public insurance and channel their mandatory payroll contributions to one of the private insurances managed by the ISAPREs. As mentioned, ISAPREs can demand unregulated extra premia (i.e. a surplus to the mandatory contribution) depending on the estimation of health risks and they can vary financial coverage according to the provider and plan purchased[24] (Cid et al., 2014). Moreover, the financing structure allows the ISAPREs to keep the resources in independent funds separated from each other and the public fund managed by FONASA-Chile (Frenz et al., 2018). Thus, there is no solidarity or possibility of redistribution in the private sector, not even chances of intrapersonal solidarity as surpluses of individual contributions are appropriated by the ISAPRE, instead of being kept in savings accounts that the same individuals may use in the future (Sojo, 2017).

In contrast, regarding FONASA-Chile, mandatory contributions are the unique premium, with the lowest income group (Group A) being exempted from contributing, and copayments are progressive (FONASA, 2018). In this fund, general revenues represent about 60% of income, and the remaining 40% comes from contributions and copayments (Estay et al., 2018). All revenues are pooled in a single fund allowing solidarity and redistribution, thus enabling greater horizontal and vertical equity among those at FONASA-Chile. However, it is also important to draw attention to the increasing draining of resources to the private sector through the service purchasing from private providers (Goyenechea, 2019).

[24] Currently, more than 12,000 different plans are offered by ISAPREs (Cid *et al.,* 2014), which hinders significantly the ability of those enrolled to compare and make informed decisions.

These financial arrangements make a context where the middle-classes finance by themselves their access to health care through the payroll contributions, prepayments and OOP. In the public sector, they pay proportionally by contributing and co-paying and benefit from solidarity when facing high-cost health problems. In the private sector, holders pay for everything they get and, with the exemption of the AUGE-GES and guarantees for catastrophic diseases (known as Law Ricarte Soto [LRS])[25], they do not have any option of solidarity.

In a nutshell, the model of financing reinforces the dual character of the system (Cid et al., 2014; Cid and Uthoff, 2017). The mechanisms for solidarity and redistribution present in the public sector are restricted by the broader financing structure, which brings consequences that go even beyond the financial sustainability of the system. In fact, the OECD and the World Bank (2020) recognised in the last regional health report that fragmented systems that lack pooling of resources and mechanisms for solidarity impair the effectiveness of insurance mechanisms, access to health care and health outcomes.

4.4.1.3. Benefits - Who defines them, and what are they?

The Ministry of Health defines benefits, which are comprehensive (i.e. including primary, secondary and tertiary medical care plus some medicines) for all enrolled in public insurance, independently whether they participate via contributions or subsidies (Cid et al., 2014). ISAPREs, in turn, have to include in their health plans a minimum group of benefits also defined by the state. Nonetheless, health plans significantly vary in terms of the rest of the benefits included and the extent of available care suppliers. In this context, members of the middle-classes enrolled in FONASA-Chile are formally entitled to comprehensive benefits as with everybody in the public insurance. Meanwhile, if they enrol in ISAPREs, benefits depend on the specific plan, namely, the higher investment they do more comprehensive the health plan they can get. Complementarily, the AUGE-GES Plan guarantees services, deadlines, quality, and financial protection for 85 health conditions (MINSAL-Chile, 2019), whilst the LRS offers diagnosis, treatment, and medicines for 14 high-cost diseases to all, independently of their type of insurance or previous performance (BID, 2017).

4.4.1.4. Delivery - Who does what?

Health care delivery is fragmented between providers of the public and private sectors. FONASA-Chile preferably purchases services from public providers, and ISAPREs opt for private for-profit suppliers (Castillo-Laborde, C and Delgado Becerra, 2019), with whom, despite various regulatory efforts, they usually have commercial ties (vertical integration) (Cid et al., 2014; Frenz et al., 2018). Hence, access to public services typically has to do with the enrolment in FONASA-

[25] In 2015, Law 20.850 (known as Law Ricarte Soto, LRS) defined, for the first time, a set of benefits that is universal (i.e. covers all people with all types of insurance, including FONASA-Chile, ISAPREs and the armed forces, independently of socioeconomic background).

Chile (i.e. eligibility based on payroll taxes or need), whilst private delivery relies on the payment capacity.

In the case of no availability of services in the public sector, FONASA-Chile can purchase them from private providers. Moreover, FONASA-Chile supplies vouchers to those who opt for private through the MLE (Bitran, 2014; FONASA, 2018) in such a way that users can seek services privately provided by relying on funds originally paid to public insurers (Vargas and Méndez, 2014). Public financing of private service grew in recent years (Goyenechea, 2019), with FONASA-Chile increasingly purchasing private services for its holders through the MLE, the AUGE-GES guarantees, the emergency law, and for the resolution of waiting lists (Gómez Bradford et al., 2019).

In this scenario, the middle-classes have far more options for choosing providers than the poor, whether they are insured by FONASA-Chile or ISAPRE. In the first case, they can access public providers (by the MAI) and private supply (by the MLE). Meanwhile, when holding ISAPRE, they can access private care and could potentially seek care in public hospitals. Nonetheless, the FONASA-Chile´s MLE and ISAPREs´ cheaper plans usually have restrictions in the range of suppliers.

4.4.1.5. Outside Options - How do governments manage market-based alternatives?

The country has a large number of highly deregulated market-based insurance and providers. In 2020, twelve ISAPREs (six open to everyone and the other six exclusively for workers of some companies) managed private insurance (Superintendencia de Salud, 2021), and 18% (3.4 million people) of the country`s covered population had been enrolled in an ISAPRE by 2018 (Superintendencia de Salud, 2019). In 2014, private providers supplied about 37% of all health services (Cid et al., 2014) and in 2018, the association of private providers (Clínicas de Chile) estimated the potential demand in 49.7% of the population (9,312,106 million people), with the majority (5,828,395 million people) coming from FONASA-Chile (Clínicas de Chile, 2018).

Despite improvements in regulation vis-à-vis the early stages of the dual public-private system, ISAPREs continue to adjust premia and plans (i.e. coverage, benefits and copayments) to attract some groups and exclude others (i.e. risk creaming) as well as practicing vertical integration with private providers (Cid et al., 2014). As a result, the private health sector has achieved one of the highest profitability levels (30% average rate between 1990-2015) in the Chilean market (Cid and Uthoff, 2017). In general, the middle-classes have been brought into close contact with market options; they are particularly exposed to the practices of discrimination and risk selection by private institutions.

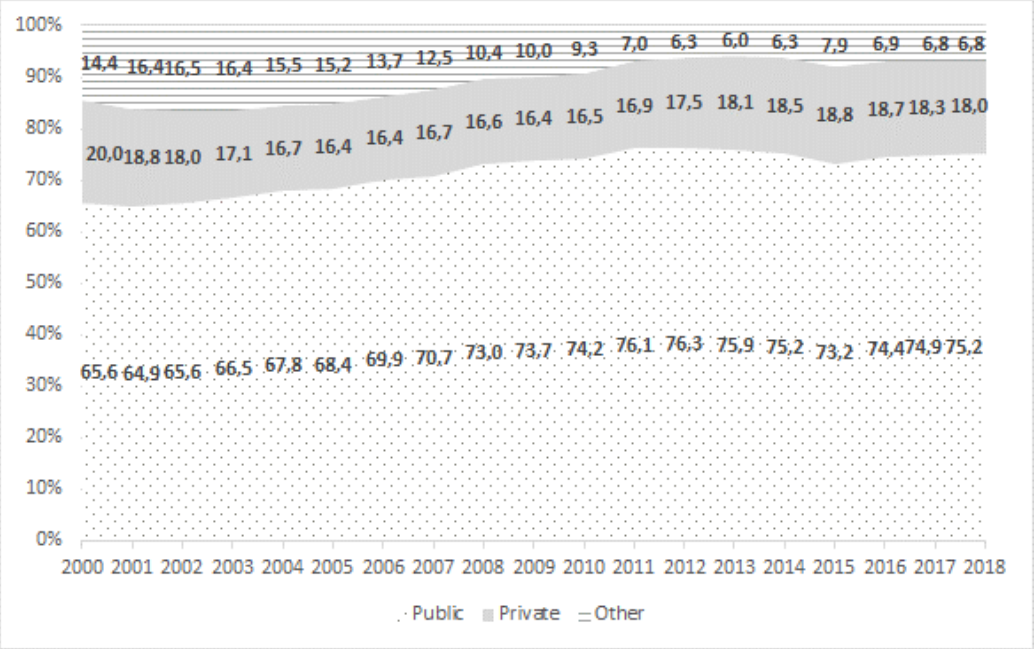
4.4.2) Health Care Policy Outputs

4.4.2.1. Population coverage

Chile massively advanced population health coverage in recent decades. In 1980, it was just 67.3% (Mesa-Lago, 1985), whilst household surveys data show that coverage came at 87% in 1990, 90% in 2000, and above 95% in 2017 (Observatorio Social CASEN, 2018). In terms of composition, an analysis conducted by Sojo (2017) indicates that between 2000 and 2013, coverage rose for salaried and self-employed workers, increasing higher for the latter. The gradient of coverage by income quintile disappeared for those salaried from 2000 to 2013 and was inverse for the self-employed, with upper and middle-income self-employed being the groups that lacked coverage the most.

Concerning the distribution of coverage, data consistently indicate the predominance of public insurance. In 2018, FONASA-Chile reached 14 million people, whilst ISAPREs, the second most massive option, were far below with 3.4 million people in the same year (FONASA, 2020). The percentage of coverage by FONASA-Chile slightly declined throughout the 1990s, during the democratic transition ruled by Christian Democratic presidents, when the country experienced steep economic growth and market liberalisation. From 1998 to 2011, public enrolment recovered steadily, concurring with two consecutive Socialist governments, a period of financial retrenchment, and the regional turn towards a universalistic approach. Nevertheless, it dropped again during the subsequent right-wing government (2010-2014) and remained steady until the end of a new Socialist government (2014-2018) (see Graph 4.2). Lastly, most of those not covered by FONASA-Chile nor ISAPREs participate in alternative schemes, such as the insurance for the armed forces and the police and the Programme for Victims of Human Rights Violations (Programa de Reparación en Atención Integral en Salud [PRAIS]) (Villalobos Dintrans, 2018).

Graph 4.2. Distribution of covered population by type of insurance for Chile, 2000-2018

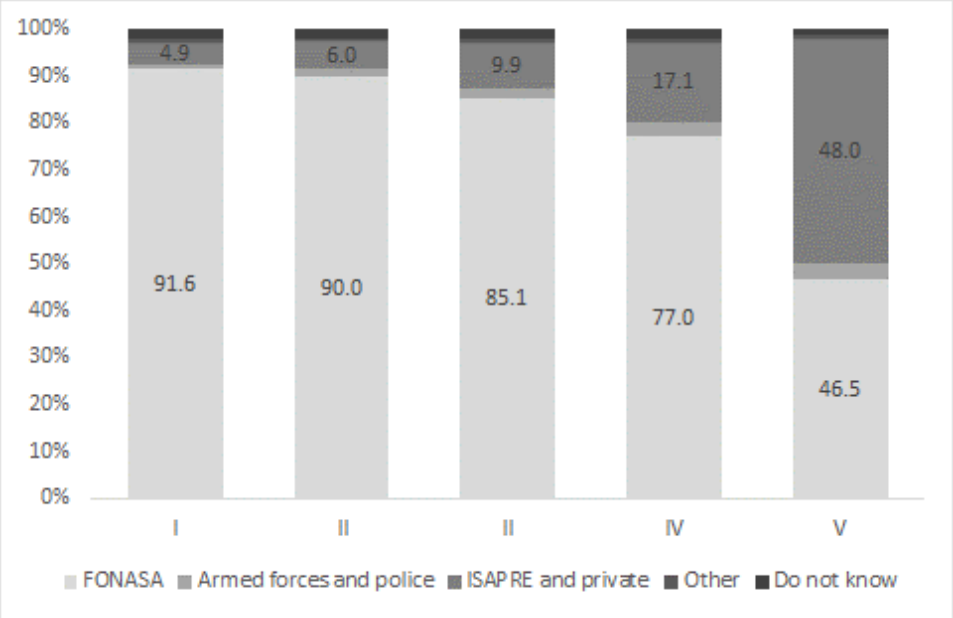


Source: Bernales-Baksai and Velázquez Leyer (2022) based on Boletín Estadístico FONASA 2000-2019

Further to the numbers, the features of the population enrolled with FONASA-Chile vis-à-vis ISAPREs represent the most notable difference between both types of insurance. Public insurance concentrates those groups with higher health risks and health care needs: when compared with ISAPREs, FONASA-Chile has three times the percentage of older people, 56% of holders with completed secondary education vs 92% (Frenz et al., 2018), and the proportion of females and children is markedly higher (Asociación de Isapres de Chile, 2016; Sojo, 2017).

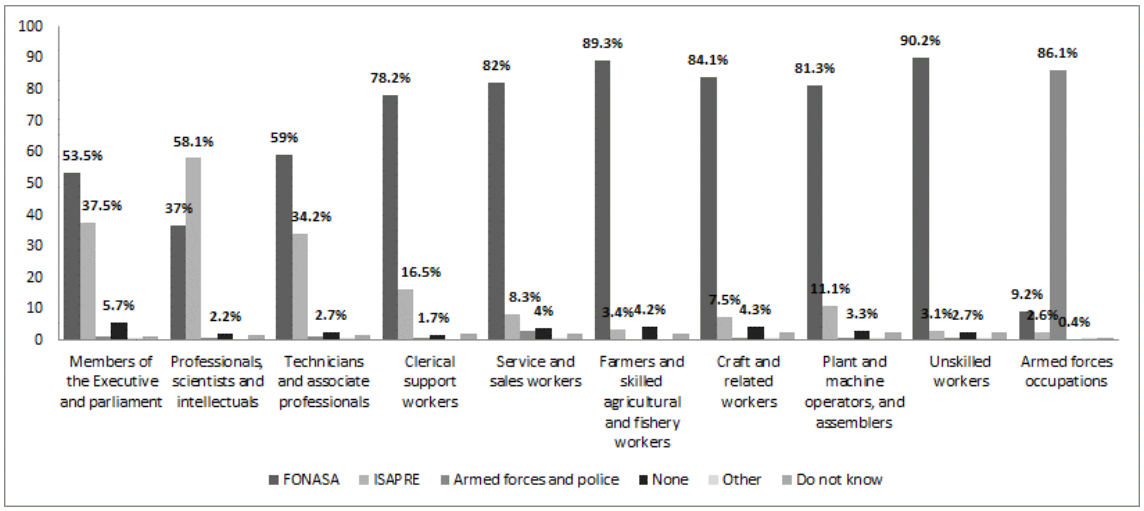
Analyses of households' surveys corroborate the segmentation using income and occupational categories as a proxy of social class. Graph 4.3 shows that ISAPREs concentrate those on higher incomes, whilst Graph 4.4 indicates that enrolment in ISAPREs is higher among occupations traditionally linked with the middle and upper-middle-classes (Groups I to III). In contrast, public insurance predominates in occupations associated with the lower social classes (Groups IV to IX). Moreover, there is a positive relationship between private insurance and higher autonomous income (Observatorio Social CASEN, 2018). Concurringly, a study conducted by the PNUD (2017) shows that 75% of the upper-middle class hold ISAPREs vis-à-vis 2% of the lower classes, also pointing out that middle-classes in FONASA-Chile usually access private services by the MLE.

Graph 4.3. Affiliation to social security of health (2017) by income quintile (% of total population per type of insurance)



Source: Own elaboration based on the CASEN survey (2017)

Graph 4.4. Affiliation to social security of health (2017) by occupational categories (% of total population per occupational category)



Source: Own elaboration based on the CASEN survey (2017)

To summarise, population coverage is almost universal in the country in terms of numbers but highly segmented in its composition. The duality of the system favours ISAPREs in covering those with less risk and higher income, thereby boosting vertical inequity, as the population with higher health risk is concentrated in FONASA-Chile, which has fewer resources to respond to these needs (Bernales-Baksai and Velázquez Leyer, 2022). This pushes the middle-classes towards private options of insurance, or failing that, private provision.

4.4.2.2. Generosity

The outputs of generosity indicate that Chile performs high within the regional context. Total and public expenditure in health surpass regional averages and have steadily increased over the last few decades (ECLAC, 2020). The higher investment has translated into more human resources, hospitals, and medical supplies, which are expected to have a positive impact on healthcare quality and comprehensiveness.

Nevertheless, similar to what has been observed regarding coverage, generosity is not uniform across the system, but rather segmented. Resource allocation per capita is adjusted to risk calculation (i.e. progressive) within the public sector, whereas resources are individual in the private sector, thus preventing any form of solidarity. In addition, the public sector has between 30% (excluding OOP) and 39% (including OOP) fewer resources per capita than the private sector, not even considering the differences in risk profiles (Frenz et al., 2018).

As for human resources, the situation is similar. At the beginning of the reform, from 2004 and 2008, the public sector increased the number of physicians by more than 80% for primary health care and 20% for the secondary and tertiary levels (Guillou, J and Bustos, 2011), and between 2010 and 2017, health care personal further increased by 20% (Bachelet, 2017). Nevertheless, there is a significant gap in human resources, as 50.4% of physicians and 48% of medical

specialists exclusively delivered services in the private sector by 2018 (Clínicas de Chile, 2018). The infrastructure also reveals differences. In 2019, there were 194 public hospitals, with 69% of the country's beds, which represents a 4.5% increase from 2010. Private hospitals (known as clínicas) amounted to 74, with 19% of the beds, which represents a 20.8% increase in the same period (Clínicas de Chile, 2018).

Differences in resources translate into inequities for timely attention. In the public network, waiting lists surpass 1.6 million people and on average, people wait 400 days for surgery not covered by the AUGE-GES guarantees (Frenz et al., 2018). This is not the case for users of the private sector, as anyone who can pay has access to some private supplier to get the treatment without waiting lists. Consequently, it is not surprising that, despite copayments, many FONASA-Chile holders who belong to the middle-classes seek care with private providers using the MLE (Cid et al., 2014; Clínicas de Chile, 2018).

In conclusion, whilst cross-national comparisons indicate Chile (along with Costa Rica and Uruguay) performs well above the regional average in health care generosity (Martínez Franzoni and Sánchez-Ancochea, 2018), it is still far from being universal. In this context, the middle-classes either insured by ISAPREs or FONASA-Chile have to invest beyond the mandatory contributions to get timely and quality care. If insured in ISAPREs, they have extra prepayments and unregulated copayments. In public insurance, despite just contributing the compulsory 7% of their salaries, usually, they face higher copayments for accessing private supply to get timely attention.

4.4.2.3. Financial protection

Like population coverage and generosity, financial protection impacts on equitable access to health care (Tangcharoensathien et al., 2013; Saksena, Hsu and Evans, 2014) and hence, the degree of universalism reached by the country`s health policy. Currently, there are four main areas of subsidies that delink health care access from payment capacity and enhance financial protection: coverage of the poor (Group A of FONASA-Chile) and pensioners by the public insurance; exemption of copayments in the public network of providers for the poor and those earning below the established threshold (Groups A and B of FONASA-Chile); exemption of copayments for everybody enrolled in FONASA-Chile for primary health care in the public network; and allocation of financial resources to deliver AUGE-GES and LRS´ services (FONASA, 2018). The first two target low-income households, whilst the third and fourth may include people with different income levels, but are limited to primary health care and a group of health conditions, respectively. All of this leaves a large proportion of the population belonging to the middle-classes without any state support.

Scholars agree in qualifying financial protection in Chile as weak (e.g. Koch, Cid Pedraza and Schmid, 2017; Bruzzo, Henríquez and Velasco, 2018; Villalobos Dintrans, 2018; Castillo-Laborde, C and Delgado Becerra, 2019). In the private sector, both prepayments and OOP are a significant concern. Prepayments for private health insurance remained above 6.5% of the total health expenditure between 2010 and 2017, whilst the OECD average declined from 6.5% to 5.5% over

the same period (OECD/WB, 2020). Cid et al. (2014) indicate that holders of private insurance, on average, pay an additional 3% to the 7% mandatory contribution to the ISAPREs.

The situation is entirely different for FONASA-Chile holders, as no one prepays more than the compulsory 7%, and a non-negligible percentage is even exempted from this contribution (i.e. Group A). Nonetheless, expenses occur mainly as copayments or other forms of OOP, especially when seeking private attention. Thus, by 2013, financial coverage for private attention by the MLE was 39.3%, meaning there was above 60% of copayment, while ISAPREs covered 70%, on average, for hospitalisation and 60% for outpatient attention with private suppliers (Cid et al., 2014).

Regarding health problems included by the AUGE-GES Plan, copayments cannot exceed 20% regardless of people get their services from public or private providers (Castillo-Laborde, C and Delgado Becerra, 2019). For catastrophic diseases, ISAPREs offer additional coverage against a voluntary prepayment (i.e. the CAEC) (Superintendencia de Salud, 2018), and the LRS covers a group of high-cost health conditions for all (BID, 2017).

Further to copayments, other expenses count to create an unfavourable OOP landscape in the country. Currently, OOP reaches 34% of the total health expenditure, that is, the same as the average for the Latin America and the Caribbean region (OECD/WB, 2020), notoriously higher than the OECD average of near 21% (OECD/WB, 2020), and far above the maximum 20% that indicates high vulnerability to catastrophic health spending (WHO, 2010, 2019a). Despite this, it should be noted that the country significantly reduced OOP spending from 2000 when it was 48.8% (Atun et al., 2015), whereas most OECD countries showed only slight reductions and even some increases (OECD, 2019).

Bruzzo, Henríquez and Velasco (2018) have elicited that households devote above 5% of their total spending on health services, this being higher among upper-income groups. Villalobos Dintrans (2018) shows that OOP expenditure patterns remained similar the last ten years, with medicines as the most crucial item, followed by outpatient care and dental health, representing 60% of the OOP independently of the type of insurance in which households participate. Nevertheless, he also points out notorious differences by type of insurance and income level: among people with public insurance, the ratio between expenditure and income is similar across income groups, but among ISAPREs holders, the relation is inverse, revealing the regressivity of private insurance. Moreover, a study conducted by the Ministry of Health (2015) indicates that, on average, households with FONASA-Chile spend around 39% less OOP than those insured with ISAPREs.

In sum, those insured by FONASA-Chile who can opt for private supply (i.e. middle-classes) have to deal with high copayments, whilst those insured with ISAPREs are exposed to high prepayments and OOP. ISAPRE holders who do not belong to the wealthier groups hire cheaper health plans, have access to a narrower range of suppliers and have higher copayments. This scenario reveals that, despite decreasing the total OOP in the country, improvements in financial protection leave a missing middle. Subsidies predominantly target the poor, who can obtain free health care in the public network of providers. In contrast, middle-income households need to

rely on their economic resources and opt between contributing to FONASA-Chile with higher copayments outside the public network or investing high prepayments for private insurance.

Lastly, the degree of universalism reached in terms of financial protection also expresses itself in terms of service utilisation. In this regard, even though most Chileans report that they get attention in case of need (Observatorio Social CASEN, 2018), the averages shadow inequities both within and between the public and private sectors. Within enrolment in FONASA-Chile, higher-incomers (i.e. Groups C and D) display higher service utilisation vis-à-vis the subsidised population (i.e. Groups A and B) (Bernales-Baksai and Solar-Hormazábal, 2018), as a significant proportion of them get seen to private providers (MDS, 2016). Also, there is a positive correlation between service utilisation and enrolment in ISAPREs (Aguilera et al., 2014; Henríquez and Velasco, 2016; Castillo-Laborde, C et al., 2017; Bernales-Baksai and Velázquez Leyer, 2022).

To conclude, it is interesting to note the analyses by the Chilean association of private providers, which has reported a steady increase in private care-seeking. Between 2016 and 2018, private provision grew by 9% and in 2018, near 43% of these services were delivered to FONASA-Chile holders (Clínicas de Chile, 2018). On the one hand, these figures reveal that most people enrolled in FONASA-Chile who are not poor seek market-based options, which ends eroding the progressivity of contributions and copayments in the public sector. Thus, to opt for public insurance ends up being expensive for the middle-classes. On the other hand, those members of the middle-classes who opt for private insurance also end up investing high amounts in health care either because of the prepayments for expensive plans or the copayments that the middle and lower-middle groups, face because they cannot afford better plans (i.e. regressivity of private insurance). All this illustrates the multiple paths by which segmentation is generated, even beyond the obvious separation between public and private insurance, for it also occurs within each of them.

4.4.2.4. Sufficiency and equity of policy outputs

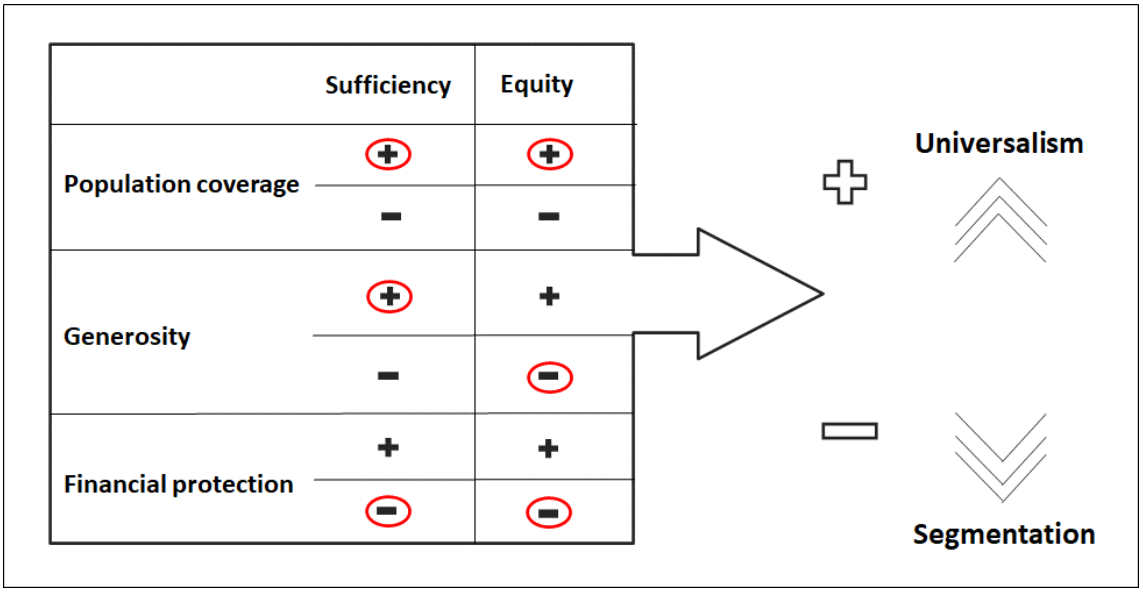
The examination of the three dimensions of the policy outputs of health care presented above allows for the elements for reaching insights of what I have called the cross-sectional dimensions of universalism (see Chapters II and III and Figure 2.3), namely sufficiency and equity. These two cross-sectional dimensions manifest themselves in terms of coverage, generosity and financial protection, but they may not be visible at first sight. Hence, in the following, I briefly stress some points that were not necessarily explicit in the previous pages.

It is clear that Chile performs well in terms of sufficiency for population coverage and generosity, that is, these two dimensions are high on average amongst Latin American countries. However, outputs are less favourable from the perspective of the sufficiency of financial protection, as the OOP spending, and hence, financial risk, continues to be high. These conclusions are supported by Martínez Franzoni and Sánchez-Ancochea´s (2018) findings that show the country among the best performers of universalism, overall, within the region (along with Uruguay and Costa Rica), but still with a low performance regarding private spending.

The main barriers to universalism in health care relate to equity. First, the analysis above indicates that, despite coverage being extended throughout all social groups, the population is markedly segmented by type of insurance and even within private insurance, depending on the households´ payment capacity. This might not be an issue, if the implications are only formal, but this is not the case when it is considered along with the outputs in terms of generosity and financial protection. Segmentation in coverage translates into inequities in resources per capita, human resources and infrastructure. Thus, those enrolled in ISAPREs access timelier and quality services (i.e. more generous health care) than those under FONASA-Chile. Likewise, within the private sector, the better-off hold more comprehensive plans as well as more options for providers and higher financial coverage (i.e. lower copayments).

Furthermore, shortcomings in financial protection exacerbate inequities in generosity. Whereas lower income groups have some level of financial protection, because of the state`s subsidies and the wealthy population can hire health plans that offer higher financial coverage, the lack of financial protection seriously impairs the access of middle-income groups and even of groups that, without being wealthy, have higher incomes than the average. The unregulated prepayment and copayments in the private sector, low financial coverage for private services got through the MLE, and the high levels of OOP, are examples of financial issues that significantly affect the access of these groups. Figure 4.1 summarises the country´s outputs from the perspective of the sufficiency and equity in relation to population coverage, generosity and financial protection. Hence, it reveals the contribution that each of these dimensions is currently making to the universalism/segmentation of health care.

Figure 4.1. Outputs for universal health care by dimensions, Chile



Source: Own elaboration

4.5.- Middle-classes´ access to health care

The previous two sections showed the fragmentation of the Chilean health system, how this drives inequities and segmentation in health care and some of the implications for the middle-classes. By analysing the perceptions and practices for accessing health care, this section focuses on understanding how the middle-classes deal with this scenario and how these practices feedback to the current policy architecture of health care and its outputs. However, attending to the argued heterogeneity of middle-classes within and across countries, this section starts by briefly profiling this broad category in the country.

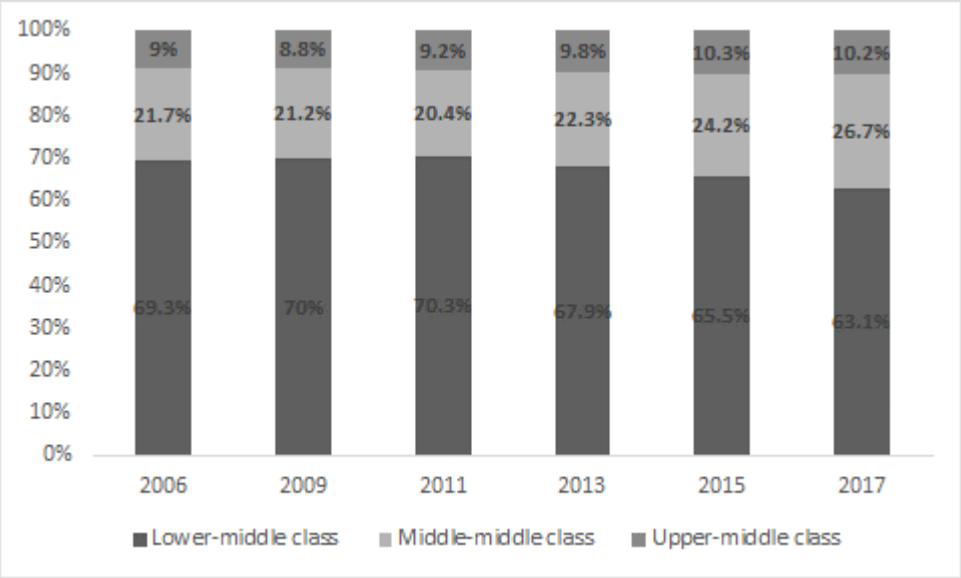
4.5.1) The middle-classes in Chile

Regardless of the preferred operationalisation, most studies agree that the middle-classes increased in Chile over the last few decades. Using employment data, Ruiz Encina and Boccardo (2015) estimated that they increased from 26.2% in 1971 to 29.5% by 1980 and 29.9% in 1990, rising even faster in the next two decades, reaching 34.5% in 2000 and 37.1% in 2009. Using occupational-based calculations, Gayo, Teitelboim and Méndez (2013) estimated that, in 2009, the middle-class was 27.7%, whilst the PNUD (2017) held that by 2015 the lower-middle-class represented 50%, the middle-class 15%, and the upper-middle and upper classes 10% of the working population[26]. Also using an occupational approach, Barozet et al. (2021) pointed that the middle-classes represented 40.4% of the population in 2019. Estimations relying on self-definition indicate that, in 2018, 3.5% of interviewees perceived themselves as the upper-middle-class, 36.9% in the middle-class, and 37.7% in the lower-middle-class (Latinobarómetro, 2018a).

Income-based measures concur with the rising trend. The PNUD (2014) shows that the middle-classes grew from 32.2% to 44% between 2000 and 2012 and Arzola and Larraín (2019) an increase from 44.3% to 68.5%, with the World Bank's thresholds, and from 43.2% to 65.4% using the national poverty line, between 2006 and 2017. According to this measure, the lower-middle-class locates between the third and the seventh income deciles and is the largest group (63,1%), counting for 42.5% of households in the country, whilst the middle group is mainly located in the seventh and eighth deciles and the upper-middle-class in the ninth (Graph 4.5).

[26] Based on the CASEN Survey (2015)

Graph 4.5. Middle-class households by sub-group, 2006-2017



Source: Arzola and Larraín (2019) based on the Casen survey data, 2006-2017

Arzola and Larraín (2019) also found that 14.8% of households belonging to the middle-classes experience deficiencies associated with multidimensional poverty, especially relation to in schooling and social security. Along the same lines, the OECD (2018) claims that middle-income deciles Chileans exhibit one of the highest probability of falling into poverty within four years and that upward social mobility is minimal. Moreover, Contreras (interview by Jaque, 2020) stresses that Chilean middle-classes are fragile and unstable, with 30%-40% of the population exposed to a significant fall in their income from any shock, among which, of course, are the health-related problems.

Further to income variations, scholars broadly agree about the heterogeneity of the middle-classes, arguing that the sub-groups (i.e. upper, middle and lower) substantially differ regarding occupations (PNUD, 2017), employment conditions (Arzola and Larraín, 2019), education, representation channels, social identities and lifestyles (Barozet and Espinoza, 2016), social experiences (Araujo and Martucelli, 2011), cultural practices and patterns of consuming (Gayo, Teitelboim and Méndez, 2013; Gayo, Méndez and Teitelboim, 2016).

Even though middle-classes´ households have in common higher access to social welfare vis-à-vis the lower-classes. López-Calva et al. (2014) showed that, circa 2012, 11.9% of the middle-class(es) in Chile faced constraints for accessing medical services vis-à-vis 26.7% of the vulnerable group and 55.5% of the poor. Nonetheless, an investigation conducted by the PNUD (2017) shows a diffused perception of insecurity. The ´fear of falling` and the assessment of limited social protection are extended even among professionals -considered by the study as part of the upper-middle group-. In this scenario, the upper-middle and consolidated middle-classes would hold other routes to seek security, such as investing in private options (e.g. private schools and private health insurance). Meanwhile, less-advantaged groups of the middle-classes also have their sights on accessing private services co-financed by the state (e.g. private health

services through the MLE), because of the perception of the limited-quality public services (PNUD, 2017).

The same study shows that the narratives of individual effort and mistrust in publicly provided social services and opting-out practices towards market-based alternatives co-exist with the growing agreement on the need for higher state involvement to decrease social inequalities (PNUD, 2017). In this context, the country has been experiencing consecutive waves of social mobilisation, demanding higher equality and the strengthening of social protection (McSherry and Mejía, 2011; PNUD, 2012; Simbuerger and Neary, 2015; Pribble, 2017; Ganter Solís, 2020).

At first glance, the co-existence of these individualised narratives and opt-out practices, on the one hand, and the demands for a state more committed to social protection[27], on the other, may seem contradictory. Nevertheless, the discussed welfare policies´ trajectory provides contextual clues to grasp the intricate links that the middle-classes establish with market-based options and their estrangement from the public ones.

In the health care domain, dissatisfaction with access inequalities reached 68% in 2016 (PNUD, 2017), and the perception of the need for profound transformation of the health system is widespread (i.e. 90% of those enrolled in FONASA-Chile and 87% of those under ISAPREs) (Data Voz, 2016). Surveys indicate that the perception of being protected is less frequent among those signed up for FONASA-Chile vis-à-vis ISAPREs holders (Universidad de Concepción, 2018). Also, this perception of protection by those with ISAPREs declined from 73% in 2015 (Data Voz, 2016) to 63% in 2017 (Universidad de Concepción, 2018). In turn, qualitative inquiries reveal the mistrust in public health care institutions (Nous, 2015), the perception of the predominance of consumers´ rights over the possibilities to exercise citizens´ rights (Sgombich et al., 2018), and the need to cope with health risks individually (Banco Mundial, 2015).

Nonetheless, neither surveys nor qualitative studies allow for nuanced differentiations between social groups. Available research makes broad distinctions by income level and type of health insurance, but this does not enable the accurate analysis of middle-classes´ practices for health care, the perceptions behind these practices, and their particularities (if any) vis-à-vis other groups. This lack of knowledge turns more critical in the present scenario, where after about twenty years of demobilisation (Garay, 2016), the middle-classes are back into making social demands (Barozet and Espinoza, 2016).

The expression ´Chile Despertó` (Chile Woke Up) raised in 2019 synthesises the expansion of a movement that currently involves both the middle-classes, now larger than ever, and lower classes. The broadness of the mobilisation has perhaps sown the conditions for forming unprecedented cross-class coalitions to deal with the co-optation of social welfare by market mechanisms. In a recent publication, Araujo (2020) dramatically illustrates the ongoing situation: ´What we, as a country, are facing is not just an outbreak because of the people´s

[27] A survey conducted some days after the beginning of the country wide unrest in October 2019 shows 85.8% of support for the social movement, which interviewees define according to the concepts of inequality and social justice. Among the demands, old-age pensions, health care, and education are the three most prioritised areas (DESOC & CMD, 2019).

saturation. This is more profound […] The country is, certainly, in a dispute about the redistribution of power and wealth across the society`[28] (pp. 33-34). By shedding light on the patterns of relationship that members of the middle-classes establish with social institutions for health care, the next pages contribute some of the elements for grasping an understanding of the roots of the processes that the country is currently witnessing.

4.5.2) Middle-classes´ practices for achieving health care

The analysis below draws upon in-depth interviews with 18 members of the middle-classes. The interviews took place from October-December 2017 and in June 2018 in the Capital of Chile, Santiago. Participants divided evenly by gender (nine women and nine men), ranged between 36 and 60 years old and were diverse in terms of family status (single and married, with and without children), employment category (salaried and self-employed), household income, and participation in social movements. At the time, six of them held insurance with FONASA-Chile, whilst the other twelve were signed up to an the ISAPRE (See Appendix 2 for a more detailed account of the sample).

The analysis below starts by considering participants´ perceptions regarding the health system, private and public insurance as well as public and private service delivery (Subsection 4.5.2.1). Then, Subsection 4.5.2.2 differentiates four alternative clusters of practices that interviewees deploy for meeting their health care needs. Each cluster comprises practices of insurance, care-seeking, and strengthening strategies. Lastly, this subsection delves into how the participants understand their performance in light of their vision of the health care system.

4.5.2.1. The perceived health system

As discussed, the current policy architecture of the country enables formal coverage to almost the entire population. On this basis, participants perceive that the system comprises a wide range of options beyond choosing between public (FONASA-Chile) and private (ISAPREs) insurance. Narratives tell about a continuum composed not of two, but rather, multiple tiers, with different quality, security, and costs. Such differences relate to the election of a type of insurance and several alternatives for service delivery, either in the private or public sector. At one extreme of this continuum, there are very prestigious private hospitals (known as clínicas) that are *´like five stars hotels`* (Cesar, single man, 36 years old), usually accessed by private insurance. In the middle of the continuum, there are *´standard clínicas`* (Gonzalo, father of 2 children, 43 years old) that can be accessed either through ISAPREs or FONASA-Chile (i.e. via the MLE) and a few prestigious public suppliers usually located in middle-income neighbourhoods of the city. Finally, at the other extreme, there are many public hospitals and facilities and low-

[28] Original in Spanish: ´Lo que enfrentamos en el país, así, no es un simple estallido por saturación. Es más profundo […]. Se está, por cierto, en una disputa por la redistribución del poder y de las riquezas de la Sociedad`.

quality private practices that many consider *´worse than the public* [ones]` (Domingo, father of 5 children, 58 years old).

Against this range of options, interviewees observe themselves in a position where, theoretically, they can evaluate each option's pros and cons and then, prioritise. Enrolment in private or public insurance is the first and more evident decision. They have to choose between directing their payroll taxes to an ISAPRE and paying extra premia or to FONASA-Chile and co-paying, if they want to opt for private supply. Thus, the middle-classes become the ´owners` of their individual decisions: *´They give you options, and that is the problem [...] If I decide A, I have to pay. If I decide something else, I have to pay too`* (Flavia, single woman, 41 years old).

A second decision has to do with the thousands of private insurance plans, with different services, copayments, and preferential providers, whilst a third decision relates to the specific provider where they seek services, which, as mentioned, cover a wide spectrum. The moot point here is that these are not actual decisions. As Flavia´s quote clearly points out, their assumption as middle-classes is that they have to pay one way or another, also because to be middle-class is to pay privately. In turn, this suggests that the supposed architecture of choice is formal, but does not have an actual expression since each group just gets what is able to pay for.

In this scenario, interviewees consider that the degree of protection links to the amount paid: *´[…] It depends on the health plan you get. The ISAPREs seem to be a good system for high-incomers, but are not good for people with lower income`* (Domingo, father of 5 children, 58 years old). Thus, when asked about the ideas or images they associate with the ISAPREs, interviewees concurred around mistrust, injustice, and commodification.

> *´Injustice, that is what I associate with the ISAPREs`* (Cesar, single man, 36 years old);
>
> *´[...] they are always putting their finger in your mouth`* (Damian, father of 1 child, 44 years old);
>
> *´Business, private, profit, and Chile […] It is so Chilean, so our, so neoliberal`* (Gonzalo, father of 2 children, 43 years old).

Moreover, the participants perceive that getting private insurance can be harder for some groups. It is general knowledge that ISAPREs offer cheaper plans to single young men and expensive ones to older people, babies, and women of reproductive age: *´Be paying every month so much money for the ISAPRE. Besides, my daughter and I are in the most expensive section. So, I find this super unfair`* (Luna, mother of 2 children, 37 years old).

Nevertheless, interviewees consider ISAPREs as the easiest route to private services, as they have preferential agreements with specific market-based providers (mentioned previously in this chapter as vertical integration), which are valued because they have more resources as well as offering comfort and timely attention: *´To me, it means more support, infrastructure, human resources, more technology and it´s faster [...]`* (Manuela, mother of 1 child, 36 years old). The participants are aware of variations in the standards of quality: *´There are many types. You have*

a limited group of clinics that people identify as good health [...] and from there is the degradation, with all kinds of private care, to one of terrible quality` (Domingo, father of 5 children, 58 years old). This last quote relates to a prevailing perception: the experience of needing to trade-off to find a balance between investment (i.e. the amount paid either for a plan of insurance or as copayment for service supply) and the quality of the services received.

Public insurance and providers are believed to be more solidaristic and oriented towards social welfare. Several participants stressed the health professionals´ commitment to delivering quality services and highly valued the guarantees of the AUGE-GES Plan and primary health care services. Two participants, who recently had the experience of seeking provision with public providers talked about their experiences: *´Chile Crece Contigo*[29] *has wonderful provision, at the European level. You can get perfect care for a child without having to change [to the ISAPRE]*` (Emilio, father of 2 children, 41 years old); and *´Recently, my parents, eighty-eight and eighty-four, started going to the [public] health facility. [...] they didn't have to wait more than twenty minutes, receiving milk and other dietary supplements for their age*` (Domingo, father of 5 children, 58 years old).

Nonetheless, most participants consider that public health care is precarious, especially at the secondary and tertiary levels of provision. *´It [public services] damages the quality of life [...], waiting times, it is horrible*` (Esther, mother of 3 children, 53 years old). Lack of timely attention is the most regretted deficiency. Because of this, participants perceive that there is not enough security, even if the medical quality is similar to private options: *´The problem is not dying lying on a hospital bed [...] The quality is good, but it is not fast enough as one needs*` (Damian, father of 1 child, 44 years old).

With these shortcomings, the public system becomes the obligated alternative for those who cannot afford anything else. *´After all, if you have no other economic possibility, you have to get FONASA*` (Manuela, mother of 1 child, 36 years old); and *´[…] people look at them [public facilities] like places for the poor, those abandoned to their fate* `(Emilio, father of 2 children, 41 years old).

Summing up, interviewees perceive the health system as multi-tiered, namely, a fragmented and stratified system with variations in quality standards (especially regarding timely attention) and status by payment capacity. The system enables higher security for the better-off with good-quality and timely services and from there, the standard of security gradually decreases as people drop in the social hierarchy.

In this landscape, as members of the middle-classes, interviewees observe themselves navigating the system relying primarily on their individual or family´s resources. These perceptions concur with what Van de ven (2013) identifies as the trade-off between the welfare gain due to risk reduction and the welfare reduction due to moral hazard and fee costs. A transaction in which individuals and families perceive themselves having to weigh the pros and

[29] Chile Crece Contigo is a cross-sectoral policy for comprehensive child protection launched by President Bachelet in 2009.

cons in an intricate calculation, because of the possible interactions between the advantages and disadvantages.

The public sector is considered as having insufficient quality and entailing insecurity and a highly commodified private sector create an incentive structure that pushes the participants to play by the market rules looking for the best cost-benefit balance in an individualised manner. Luna (mother of 2 children, 37 years old) illustrates this individualised view: *´It is unfair that people who never get sick have to pay the same as a person who gets sick all the time`*. In this way, as discussed in the following pages, participants` perceptions translate into practices in which individualised risk management predominates.

4.5.2.2. Practices to achieve health care

The perceptions of the health system expressed by participants illuminate that, amongst the possible options they identify for accessing health care, not all are equally acceptable or desirable and thus, doable. The examination of the narratives shows four alternative clusters of practices that entail different combinations of insurance enrolment, care-seeking, and strengthening strategies.

Starting with the most predominant among interviewees, eight participants reported practices that shape the most market-embedded cluster. Those who deploy practices of this **first cluster** enrol on ISAPREs and seek services only with private practices. However, the most salient feature is that they establish further links with market-based options by investing in a wide range of supplementary private insurance to settle copayments with private suppliers. *´[…] We have five insurance types: the ISAPRE; the insurance my job gives me; my husband`s job insurance; the insurance offered by the clinic; and the school insurance for our children`* (Esther, mother of 3 children, 53 years old). These supplementary insurances imply sustained extra, but controlled, investments and seem to offer some security against high-cost care needs: *´When I lost my job, the only thing I decided to continue paying the same was the ISAPRE. I hired a preferential plan for the Clínica Alemana [an elite clinic] and bought the Todo Alemana insurance offered by the clinic. Thus, if something happens to me, I will have medical attention without the need of asking for support from my family and friends`* (Javiera, single woman, 44 years old).

The **second cluster** of practices also comprises the evident preference for private options. The four participants who described these practices, opt-out from the public to enrol at the ISAPREs and rely on strategies to decrease the high costs of some private options. *´The last time I went to the doctor of the medical centre associated with my ISAPRE. […] It is cheaper, and the payment system is integrated […]`* (Cesar, single man, 36 years old).

Within this cluster, there also are practices of mixing services at private practices and public facilities as a strategy for coping with high copayments. However, this is not a feasible option for everyone or for all kinds of services and therefore, requires being knowledgeable about the system so to be able to manage getting public attention, while being insured with the ISAPRE. Those who engage in these practices usually opt to go private for specialities and medical tests,

but seek public services for routine needs (e.g. vaccines, healthy child controls), which is consistent with the perception of high quality public primary health care and deficient services for specialities discussed in the previous sub-section. *´Lately, we have chosen to get preventive controls at the public facility […], and if one of the children gets sick, then I take him to the clinic or the anthroposophical doctor […]`* (Juan, father of 3 children, 41 years old). None of the participant families with practices of this cluster has health conditions that require regular care, and they all come from birth families that held public insurance and attended public providers during their childhood.

In addition to the previous two, there are two other clusters that show clearer ties with public options. One of them, the **third cluster**, consists of enrolling in public insurance, but seeking care with private providers that enable access via the FONASA-Chile´s MLE. Since seeking private care involves high copayments for those who hold public insurance, the four participants who narrated practices within this cluster perform supplementary strategies, such as identifying private providers with agreements with FONASA-Chile, to mitigate this disadvantage and reinforce their possibilities of getting adequate services and avoiding unaffordable payments. ´We had our son in a private clinic with a voucher from FONASA ` (Emilio, father of 2 children, 41 years old). Nevertheless, in severe circumstances, those who engage in the practices of this cluster end up spending much money: *´I always was with FONASA […] It was not expensive, a good option. I paid for the MLE, so I attended to the specialist [...], but when I got cancer, I ended up at Clínica las Condes [an elite clinic] and paid a lot. The treatment I wanted was unavailable in the public system`* (Flavia, single woman, 41 years old).

Finally, two participants reported practices that shape the **fourth cluster**, which is the closest to using the public facilities. They access health care relying on FONASA-Chile and publicly provided services. These two men have chronic diseases covered by the AUGE-GES Plan, and due to their pre-existing conditions, ISAPREs do not accept them for insurance. *´I have GES that covers my tests and everything […] They don`t accept me in any ISAPRE. Or they accept me, but don`t cover my condition, so what`s the sense, if that is the disease for what I need treatment [...] when you need them most they [ISAPREs] least want you. They want you only when you`re healthy`* (Luis, single man, 39 years old). To strengthen their chances of obtaining quality health care, they adopt the strategy of being informed about the benefits legally granted by the AUGE-GES and identifying the best facilities within the public network of suppliers.

When looking at the clusters of practices as a whole, it is clear that, despite the criticisms that participants expressed about market-based options and the perception of lacking protection, whenever they can, the majority opt for private insurance or services (14 of 16).

Complementarily, the analysis of narratives concerning the vignettes shows that, against other people's hypothetical health care needs, most participants kept the same options as they held for themselves. Thus, the three men enrolled at FONASA-Chile recommended public insurance to the vignettes´ characters. In contrast, most participants insured with ISAPREs opted in the vignettes for paying private insurance too.

It is relevant to consider the conditions that make the difference for a participant to follow practices of one or another cluster. In this regard, the analysis draws attention to four conditions. First, there is being part of a risky/non-risky group, as private insurance is less accessible for people with health problems, the elderly, and women (i.e. ISAPREs´ risk creaming). In fact, participants with chronic diseases were precisely the ones found to be enrolled in FONASA-Chile, although some relied on public facilities (i.e. fourth cluster) and others on private services (i.e. third cluster). In turn, what seems to divide these two clusters (i.e. the second condition that makes a difference) is to hold a health problem covered, or not, by the AUGE-GES guarantees. Thus, both interviewees with conditions included in the AUGE-GES remit seek services in public facilities, whilst the other two participants at FONASA-Chile mostly rely on private service supply using the vouchers delivered by FONASA-Chile through the MLE. The third and fourth conditions differentiate the practices between those enrolled in ISAPREs, these being household income level and previous family experience (e.g. type of services accessed in the birth family). Those with a lower level of income or who have been with FONASA-Chile at some point in their lives are more prone to look for cheaper private providers and sometimes seek care at public facilities. In contrast, those with a higher income and who always attended private clinics tend to purchase supplementary insurance, thus deepening market practices. Hence, this could be considered a gradient of acceptability that responds to the history (even intergenerational) of family practices and the effort that is implied for a household to opt for elite private services (e.g. stop acquiring other assets and indebtedness).

Lastly, the strengthening strategies included in all clusters of practices (e.g. supplementing private insurances, seeking cheaper private providers, using the MLE) are grounded on an individual approach for risk management and unveil the fears that the participants are facing. Narratives repeatedly express how they are afraid of suffering from a health condition and not having timely and quality service provision. In their opinion, the public system does not provide enough guarantees except for AUGE-GES covered problems. Meanwhile, in the private sector, they fear not having sufficient resources to pay for severe disease treatment and therefore, many make further investments (e.g. supplementary insurance).

Narratives and practices express an intricate relationship with the health system. On the one hand, they do not trust the security provided by the public sector. On the other, they are critical when referring to market-based options since they consider that the private sector profits from health and does not grant protection when needed. In their practices, however, most seek care at these for-profit options. In this scenario, they have to make further options (i.e. beyond choosing a type of insurance) and perform several strategies to strengthen their chances for acceptably meeting their health care needs. These strategies involve fluid movements (e.g. between private and public options or supplementing private insurance) to cope better with the risks present in a highly commodified health system. Practices of insurance, service seeking, and strengthening strategies become entangled with each other and are mutually supportive. Hence, most participants play by the market rules, namely seeking to meet their health care needs based on individualised practices and drawing on resources that hinder the possibilities of solidarity and intra and inter class alliances; looking for the best cost-benefit balance, which they entirely never reach in most cases.

Concerning the meanings they give to these practices, for a majority opting to go private is largely unquestioned and seems the natural course of action as far they are in the economic position to afford it, as Manuela´s quote illustrates: *´[...] we never discussed whether it is the public or private system. I grew up attending the private practice, my husband too, so we looked for the best option for the family`* (Manuela, mother of 1 child, 36 years old). As they use the system (i.e. as holders of private insurance), however, most realise that it does not offer sufficient protection and, usually, imposes the need for further investments to feel protected. Nonetheless, private attention is still considered more acceptable for several reasons. First, as expressed by Elise, the possibility of getting timely care is highly valued: *´I have worked to have a health system that I can attend without having to wait for days, hours, months in a hospital`* (Elise, mother of 1 child, 47 years old). Second, participants price freedom of choice regarding specialities and medical centres: *´It is costly, but I am satisfied because I can go to the doctors when I need; I can take the tests I need`* (Javiera, single woman, 44 years old). Third, they appreciate the comfort and the possibility of saving time at private centres. However, many explicitly expressed that this is not fundamental, and they would not mind fewer amenities at public centres, if provision was timely and of high quality. Nevertheless, the stigma of public facilities (i.e. the option for the neediest) and the status associated with elite clinics are sometimes recognised as reasons for paying higher.

Despite the mentioned benefits of private attention, participants emphasised the financial barriers they face in accessing market-based options. They attribute this to the interest of the ISAPREs, and private health sector in general, of getting profit from health, instead of protecting people: *´[The private system] is structured more for the healthy than for the sick. ISAPREs want to maximise their profits`* (Esther, mother of 3 children, 53 years old). It is against this realisation that interviewees consider it necessary to deploy additional courses of action (i.e. strategies) to cope with financial hardship. With this perspective, they make sense of the apparent discordance between their criticisms of the market principles that drive the private sector, on the one hand, and their engagement in practices that deepen into the market mechanisms, on the other.

Participants try to feel more protected through their practices of insurance, care seeking and strengthening strategies. Nevertheless, they understand that this protection is precarious and are aware of their vulnerability to any contingency: *´[protection] is super fragile, because at some point we can get into a difficult situation, and I don't even know if we have insurance`* (Gonzalo, father of 2 children, 43 years old). The feeling of precarious protection lies fundamentally in two perceptions. First, that the state provides basic security (i.e. subsidiary state), that is, within restricted limits, outside of which they would be vulnerable, if they depended on public support. Second, the understanding that the advantaged access to health services they currently enjoy as members of the middle-classes is a product of their individual or family effort, so they have the pressure to maintain that capacity. Catalina clearly illustrates these points:

> *´Perhaps, as a tactic, it would be good to get complementary health insurance. Something that allows you not to be so helpless, if you have a severe disease [...] or maybe FONASA is the best alternative. At least FONASA is not going to leave you [...] In the private system, things are clear, that is, if you get something serious we cover you up here and you fix the rest for yourself`* (Catalina, mother of 1 child, 37 years old).

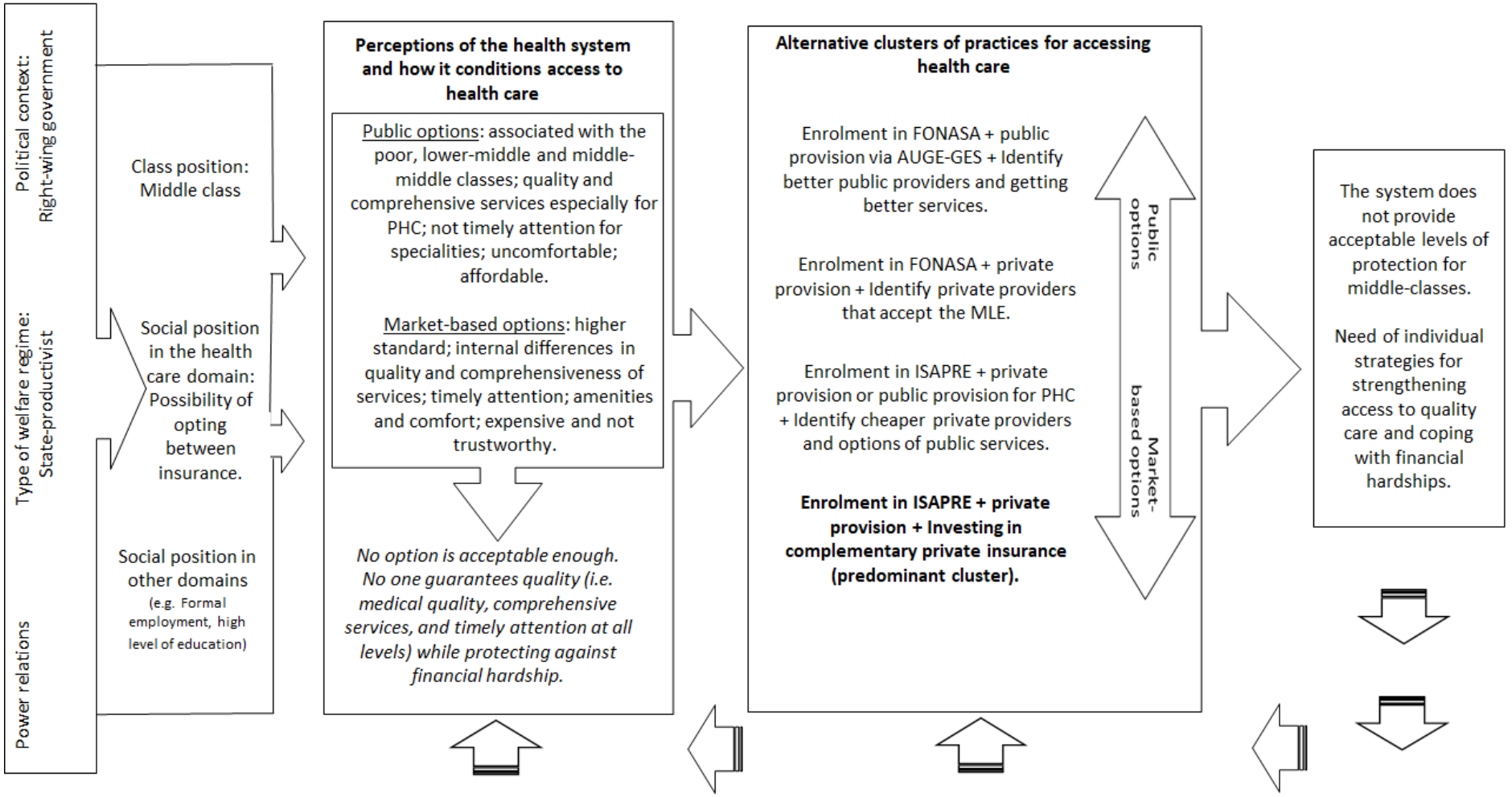
Thus, the conjunction of public protection not being sufficiently developed with powerful market mechanisms translates into the experience of vulnerability. At a glance, it may seem inconsistent with the social position of the middle-classes, but it is understandable in this highly commodified context. This conjunction contributes to explaining why, far from requiring public assistance in a system where they do not feel included, they perform practices that deepen the market rules, thus creating a vicious circle.

Moreover, these middle-classes come from a history of four decades marked by a neoliberal model, that, as discussed previously, radically undermined solidarity and social welfare. Hence, participants are narrating an experience of fragility lived in the present, but built throughout historical circumstances.

> *´I feel that we are super alone, especially in the class in which I am. Although it is high in terms of education or income according to what we see in the country, it is worse. They charge you more and consider you a rich person when you are not. You have more charges, no benefits, and in the end, you are the ham of the sandwich between the rich and the poor`* (Javiera, single woman, 44 years old).

Participants experience the health system as unfair and non-protective, which arises from the lack of quality or, alternatively, the high economic costs for accessing quality provision. Nonetheless, at the same time, most perform practices that support the logic of the system and reinforce segmentation. By opting to go private, the solution they adopt is accessing a separate system from the rest of society. Nonetheless, those practices do not ensure protection (see Figure 4.2). Despite them knowing that through their practices they are reproducing the system without getting any more than precarious protection, they see no other option as meeting their needs.

Figure 4.2. Middle-classes´ perceptions of and practices when accessing health care in CHILE



Source: Own elaboration

4.6.- Integration and conclusion: iterations between the policy architecture, policy outputs and middle-classes´ practices

The analysis presented throughout the chapter has unveiled several aspects pertaining to the drivers of health care segmentation in Chile. These include structural and institutional conditioning as well as the practices by which the middle-classes access health services. The chapter has illuminated how the policy architecture of health care with parallel public and private sectors embedded in a state-productivist welfare regime, has shaped historically and largely perpetuated in the present, the middle-classes´ practices for meeting their health care needs. Moreover, the examination has shown that middle-classes´ practices tend to support the segmentation of health care, despite their criticisms of the current system.

The cross-sectional examination of the policy instruments has revealed that they constitute a fragmented architecture that, as the policy outputs reflect, results in segmentation. This is not surprising since previous research has indicated that the fragmentation of health systems hinders the advancement of universalism (Cotlear, Gómez-Dantés, et al., 2015; Cotlear, Nagpal, et al., 2015). It would appear that the dual public/private Chilean design necessarily involves segmentation or, in other words, that universalism is not possible in a dual system like this. Differences in the eligibility criteria between the public and private sectors translate into markedly uneven socio-demographic profiles of the insured population. Consequently, despite the country performing highly regarding coverage (first dimension of policy outputs) in terms of sufficiency and equity (i.e. almost the whole population and social groups are insured), the population is prominently segmented according to the type of insurance. In this context, the middle-classes primarily seems to opt for private provision either by enrolling in private insurance or by seeking private services, despite being registered with public insurance.

In turn, segmentation fundamentally relies on financing arrangements that shape an institutional mechanism of opting-out (Bernales-Baksai and Velázquez Leyer, 2021), which consists of channelling compulsory social security contributions to ISAPREs and placing market options in a similar position to social security institutions, despite the fact that the formers do not fulfil the most fundamental social security principles, such as offering protection when people are in need (Barr, 2001). Moreover, separate pools of resources prevent solidarity and redistribution, thereby hindering the potential redistributive impact of the pooling of resources and progressive resource allocation by FONASA-Chile. Maintaining multiple pools, with ISAPREs capturing the better-off´s contributions, drives less availability of resources under public insurance, thus impairing the generosity of the services supplied (second dimension of policy outputs). Hence, despite the analysis having indicated that the country performs acceptably well regarding generosity, on average, it fails to provide equitable access to such generosity. In this context, the middle-classes need to find a balance between the levels of generosity they expect to access and the investment they are willing to make.

Inequities have emerged even among those groups that pay for private insurance. That is, those who are not part of the top-income group purchase more limited health plans and access lower-quality providers. Thus, the fragmentation of the system ends up also segmenting between those sectors of the middle-classes that invest in basic health plans and those with the payment capacity for buying more comprehensive ones.

Also, the arrangements ruling service delivery hamper the public sector`s efforts at progressivity and quality since they promote the withdrawal of those with higher payment capacity, thereby leaving the public sector devoid of more demanding users. Moreover, the increasing private delivery for public insurance holders promotes the second and third mechanisms of opting-out, consisting, respectively, of the provision of vouchers when they utilise private services and the purchase of private services to face the unavailability of services in the public network of providers (Bernales-Baksai and Velázquez Leyer, 2021), which drains the resources that might strengthen the public network. Hence, the quality gaps between public and private providers widen, while financial protection worsens (third dimension of policy outputs), because of the high copayments associated with private supply. The deregulation of the private sector further reinforces shortcomings in financial protection, especially for upper-middle and middle-classes households that have to cope with financial risks through their resources. In this way, the increasing participation of private providers in service delivery along with the deregulation of market-based options generates conditions that translate into the segmentation of health care. This further empowers private actors to prevent transformations in the current policy architecture, and to consolidate the fragmented multi-tier system.

The analyses have also revealed that the current policy architecture is not only fragmented, but also, commodified, which further hampers universalism. The salient market participation brings segmentation, whilst at the same time, undermining the performance of the public sector (Atun et al., 2015; Bernales-Baksai, 2020) and the unification of the other components of the policy architecture (Martínez Franzoni and Sánchez-Ancochea, 2016b). Moreover, the literature indicates that when commodification is a predominant feature, it results in substantial withdrawal of the middle-classes from public services (Martínez Franzoni and Sánchez-Ancochea, 2016b). Fragmentation and commodification are entangled, such that they mutually reinforce and jointly lead to inequities and segmentation between the poor and the rest of society and among the middle-classes. In sum, the current policy architecture supports a type of fragmentation that is commodification-led, which manifests itself in a system with multiple tiers ordered in a gradient of generosity and security according to investment capacity.

The middle-classes were left behind through the social policies of the 1980s and even after the recovery of democracy in the 1990s. Thus, four decades of subsidiary state and commodified social policies have created middle-classes accustomed to calculating the costs and benefits with an individualised rationale. Therefore, it was a material ground (i.e. targeting and narrow welfare policies) that broke the old rationale of the middle-classes, which -as Baldwin (1990) explains for other countries- valued the possibility of risk-sharing and longed for reciprocity. Nowadays, social policies are more generous and have steadily increased the inclusion of the middle-classes. Nonetheless, the state continues to push them towards market-based options.

These are the health care policy features that, coming from a historical origin, condition the middle-classes´ practices for health care in the present.

Through the interviews, it became clear that, despite the country offering an extended public basis of health insurance (represented by FONASA-Chile), the middle-classes seem to have entered an endless circuit of investment on investment or, failing that, they have deployed alternative strategies in the quest to achieve the desired security that, however, they do not achieve. As Sojo (2017) argues, the limits imposed by private insurance lead to financial insecurity for households precisely when they face high-cost health situations, which are precisely the situations in which insurance is sought.

Summing up, the health system, and more broadly speaking, social welfare arrangements that have dominated the country, have created middle-classes trapped in commodified health care that, through its practices, support and reinforce segmentation. This has led to a vicious circle in which their practices for facing the risks hinder the possibilities to overcome segmentation and advance universal health care, defined as access for all to equitable and sufficiently generous services without incurring financial risks. In this sense, it may be argued that, so far, the middle-classes have been operating as reproduction agents. Yet, it does not mean that it cannot be otherwise. Indeed, the perceptions and meanings expressed by participants of this research regarding the health care system, the private sector, and their discomfort and insecurity with their current functioning may indicate that there is a breeding ground for some sectors of the middle-classes to emerge as agents capable of altering the correlations of power and triggering morphogenetic processes of structural reforms.

Moreover, despite at present, middle-classes´ practices being functional to the architecture of health care, they also reveal slots through which transformational processes are possible. Examples of this are the favourable view of several participants regarding public primary health care, their criticism of the principles that govern the private sector, their perception of precarious protection, and their perception of making significant investments to access private services.

In this scenario, practices with an individualised rationale, such as those described by most participants, are understandable. The perception of precarious protection in the context of a dual system that offers unequal services depending on the ability to pay and risk profiles makes sense of the insurance options, service seeking and the strengthening strategies reported. The middle-classes see themselves as being vulnerable in the face of a commodified private health sector and a public sector that does not meet their expectations. In this mismatch between perceived vulnerability and expectations, a space is possible for both state action to deploy new policy architectures and social agents to transform their practices.

CHAPTER V ECUADOR: WELFARE REGIME, POLICY ARCHITECTURES OF HEALTH CARE AND MIDDLE-CLASSES PRACTICES TO ACCESS HEALTH CARE

5.1.- Introduction

Continuing with the case studies, this chapter is devoted to Ecuador. Like the previous one, the chapter begins (Section 5.2) by examining the country´s welfare regime. This examination demonstrates that, currently, the achievement of social welfare in Ecuador significantly relies on the market and especially, the family´s support. This suggests that, despite since the second half of the first decade of the 2000s the state has been aimed at providing universal benefits, it has not been achieved because the public sector has not been able to provide access to sufficiently generous benefits and services to the whole population. Then, Section 5.3 reviews the health policy trajectory, showing that the health system has historically been underdeveloped, fragmented and not able to include the majority of the population. Section 5.4 unveils that the ambitious health reform started during the 2000s was constrained by the previous deficiencies and despite some notable advances, the system continued to be fragmented and lacking sufficient generous services in the public and social security schemes. All of this has been boosting the implicit commodification of health care, thus pushing the middle-classes towards market-based options and the segmentation between the middle-classes and the poor.

Regarding the middle-classes perceptions of and practices for health care, Section 5.5 reveals that none of the schemes contemplated by the policy architecture nor the outside private options provides sufficiently generous services nor acceptable levels of protection for the middle-classes. Hence, prevailing practices of picking-up services from the different alternatives of provision according to the type of need and other contingent conditions. In doing so, the middle-classes need individual and sometimes informal[30] strengthening strategies to boost the chances of getting quality health care.

Finally, by integrating all the previous analyses, in Section 5.6, it is argued that, despite a significant move towards creating a welfare regimen more able to protect the whole population and to develop a universally-oriented health system, health care continues to be insufficiently generous and driving segmentation. These shortcomings push the middle-classes towards market-based options that are not recognised in the policy architecture nor regulated. Thus, in spite of the middle-classes being formally covered through the social security schemes, which operate as a buffer against more severe health conditions, they usually end up relying on private services against OOP spending. This hinders their financial protection and shapes a feeling of lack of protection, which leads to cherry-picking services from social security and the private sector, thus deepening segmentation and hampering further the possibilities of obtaining social support for improving health care provision.

[30] Informal strengthening strategies refer to those that are not based on the institutional framework.

5.2.- The Ecuadorian welfare regime in the 21st century: progress and limits in the achievement of social welfare

Martínez Franzoni´s (2007, 2008) typology classified Ecuador as a non-state familist welfare regime. Accordingly, by the beginning of the century, the country presented: *i.* Weak commodification in the labour market; ii. Exclusionary social policies; *iii.* Significant reliance on families for the production of welfare; and *iv.* A poor performance in well-being and quality of life. In short, social welfare production depended more on informal practices, especially family assistance, than on an institutionalised support network.

Nonetheless, as this chapter illuminates later, left-wing governments headed by President Correa (2007-2017) involved noticeable transformations of social policies. Some authors (e.g. Martín-Mayoral, 2009; Minteguiaga and Ubasart-González, 2015) have even argued that Ecuador would appear to have initiated a transition of type of welfare regime. Following this, I examine the country's current performance in this matter, by analysing the four dimensions used by Martínez Franzoni to qualify Ecuador within the typology of Latin American welfare regimes, namely commodification in the labour market, decommodification of social welfare as well as defamilisation of social welfare and outcomes.

Regarding *commodification in the labour market*, Table 5.1 indicates that from the early 2000s economic participation rate (total and females) grew whilst unemployment fell substantially as well as child labour. Nevertheless, the quality of jobs is meagre. The percentage of employees decreased, and levels of informality in employment remain higher than the regional average[31]. The most remarkable shifts in the dimension of commodification in the labour market relate to the extraordinary economic progress experienced from 2007 onwards. This led to the country reaching the category of upper-middle-income economy (WB, 2019), with dramatic declines in poverty and income inequality (Table 5.1). Regarding poverty reduction, Espinosa *et al.* (2017) note that the leading factors varied throughout the period: Between 2000 and 2006, economic growth explains 92.8% of the poverty decline, and income distribution was responsible for the remaining 7.2%. Whereas between 2006 and 2016, 65.6% of the reduction was because of the distributive effect, and 34.4% related to economic growth.

As for inequality, Ecuador was the country that most decreased income inequality in Latin America between 2007 and 2011 (ECLAC, 2012). Nevertheless, the endurance of a development model that mostly relies on primary exports has been strongly criticised (Caria and Domínguez, 2016). Some have called into question the sustainability of the achievements regarding inequality (e.g. Minteguiaga and Ubasart-González, 2015), whilst others have stressed that the concentration of wealth remains unchallenged (e.g. Acosta, 2013; Caria and Domínguez, 2016).

[31] The marked increase in informality indicated by Table 6.1 may be partially explained by changes in the methodology of its measurement.

Table 5.1. Indicators for the dimension commodification in the labour market for Ecuador years, 2000 and 2020 (or the nearest year)

Indicator	Year	
Economic participation rate (% of the working-age population) [i]	2000: 61.9%	2019: 66.6%
Employees (% of the total employed population) [ii]	2000: 52.2%	2019: 48.8%
Unemployment (Average annual rate) [i]	2000: 7.3%	2019: 3.8%
Women economic participation rate (% of the working-age women population) [i]	2003: 47.0%	2019: 54.5%
Children in employment, total (% of children ages 7-14) [iii]	2004: 12.0%	2015: 5.6%
Share of workers in informal employment (% of non-agricultural employment) [ii] [iv]	2000: 48.1%	2019: 73.6%
GNI per capita, PPP (constant 2017 international $) [iii]	2000: 7,662	2019: 11,052
Poverty headcount ratio at $5.50 a day (2011 PPP) (% of population) [iii]	2000: 72.7%	2018: 24.2%
Gini coefficient [i]	2000: 0.538	2019: 0.456
Personal remittances, received (% of GDP) [iii]	2000: 7.2%	2019: 3.0%
Rural population (% of total population) [i]	2000: 39.6%	2020: 33.9%

[i] ECLAC (2020), CEPALSTAT
[ii] ILO (2021), ILOSTAT
[iii] WB (2021), World Development Indicators
[iv] ILO (2015), KILM 9th ed. for year 2000

Transformations in the dimension of *decommodification of welfare* are also remarkable. By the early 2000s, when Ecuador was classified as a non-state familist welfare regime, public social expenditure per capita was the second lowest (after Nicaragua) in Latin America (CEPAL, 2007). Social policies covered a narrow percentage of the population (Espinosa, 2010), and many were disenchanted by public services, which were mainly devoted to covering basic needs (Martínez Franzoni, 2007).

In 2008, Ecuadorians approved a new political constitution known as the *Constitution of Montecristi* grounded on the principle of *Good Living* (*Buen Vivir*). This started to change the residual role of the state, defining public policies as a central device to reach equity, poverty eradication, redistribution, and sustainable development (SENPLADES, 2009). Public social expenditure substantially increased (Table 5.2), reaching the regional averages in most areas (ECLAC, 2020). On average, the level of social protection reached by the country for the decade 2002-2012 corresponded to an intermediate level within the region, according to the multidimensional index of social protection (Ocampo and Gómez-Arteaga, 2016). Despite these advances, some have criticised the prioritisation of cash transfers and poverty reduction over social justice and equality, thus contradicting the universalistic prescriptions for *Good Living* (Caria and Domínguez, 2016). Meanwhile, others underline that the endurance of quality gaps between public and private services continue to undermine the access of the vulnerable populations to essential social goods (Minteguiaga and Ubasart-González, 2014).

Table 5.2. Indicators for the dimension decommodification of social welfare for Ecuador, years 2000 and 2020 (or the nearest year)

Indicator	Year	
Private health expenditure (% of Total health expenditure) [i]	2000: 68%	2018: 48%
Out of pocket health expenditure (% of Total health expenditure) [i]	2000: 64%	2018: 40%
School private enrolment, primary (% of total primary) [ii]	2000: 21.7%	2016: 22.6%
Households and NPISHs final consumption expenditure (% of GDP) [iii]	2000: 64.6%	2019: 60.5%
General government final consumption expenditure (% of GDP) [iii]	2000: 9.4%	2019: 14.5%
Public expenditure on health care (% of GDP) [iV]	2000: 0.7%	2018: 2.7%
Public expenditure on education (% of GDP) [iV]	2000: 1.9%	2018: 4.5%
Public expenditure on social protection (% of GDP) [iV]	2000: 0.4%	2018: 1.4%
Overall social expenditure (as % of GDP) [iV]	2000: 3.2%	2018: 9%
Old-age contribution ratio (% labour force) [V]	--	2009: 29.6%
Old-age pensioners recipient ratio above retirement age [V]	--	2011: 53%

[i] WHO (2020) , Global Health Expenditure Database
[ii] UNESCO (2021)
[iii] WB (2020), World Development Indicators
[iV] ECLAC (2020) , CEPALSTAT
[V] ILO (2016), Social Security Inquiry

These substantial transformations should have signified the *defamilisation of welfare*. Nevertheless, updated information indicates that the impact of changes in the commodification in the labour market and decommodification of welfare on this dimension have not been as significant as might be expected. Most indicators of Table 5.3 have not changed since the early 2000s, thus demonstrating that families and especially females, continue to be substantially supporting social welfare (Martínez Franzoni, 2007). Minteguiaga and Ubasart-González (2014) relate this to the absence of improvements to the lack of social policies explicitly addressing gender gaps and the transfer of care duties from women to the institutional domain.

Table 5.3. Indicators for the dimension defamilisation of social welfare for Ecuador, years 2000 and 2020 (or the nearest year)

Indicator	Year	
Extended and composite households (% of the total number of households) [i]	2000: 29.5%	2019: 29.3%
Domestic servants (as % of total employment) [i]	2001: 3.7%	2019: 3%
Women full-time to household chores (% of the population of women aged 15 and over) [i]	2001: 25.7%	2018: 25.6%
Female share of part-time employment (% of total employment) [ii]	2000: 52.2%	2012: 56.4%
Female heads of households (% of the total number of households) [i]	2000: 18.7%	2018: 28.2%
Demographic dependency ratio (children and older persons) [i]	2000: 66.3%	2020: 53.8%

[i] ECLAC, CEPALSTAT
[ii] ILO, KILM 9th ed.

Lastly, regarding *outcomes*, by the early 2000s, indicators of well-being and quality of life were poor (Martínez Franzoni, 2007). Nowadays, Ecuador still exhibits a lower performance than countries such as Chile and Uruguay, but it has seen noticeable improvements (Table 5.4). However, progress in other indicators, such as child malnutrition as well as maternal and infant mortality, are less encouraging (Espinosa, Palacios and Cisneros, 2017).

Table 5.4. Indicators for the dimension outcomes for Ecuador, years 2000 and 2020 (or the nearest year)

Indicator	**Year**	
Under-five mortality rate (Deaths per 1,000 live births) [i]	2000: 28.9	2019: 14
Expected years of schooling [ii]	2000: 12.4	2019: 14.6
Gender Development Index (GDI) [ii]	2010: 0.959	2019: 0.967
Homicide rate (per 100,000 people) [ii]	2000: 14.5	2018: 5.8
Individuals using the Internet (% of population) [i]	2000: 1.5%	2019: 57.3%

[i] WB (2021), World Development Indicators
[ii] UNDP (2021), Human Development Data Center

Summing up, the updated information indicates that, despite noticeable improvements that have boosted the population access to social welfare, the state continues to have a limited capacity to grant massive access to generous benefits and services. Hence, social welfare continues to be significantly based on the market and families.

Table 5.5 summarises the updated features of the Ecuadorian welfare regime by each of the dimensions examined above. The analysis presented reveals that the scenario where the current architecture of health care is embedded is that of a welfare regime, with important deficiencies both in terms of the commodification in the labour market and in the decommodification of welfare. This is evidenced by the high levels of informality that persist in the country and the still limited coverage of the social policy, as witnessed in the limited outcomes of wellbeing.

Table 5.5 Updated features of the Ecuadorian welfare regime by dimensions of the Martínez Franzoni's (2007) typology of Latin American welfare regimes

	ECUADOR
Type of welfare regime	**Non-state familist welfare regime**
Commodification in the labour market	**Similar to regional averages, limited performance** Low job quality, with no significant improvements from the early 2000s. Progress in economic performance, with a substantial decline in poverty and inequality, but the latter remains high.
Decommodification of welfare	**Limited and dual** Progress of the public welfare system, but improvements are still restricted. Market-based options fill the gaps of publicly provided social services.
Defamilisation of welfare	**Low**

	Reliance on families remains high.
Outcomes of wellbeing	**Low performance**, but marked improvements from the early 2000s onwards.

Source: Own elaboration based on Tables 5.1 to 5.4

The next Section 5.3 complements this picture by examining the trajectory followed by health care policy and some milestones of the welfare system´s development, thus putting into place the initial pieces to comprehending the current policy architecture of health care and the middle-classes` practices for meeting their care needs.

5.3.- Historical trajectory of the policy architecture of health care

Compared to other Latin American countries, Ecuador was a latecomer in creating a welfare system (Mesa-Lago, 1985). Public provision of social services first focused on developing an educational system autonomous from the Catholic Church and landowners and was only in 1935, that the National Institute for Social Security (Instituto Nacional de Previsión, later called Caja Nacional del Seguro Social) came into force (Espinosa, 2011). Regarding health care, in 1967, Ecuador was the last country in America to establish a Ministry of Health (Ministerio de Salud Pública [MSP]), although the Ministry of Social Security already provided some health services (Velasco, 2010).

Like in most of the region, the ISI development model (1930s-1970/80s) implied higher involvement of the state in the economy and the expansion of social policies. This approach strengthened during the 1970s, with the oil boom and, unlike in other Latin American countries, was not undermined by a military regime (Vásconez, Córdoba and Muñoz, 2005). Nonetheless, the welfare provision remained limited, and within it, social security and health care were not a priority, with coverage below 20% qualifying it as an exclusionary welfare system[32] (Filgueira, F., 1998). Moreover, the restricted social services were more generous for the incipient middle-classes, whilst being scarce and providing only basic assistance for the poor (Espinosa, 2010) and the indigenous population (Botero, 2001, 2013).

In the 1980s, Ecuador abandoned the ISI model and adopted the export-oriented and neoliberal economic strategy pushed by the IMF and the World Bank (Vásconez, Córdoba and Muñoz, 2005). This involved applying measures of structural adjustment and further constriction of social policies (Espinosa, 2011). The state returned to a minimalist role in social affairs (Martín-Mayoral, 2009), which in the context of a weak economy and labour market, reinforced the exclusionary and familist welfare model. Despite this, in 1982, the health sector defined the delivery of public services through the MSP and began to advance free health care for the reduced part of the population that benefited from social security (Velasco, 2010). This approach

[32] Filgueira (1998) assigned this label to Ecuador, The Dominic Republic, Guatemala, Honduras, El Salvador, Nicaragua and Bolivia.

continued throughout the 1990s and into the beginning of the 2000s. By the end of the 1990s, the country faced a deep economic crisis, with extremely high poverty rates (Martín-Mayoral, 2009) and a wave of emigration that surpassed a million people (Acosta, 2005). Governments reacted with the same assistance approach (Vásconez, Córdoba and Muñoz, 2005), privatised public enterprises, and adopted the US dollar as currency (Martín-Mayoral, 2009).

Following the overall trend, the health policy was featured with having drastic austerity measures. The MSP´s budget fell from 4.6% to 2.8% of GDP between 1996 and 1997 (De Paepe et al., 2012), whilst the participation of private actors grew with virtually no regulation, and access to health services became increasingly dependent on the households´ direct payments (Velasco, 2010). De Paepe et al. (2012) qualify this process as a silent neoliberal reform, meaning that although the health system's restructuring was not explicit but still existed. Between the late 1990s and the early 2000s, there were 17 attempts at reform to suppress the public provision of services by the MSP (Echeverría, 2007; Velasco, 2010). These failed, but drastically limited the services delivered, whilst social security slightly strengthened, despite a privatisation attempt in 1995 (De Paepe et al., 2012).

Paradoxically, in 1998, the country approved a political constitution that recognised the right to health and the state as the guarantor. In 2002, the Organic Law of the National Health System defined it as being composed of the Ecuadorian Institute for Social Security (Instituto Ecuatoriano de Seguridad Social [IESS]), the schemes for army forces (ISSFA) and the police (ISSPOL) as well as the medical units for the provision of health services (UMPS) (Jiménez-Barbosa et al., 2017). In 2006, Ecuador received a loan of USD 90 million dollars to implement the Project of Universal Health Insurance (Granda and Jimenez, 2019). Nevertheless, the system continued to be fragmented, with public health services strictly targeting the poor and social security-based schemes addressing the small percentage (near 10%) of the population holding formal jobs (Espinosa, 2010). Thus, in the early 21st century, the policy of health care in the country exhibited an evident dissonance between the principles formally declared and their implementation.

The election of President Correa in 2007 and the new political constitution (known as the Montecristi Constitution) approved in 2008 marked a turning point for the welfare system. The concept of *Good Living* was the cornerstone of three National Plans (2007-2010, 2009-2013, and 2013-2017), which, among other issues, involved the strengthening of social investment and welfare policies (Minteguiaga and Ubasart-González, 2015). Nonetheless, the institutional capacity of the government to deliver quality policies remained quite limited, being one of the least within the Latin American scene (Franco Chuaire and Scartascini, 2014).

In the health sector, Articles 362, 363 and 369 of the new constitution established the right to universal free access to public services and medicines provided by the state. Accordingly, the government started a health reform that involved several measures that challenged the exclusionary historical hallmark of health care, among them: to universalise public coverage offered through the MSP; the increase of the budget for the MSP (e.g. it rose from $615 million in 2007 to $1,047 million in 2008); the suppression of copayments to the public (MSP) and social security (IESS/SSC) providers; progressive free delivery of health services and medicines

(Velasco, 2010; De Paepe et al., 2012); the Programme of Coverage of Catastrophic Diseases (Jiménez-Barbosa et al., 2017); and the Family, Community, and Intercultural Comprehensive Model of Attention (Modelo Comunitario, Familiar e Intercultural de Atención Integral de Salud [MAIS]) (Jiménez-Barbosa et al., 2017).

The original proposal for reform presented by the Secretariat for Planning and Development (Secretaría Nacional de Planificación y Desarrollo [SENPLADES]) was to integrate the public and social security schemes into a unique national health system (De Paepe et al., 2012). In an interview for this research, the Vice-minister of Governance and Public Health Surveillance during the period explained that the aim was creating a single fund of resources based on general taxes and complemented by an additional contribution of workers. Nevertheless, veto players (especially managers and organised beneficiaries of social security schemes) promoted curtailments, which were accepted by the government that did not try to go further once it had achieved broad support by guaranteeing free services through the MSP. The original proposal was replaced by the ´functional integration` of service delivery, which involved the integration of services and financing of the MSP and the IESS/SSC at the primary level of provision, and the interchange of services (maintaining financial autonomy) at the secondary and tertiary levels (De Paepe et al., 2012; MSP Ecuador, 2012; Malo-Serrano and Malo-Corral, 2014). Nonetheless, neither of these things happened. Thus, the policy legacies created by a health system historically fragmented prevented the unification of the system. The reform was finally limited to strengthening the public sector, and the social security scheme (IESS/SSC) remained separated to cover formal workers. Moreover, the IESS/SSC was expanded to family dependents without increasing available resources, which meant that it did not benefit from the reform and, in fact, its quality substantially worsened (Former Vice-minister of Health Service Provision).

Consequently, the reform did not suppress the coexistence of several schemes, namely the IESS for public and private employees, the SSC (i.e. a specific branch of the IESS) for agricultural workers, the ISSFA for the armed forces, the ISSPOL for the police, small schemes belonging to local governments, and the public scheme of the MSP for all the non-covered population (MSP Ecuador, 2012; Jiménez-Barbosa et al., 2017). All of these have distinct regulations, financing sources, and benefits packages (Malo-Serrano and Malo-Corral, 2014; Villacrés and Mena, 2017). Nowadays, the reform remains an unfinished project that has not been a priority for President Moreno's government started in 2017 (Former Vice-minister of Governance and Public Health Surveillance).

In sum, most of the historical trajectory of social welfare in the country is featured by weak social policies with an exclusionary approach. The welfare system was, by and large, restricted to a small middle-class holding formal jobs and essential services targeted at deprived groups, with health care being no exception. The political switch that started in 2007 seemed to imply the unprecedented prioritisation of social investment and universal principles, although the actual scope of the changes implemented is contested. By analysing the current policy architecture and outputs of health care, Section 5.4 provides insights into how this trajectory has impacted on the health sector, paying particular attention to the implications for the middle-classes. Then, Section 5.5 complements the picture by focusing on the practices that the middle-classes have been deploying to access health care within this context.

5.4.- The contemporary policy of health care

5.4.1) Policy architecture of health care

5.4.1.1. Eligibility - Under what criteria do people benefit?

Because the health system remains as separated schemes, there are different eligibility criteria. As explained earlier, with the 2008 health reform, the MSP's health coverage became a right, with living in the country being the sole criterion of inclusion. In contrast, the IESS and the SSC have kept payroll contributions as the condition for eligibility, which since 2010 has been extended to spouses and 6-18 year old children of workers on a voluntary basis and with an additional contribution. The armed forces, police and their family members are eligible for the ISSFA and ISSPOL, but with more limited benefits vis-à-vis the IESS/SSC (MSP Ecuador, 2012; Jiménez-Barbosa et al., 2017).

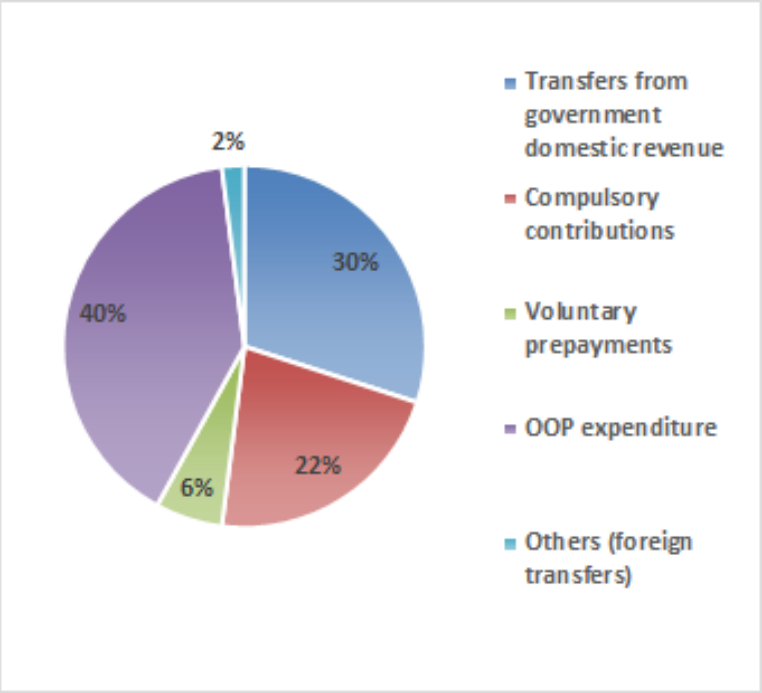
In this scenario, most middle-classes meet the contributory criterion and take part in the IESS. However, as I explain later, a salient characteristic of middle-classes` practices for accessing health care in Ecuador is the owning of more than one insurance, supplementing social security with private insurance, and the utilisation of both social security and private services, which is not exclusive to this country, for it is a significant source of secondary coverage across the region (OECD/WB, 2020).

5.4.1.2. Funding - Who pays and how?

Between 2000 and 2018, total health expenditure passed from 3% to above 8% of GDP (ECLAC, 2020), primarily due to revenues directly allocated by the government to the public scheme (MSP) and the growth of compulsory contributions. Currently, public expenditure from general revenues is near 2.5% of GDP (ECLAC, 2020). It represents the second main source of health financing in the country, after OOP, increasing from 16% to 30% of the total health expenditure between 2000 and 2018 (WHO, 2020a), which is a higher increase than the average for Latin American countries. Nevertheless, comparatively, public investment as percentage of GDP is lower than in countries such as Chile (3%) and Uruguay (3.6%) and far from the international recommendation of 6% of GDP (WHO, 2010; PAHO/WHO, 2014).

Payroll taxes also rose substantially, rising from 13% of total health expenditure in 2000 to 22% in 2018 (WHO, 2020a), although they continue to represent a low proportion of the total health expenditure (Graph 5.1) due to the high informality of the labour market. In 2016, these contributions ranged between 0.5% and 0.7% for rural workers, 0.88% and 2.88% for salaried workers, 7.06% and 18.12% for employers, 9.94% for the self-employed, and 3.41% for the voluntary enrolment of family dependents (IESS, 2016).

Graph 5.1. Health care expenditure distribution by source, Ecuador 2018



Source: Own elaboration based on the WHO Global Health Expenditure Database

Despite the increase of resources, similar to eligibility criteria, funding arrangements feature fragmentation, as the reform kept separating the funds of each scheme. General revenues primarily finance MSP coverage, which means subsidising the poor, who are the primary group exclusively covered by the public scheme (see the following subsection). In turn, payroll taxes, predominantly contributed by the middle-classes, finance social security schemes. Meanwhile, voluntary prepayments and copayments fund supplementary private insurance. This configuration prevents the equalisation of resources and solidarity between schemes, creating an inconsistency between the financial arrangements and the aims established by the health reform (Villacrés and Mena, 2017). Moreover, some claim that this financing structure impairs the public scheme, because of cross-subsidisation from the MSP to the other schemes that lack an appropriate network for supplying primary health care[33] (MSP Ecuador, 2012; Villacrés and Mena, 2017).

5.4.1.3. Benefits - Who defines them, and what are they?

The state defines the benefits covered by different schemes. The two primary ones (MSP and IESS) hold to comprehensive benefits with no exclusions, including medicines and coverage of catastrophic diseases to all holders. Meanwhile, the ISSFA and ISSPOL contemplate narrower benefits for family dependents (MSP Ecuador, 2012). The comprehensiveness of benefits of the public scheme marked a radical turn from the long tradition that restricted the MSP to providing essential services. As for private insurance schemes, there is no regulation of benefits. They

[33] The situation is different at the secondary and tertiary levels of provision, whereby the reform has defined specific procedures for purchasing services between the MSP and social security schemes.

consider various packages that are usually not comprehensive. Therefore, usually it is necessary to complement them with services provided by the IESS or directly purchased from private providers (Former Vice-minister of Health Service Provision).

5.4.1.4. Delivery - Who does what?

Service delivery remains fragmented between the public network of the MSP (i.e. the public network), providers of the IESS/SSC, and providers of other social security schemes. Furthermore, services can be delivered by private for-profit and non-for-profit private providers (MSP Ecuador, 2012). The MSP runs hospitals all over the country and 54% of ambulatory medical centres, it being the largest provider of primary health care, whilst the IESS and SSC have 30% of the primary health care centres. By the ´functional integration`, the health reform created the Comprehensive Public Network of Health (Red Pública Integral de Salud [RPIS]), which comprises all public and social security providers of primary health care. Meanwhile, regarding the secondary and tertiary levels of provision , it involved regulating prices and service purchasing between the MSP and IESS and the purchasing to private providers (Malo-Serrano and Malo-Corral, 2014).

Nevertheless, the purchasing of services for secondary and tertiary delivery gained relevance, and the primary health care was never really integrated (Former Vice-minister of Health Service Provision). Some studies have pointed out that the high number of services that the MSP purchases from private institutions risks the system's financial sustainability (Chang Campos, 2017). Hence, the private sector is incorporated into the provision of services, that is, precisely where direct contact with patients is generated, without this being recognised (and therefore regulated) by the other instruments of the policy architecture of healthcare.

5.4.1.5. Outside Options - How do governments manage market-based alternatives?

The private market-based sector includes both private insurance and service delivery. Despite private insurance being less extensive than in other countries of the region, the government estimates that this markedly grew in recent decades, reaching 27.03% of national health expenditure in 2008, being particularly targeted towards inpatients (MSP Ecuador, 2012).

The 2008 health reform opted for strengthening the public sector and made some efforts to promote the functional integration between the public and social security schemes. Along these lines, the reform kept the private sector out of the health system, without opening the possibility of formally opting-out towards private options, thus replacing social security. Nevertheless, this exclusion has also meant that the private sector remains unregulated in all areas except service purchasing by the MSP and IESS/SSC. In this way, the increasing presence of the private sector is further promoted by the transfer of public resources for services and the absence of a clear and explicit definition of the role, limitations and benefits of market-based options in the health care domain. In this context, those who invest in private insurance or simply pay for private provision at the point of receiving attention are highly vulnerable in the face of these

unregulated institutions and the commodification of health care, which is the result of the weaknesses of both public and social security health provision.

5.4.2) Health Care Policy Outputs

5.4.2.1. Population coverage

Since the 2008 health reform, all residents in the country have been formally covered. Before that, health coverage was calculated based on the population registered for social security, which in 2002 reached 45% of urban salaried workers 15 years old and over, whilst this figure was 13.4% for the self-employed. These figures grew to 66% for salaried workers and 23% for the self-employed by 2013, but continued showing a significant gradient by income quintiles (Sojo, 2017).

In 2010, once the reform had started, coverage by the MSP excluding the population with social security had reached 70.1% of the total population, but declined to 61.1% in 2016 (Espinosa, Palacios and Cisneros, 2017; Jiménez-Barbosa et al., 2017). This decline was hand in hand with an increase in social security coverage due to the enforcement of affiliation for workers (Granda and Jimenez, 2019) and the extension of these entitlements to the workers´ family dependents (MSP Ecuador, 2012).

Despite the MSP formally covering the whole population, regarding resources allocation, it considers the ´open population`, namely those without social security, as its holders (MSP Ecuador, 2012). This separation allows for distinguishing the socio-demographic and risk profiles between the schemes, which show significant differences: the public scheme primarily covers the poor and lower-middle-incomers, who also have higher health risks, whilst the social security scheme includes the middle and upper-middle classes, who exhibit lower health risks (MSP Ecuador, 2012). Analyses of household surveys show that coverage through the MSP is more prevalent among women, those with lower levels of education and middle-age groups, whereas coverage by the IESS is more prevalent for men, those with higher educational levels and the older population (own calculation based on Encuesta Nacional Multiproposito de Hogares, 2020).

Regarding groups with private insurance, and despite shortcomings in the available data, estimations indicate that private insurance is about 4% of the population (Jiménez-Barbosa et al., 2017), whilst others point to it being over 9% (Lucio et al., 2019). In relation to private provision, it is estimated that this constitutes 15% of all services delivered in the country (De Paepe et al., 2012).

In conclusion, despite the coexistence of schemes (i.e. system fragmentation), coverage is universal in the country, which is not the same as access. The available information does not provide an in-depth depiction of the profiles of the groups covered across the schemes, although it is stated that the MSP gathers those groups with higher health risks. Therefore, it is necessary

to complete the route analysing the other dimensions that shape the policy outputs to achieve a better understanding of the strengths and deficiencies of the systems in terms of universalism and segmentation.

5.4.2.2. Generosity

The outputs regarding generosity indicate that Ecuador has improved its performance since the turn of the century. Between 2000 and 2018, total and public expenditure in health increased over the regional average (ECLAC, 2020). From 2007 to 2010, the expansion of the public network all over the country was one of the principal improvements generated by the health reform (Chang Campos, 2017). The number of health facilities rose by 12% from 2006 to 2014, which encompassed an increase in the facilities of the MSP, the IESS and also private providers associated with the increase of services hired by the MSP and especially by the IESS, to face the unmet demand for health care services (Granda and Jimenez, 2019). Moreover, human resources tripled in the public sector between 2008 and 2015 (Espinosa et al., 2017), with the government setting up the Programme of Social Protection of Health (PPS) to cover catastrophic diseases in selected cases (Lucio, Villacrés and Henríquez, 2011; MSP Ecuador, 2012).

Nevertheless, the MSP Ecuador (2012) recognises that differences in service availability continue across sub-regions, and the PPS faces constraints with providing high-cost drugs and other medical supplies. In turn, the IESS remains limited in its provision of primary health care, which implies the need of seeking for those services through the MSP´s network or with private providers. Lastly, the lack of regulation of the private sector implies broad heterogeneity of comprehensiveness and quality throughout private insurance and providers (Former Vice-minister of Health Service Provision).

As for quality, it is helpful to consider as a proxy that resources per capita rose from 64 USD to 100 USD between 2008 and 2011 for the MSP. Meanwhile, those of the IESS and SSC declined from 357 USD in 2010 to 313 USD in 2011 (MSP Ecuador, 2012). Hence, the gap between both schemes narrowed, but the relationship continued about 1:3 even without considering differences in risk profiles of the covered population. On the other hand, social security schemes witnessed the constraining of their resources since the reform, which may have been at the expense of the quality of care they offer to the insured population.

Also, it is important to keep in mind that, in 2016, the total health expenditure in the country was 505 USD per capita, that is, below the regional average of 606.88 USD, of which, almost 50% (258 USD) was public expenditure (Lucio et al., 2019). In 2018, the total health expenditure increased to 906 USD per capita, but government transfers remained almost the same as in the years before (289 USD) (WHO, 2020a). These figures give an idea of the budget constraints to financing a model of provision aimed at universalism and high levels of comprehensiveness.

When comparing with the rest of Latin America, Martínez Franzoni and Sánchez-Ancochea (2018) point out that Ecuador continues to have a lower-middle performance of generosity. Their study shows important improvements in some indicators used to assess generosity, such

as antiretroviral therapy coverage and neonatal mortality. Nonetheless, the country's relative position in the region remains the same.

In sum, whilst, formally speaking, the health reform defined comprehensive and quality services for public and social security schemes, service availability and resources contradict this commandment, which leaves the poor as well as the middle-classes under the obligation of seeking alternative mechanisms to meet their health care needs. In turn, for those groups that hold supplementary private insurance, the comprehensiveness of health plans and quality of services are unregulated and heterogeneous, thus failing to be guaranteed. Consequently, all social strata, even those in the most advantaged positions, face constraints to obtaining the required services.

5.4.2.3. Financial protection

With the universal public scheme, theoretically, everybody in the country can benefit from public resources to access health care. Nonetheless, as explained, middle and upper-middle classes do not seek services through the MSP. Thus, this financial benefit primarily targets the poor and workers without social security. Moreover, even for those seeking attention from the MSP, the real impact of subsidies is conditioned by the availability of services and supplies needed to make the provision possible.

Even though the health reform set other measures to improve financial protection. One is the public fund for catastrophic diseases that offers safeguards against economic ruin (MSP Ecuador, 2012), whilst another is the suppression of copayments for the IESS and SSC. Nevertheless, these measures remain far from eliminating health-related financial risk, as the first is limited to a small number of health problems, and the second is hampered by the quality deficits of the IESS/SSC, meaning that holders still have to seek private services against OOP spending. In fact, private spending continues to represent near 50% of the total health expenditure, and OOP spending is the primary source of revenue for health care, reaching 40% in 2018, which is high even within the region (WHO, 2020a). Moreover, it is estimated that, in Ecuador, 10.3% of the population spends more than 10% of their household consumption on health care, which has driven 2.4% of households below the poverty line (OECD/WB, 2020).

Regarding utilisation of services, the situation in the first years of the 2000s was not promising, as less than a quarter of the population could effectively access health services (MSP Ecuador, 2012). Data from 2004 show that service utilisation had a negative correlation with households´ income levels (Lopez-Cevallos and Chi, 2010). A study carried out in 2007 in Quito points out that people used more private (70%) than public services (30%), because of the perception of the bad quality of the latter, especially among people belonging to the lowest income quintiles (i.e. those covered at the MSP) (Proyecto Salud de Altura cited by De Paepe et al., 2012). After the health reform, a study conducted by Armijos Bravo and Camino Mogro (2017) revealed the endurance of cross-scheme gaps, with lower service utilisation among the population in the public scheme. Nonetheless, Granda and Jimenez (2019) found that the pro-rich bias in both curative visits and overall inequalities in health care utilisation decreased following the reform.

In sum, even though formally the state grants universal free health care coverage, such allowances do not bring financial protection for middle and upper-middle classes, as the public scheme mostly addresses the poor. Moreover, the public scheme does not financially protect the most vulnerable groups owing to the failures of the availability of services. The fragmentation of the system prevents middle sectors from benefiting from some of the arrangements to financially protect the population. Moreover, fragmentation stops more resources entry into the public system because it keeps contributory funds separate, hence, undermining the possibilities of the public system to improve service availability and quality and, thus, also financial protection of the vulnerable groups. At the same time, the financial protection of the middle-classes is hampered by the quality deficits of social security health services that were not targeted by the health reform, which pushes them into seeking unregulated private services.

5.4.2.4. Sufficiency and equity of policy outputs

Grounded on the previous analyses, it is unquestionable that Ecuador has made important progress in health care since the beginning of the implementation of the health reform in 2008. Among this progress, the most evident relates to the extension of population coverage to guaranteeing access, as of right, for all groups of the population, with no exception. This represents an improvement in terms of the sufficiency and equity of coverage.

However, the persistence of system fragmentation by occupational categories leads to interrogating how this impacts on sufficiency and equity in the dimensions of generosity and financial protection, as different population groups (i.e. workers with formal jobs, agricultural workers, and workers with informal jobs) are covered by different schemes with different benefits, resources, and suppliers. Moreover, despite not being considered by the policy architecture, private options also play a significant role in health insurance, and especially in service delivery, which represents a second form of fragmentation, which, whilst not being institutionalised, does lead to the segmentation of the population.

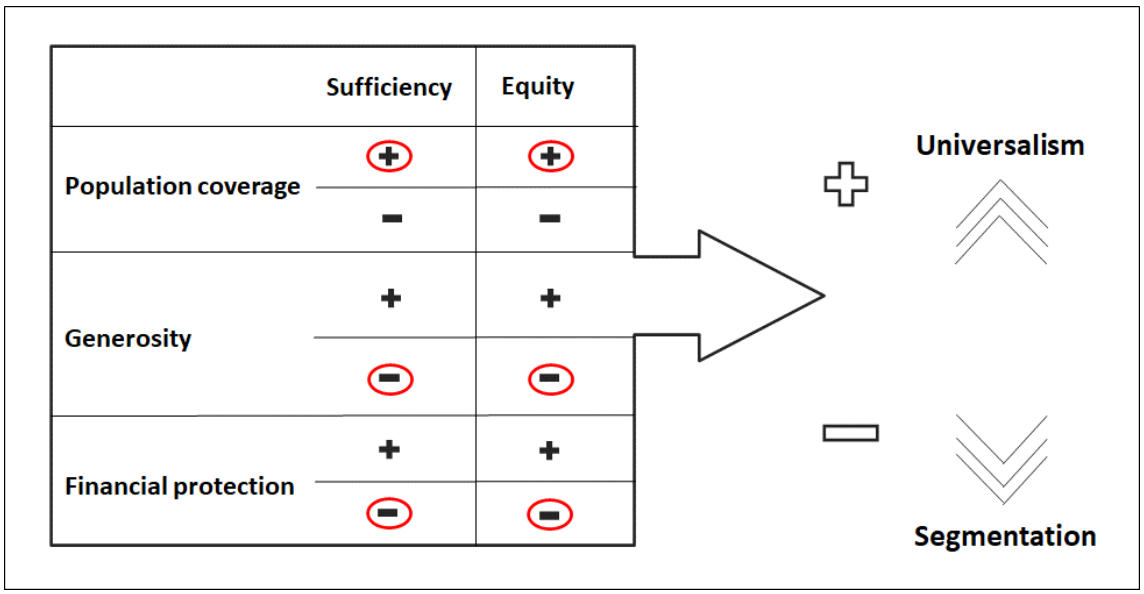
The published research is insufficient to have an exhaustive answer regarding how much progress the country has made in recent years regarding these issues. However, from the literature it is possible to verify that all population groups have to deal with deficits in generosity and financial protection. Moreover, it is reasonable to argue that the greater the social vulnerability of groups, the greater the deficiencies they have to cope with when accessing health care. At least, considering that their chances of seeking services outside (i.e. private options) are determined by their investment ability.

Available information suggests that generosity is far from being sufficient. The analysis of the previous pages has shown that deficiencies in the availability of health services and supplies in the public and social security schemes are widely recognised in the country. This translates into inequitable access, as only more resourceful groups have the chance of using other alternatives, such as private insurance and providers, to get the services that cannot be obtained in the public

and social security sectors. Hence, despite the existence of a formal right to receive health care, it is often not possible in practice.

Concerning financial protection, the unprecedented expansion of coverage in the public scheme and social security has not been accompanied by a similar increase in revenues. Previous subsections have shown that, in spite of resources significantly increasing for the MSP, they continue to be very low vis-à-vis the international recommendations. In turn, per capita resources at the IESS and SSC decreased, while the covered population expanded substantially, which, without a unification or at least the real functional integration of service delivery, undermines the availability and quality of services accessed by social security holders. These deficits push households into seeking services outside the public and social security providers without support nor regulation, thus being exposed to financial risks when striving to meet their health care needs. This is illustrated by the very high average level of OOP spending in the country, which have more impact for those groups with lower incomes. Hence, financial protection continues to be far from being sufficient and equitable. Figure 5.1 presents an overview of the contribution that each dimension of the policy outputs is making to universalism/segmentation of health care from the perspective of their sufficiency and equity.

Figure 5.1. Outputs for universal health care by dimensions, Ecuador



Source: Own elaboration

5.5.- Middle-Classes´ access to health care

So far in this chapter, the historical limitations of the Ecuadorian health care system for providing universal health care, how this relates to the fragmentation of the health care system and some implications for the middle-classes` access to health care have been discussed. This section

starts with a brief depiction of the middle-classes in the country and then, the focus is on their perceptions of health care and practices for accessing it.

5.5.1) The middle-classes in Ecuador

Like in other countries of the region, the Ecuadorian middle-classes historically represented a small part of the population as opposed to the vast majority of the people living in poverty. However, an article published in 1949 already highlighted the significance of the interests and demands of an increasing number of professionals for the country´s development. Moreover, the article pointed out the internal heterogeneity of this social group and the difficulties that many faced in obtaining a sufficient living standard (Paredes, 1949).

Regarding the size of the middle-classes, retrospective estimations of the occupational structure indicate that, in 1936 about a quarter of the working population were public (16.6%) or private (8.5%) employees very weakly organised (de la Torre, 1993 cited by Ibarra, 2008). A study by Díaz in 1961 calculated the urban middle-classes as comprising 11.3% and the rural middle-classes 13.94% of the total population, also highlighting the precariousness of these groups in terms of income (Ibarra, 2008). By examining the evolution throughout the 20th century, ECLAC´s occupational-based analyses indicate that, during the ISI development model, the middle-classes expanded from 10.5% in 1950 to 24% in 1982. However, the upward trend stopped in the 1980s-90s, with the retrenchment policies pushed by IFIs, and the middle-classes stagnated at 12% between 1990 and 2001 (Ibarra, 2008). Moreover, its composition transited towards higher participation of petty entrepreneurs and lower presence of public employees, changing from 4.2% to 7.5% and 17.5% to 11.7%, respectively, from 1990 to 1998 (Portes and Hoffman, 2003). By the end of the century, the Ecuadorian middle-classes reached around 20%, remained vulnerable to economic shocks, and were poorly supported by a weak social security system (Espinosa, 2010).

Along with poverty and inequality reduction, the middle-classes expanded over the first decade of the 21st century. Economic estimations using the vulnerability approach proposed by Lopez-Calva and Ortiz-Juarez (2014) indicate growth from 14.4% in 2000 to 26.6% in 2012 (PNUD, 2014) and 37.4% in 2015 (Gachet et al., 2017). However, the population in situation of vulnerability also increased, from 33.1% to 43%, between 2000 and 2012 (PNUD, 2014). Figures based on subjective class-positioning concur with the uprising trend, but in an increased way, reporting that by 2018, 5.3% of the population perceived themselves as upper-middle, 49.6% as middle-middle, and 30.3% as lower-middle class (Latinobarómetro, 2018b).

Gachet et al. (2017) state economic growth as the first and inequality reduction as the second most important explanatory factors for the middle-classes´ enlargement over the period 2005-2015. However, the authors notice that inequality reduction stopped contributing after 2011 and economic growth slowed, thus jeopardising the sustainability of such expansion.

In terms of their characteristics, very few studies have profiled the preferences, values, lifestyles, practices, or welfare access of middle-class groups. Some claim that there are commonalities concerning lifestyles, patterns of consumption, and access to higher levels of education, but that they are progressively heterogeneous regarding their income levels, occupations, sector of employment, and areas of residency (Cañete, 2008; Ibarra, 2008; Espinosa, 2010). Furthermore, according to Ibarra (2008), middle-classes continue lacking political representation, facing pressure on living conditions and restricted state support. Indeed, even after the expansion of welfare policies started in 2007, one-third of the service class did not contribute to pensions or health insurance (Solís, Chavéz Molina and Conbos, 2019).

Concerning health care, knowledge gaps are conspicuous. Official figures indicate there being between 4% and 8% private insurance and widespread direct payments (i.e. expressed in the OOP spending) to get private services (MSP Ecuador, 2012). Beyond these rough numbers, however, the literature does not differentiate how the different social classes access health care and hence, middle-classes practices and perceptions on this matter remain largely unexplored. The following subsections are aimed at contributing to filling these knowledge gaps.

5.5.2) Middle-classes´ practices for achieving health care

The analysis presented in this section is based on 18 interviews conducted with members of the Ecuadorian middle-classes in January and February 2018, in Quito, the Ecuadorian capital. The participants were distributed equally by sex (nine women and nine men), ranged between 30 and 63 years old and were diverse in terms of family status (single and married; with and without children), employment category (salaried and self-employed), household income, and involvement in social movements. At the time, 17 interviewees held coverage in the social security scheme (IESS), and one was with the MSP, whilst 10 participants had complementary private insurance (Appendix 2).

5.5.2.1. The perceived health system

In the current architecture of health care, formal salaried-workers (i.e. most of the middle-classes) cannot opt-out from the social security scheme of health care, whereas the self-employed have the option of voluntarily contributing to the IESS, which, according to the interviewees, is an increasing trend. The only participant that lacked IESS´ coverage was Alex, who worked as a research assistant at an academic institution paid by a scholarship and despite considering social security the most affordable mechanism to access health care, considered that, currently, his earnings were not enough to pay voluntary contributions.

Participants agreed in considering that the IESS is an affordable way to obtain health care and offers comprehensive services vis-à-vis private options. They trusted on the physicians' expertise and recognised the IESS as the cheapest option to obtain health services. In fact, the elimination of copayments was recurrently described as an advantage and an enabler for seeking provision.

However, being enrolled in the IESS, either because it is compulsory (i.e. for salaried workers) or as a voluntary option (i.e. for self-employed, family dependents, etc.), does not necessarily imply seeking health care at its facilities. Indeed, participants usually expressed their willingness to seek health care services from it only if private provision was not possible, that is, in the scenario of severe disease, loss of job along with the private health insurance linked to that job, or if the private insurance did not cover the service. In any of these three cases, the IESS was perceived as a backup that provided security. The following quote by Camila, a woman who suffered from breast cancer, illustrates this: *´I go secure. Some people have had [bad] experiences, but I go easy. I trust in social security. I have private insurance provided by my job, but when I knew about my cancer, I did not hesitate`* (Camila, single woman, 57 years old).

Nevertheless, participants also described that after the extension of social security coverage to family dependents in 2010, the demand increased and quality became lower, especially regarding timely of attention: *´[The IESS] grew far beyond its possibilities, so, with much demagogy, the insurance opened for relatives, children and pensioners. A socially important measure? Absolutely yes, but they have to create the conditions to respond. Instead, they have lowered the quality for everyone`* (Federico, father of 2 adults, 63 years old).

Further to the shortcomings in timely services, another criticism is the discomfort of getting health care. Felipe and Laura´s quotes reveal three main complaints: lack of communication with doctors, limited accessibility of medical centres, and poor organisation of services. *´It is like a disaster. They give you the service, but as if you were an object in a bed […] Sometimes doctors come with students. Of course, students have to learn, but they don't even introduce you. They don´t say "excuse me, may I come in?" `* (Felipe, father of 2 children, 36 years old); *´We don't have health centres. We have hospitals that you cannot find in your neighbourhood. They are chaotic […]`* (Laura, mother of 1 child, 34 years old).

Regarding the differentiation in the last quote between medical centres and hospitals, it is significant to bear in mind the mentioned failure in the process of functional integration for delivering primary health care using the available capacity of the MSP and the IESS´s focus on delivering services in hospitals. The deficits in primary health care promote a medicalised model, the overcrowding of hospitals, long waiting hours, queues, and most of the shortcomings criticised by the participants. As the analysis below shows, some of these aspects operate as powerful drivers of their practices in health care seeking.

In turn, the MSP´s coverage is considered the default option, but not for being comprehensively covered. If, for any reason, interviewees were not contributing to social security, they would describe themselves as uncovered. These perceptions indicate the distancing of the middle-classes from the public option, which remains stigmatised as being the scheme for the poor, despite it being formally delinked from income level since the health reform. In fact, all non-salaried participants had opted for voluntarily contributing to the IESS, rather than relying on the MSP.

Most participants had never attended the MSP´s medical centres. They recognised a contradiction between the stigmatisation and the ´good stories` that could be heard about the

public sector's improvements in the last few years. They attributed this discrepancy to deficiencies in the information provided by public entities and the perception that improvements primarily related to the treatment of severe diseases, whereas routine care continued to be exhibiting shortcomings of availability and timely services as well as being delivered in overcrowded and uncomfortable medical centres.

This quote by Laura, who had had the unusual experience of having attended the IESS, the MSP and private providers, summarises both the stigmatisation of the public scheme and the perception of a closing gap of medical quality between this and the IESS. *´[…] both [the IESS and MSP] are public, with the same quality and quantity of people waiting […], but it is like another target of people. If you attend the public hospital, there are 15 people of the first and second quintiles in the queue, I mean extreme poverty and two people of the third quintile, that is`* (Laura, mother of 1 child, 34 years old).

Finally, private insurance was perceived as a desirable option for the middle-classes, although it represented an expensive alternative and implied additional investment. Nonetheless, most interviewees evaluated that the possibility of getting the services they wanted when they wanted, timely attention and comfortability compensated for the extra effort.

> Pamela: *´What do you think are the benefits of hiring private insurance?`*
>
> *'How quickly they can give me the service. I don't like wasting time; I like it fast […] I'm paying'* (Camila, single woman, 57 years old).

Moreover, it is usual that private health insurance is included as a job benefit, and this was believed to be an enabler to hire this type of service: *´My husband's job pays his insurance, and he pays 100 extra dollars for my children and me. Then, we have a speciality clinic [...] you go and, for 4 dollars, you receive attention from a specialist. It would not be very smart of us not to accept this option`* (Isabel, mother of 2 children, 37 years old).

Nevertheless, private insurance usually is not comprehensive, which relates to the lack of regulation of the private health sector. Only the most expensive plans include all kinds of services, but they usually are unaffordable for the middle-classes and not included as job benefits. Hence, the participants counted on private services for routine attention and medical tests, rather than critical health needs, as the latter are not included in most private plans.

In sum, with all these available options and their limitations, the middle-classes assess their convenience for each type of health need. According to their narratives, no institutional scheme (i.e. public and social security) guarantees sufficient quality regarding availability and timely attention, at least for routine needs. In turn, market-based options allow for coping with most quality deficits, but they do not offer comprehensive services and are unregulated in several aspects that threaten financial security when subject to severe health conditions.

´*I believe that social insurance is for severe diseases [...] private insurance is insurance, but does not give any security, because then they tell you "this is not covered"*` (Alicia, mother of 1 child, 50 years old).

These perceptions articulate to each other and shape the general appraisal of the security (or insecurity) offered by the whole system to face health risks. The participants´ narratives demonstrate that middle-classes do not consider coverage by the MSP as genuine protection. It is the IESS that provides a sense of protection against significant health issues, but not against the simpler ones. In this scenario, they see the option of meeting the routine health care needs through private providers. However, because private services are expensive, the middle-classes are aware that having access to private provision is a privileged situation. Thus, getting complementary private insurance is an aspiration, even for some of those who, being self-employed, have opted for voluntarily contributing to the IESS, because it represents a better balance between economic affordability and health protection. In other words, the narratives reveal that, given the current characteristics of the health system, the middle-classes understand double insurance as the ´ideal`. This also unveils why, when asked about where health protection comes from, they reply that it comes from the resources and strategies that they themselves, as individuals or families, are capable of deploying.

5.5.2.2. Practices to achieve health care

Participants' perceptions about the different alternatives to access health care and the sense of (in)security resulting from these perceptions give rise to specific repertoires of practices. Theoretically, the current policy architecture of health care allows for practices ranging from reliance on public options to a significant move towards private supply. However, the interviews reveal that the middle-classes only consider suitable some of these options. More specifically, the practices narrated can be organised into the three clusters (see Figure 5.2), which are presented below from that which was the most to the one that was the least predominant within the sample.

The **first cluster** consists of holding insurance at the IESS, but seeking services from private practices for all their routine care needs. The utilisation of services delivered by the IESS is restricted to severe diseases or specific services that are not included in the private insurance plan. Those who deploy these practices usually expressed that the IESS´ services are deficient for simple health needs, but quality is higher for more complex services, which demonstrates the impact of the deficits in the IESS' primary health care regarding the middle-classes´ practices of health care seeking.

´*Usually, you end up in private. My wife has private insurance because of her job […]. It´s the first inclination. It depends on the severity [of the problem]. People here [in Ecuador], especially the middle-class, only go to social security, if they are really sick. If it´s a simple ailment, you treat yourself, self-medicate, or you go private, because they are faster. You go to the IESS when you already have something serious, something that will really cost you a lot to pay for*` (Felipe, father of 2 children, 36 years old).

Those with practices of this cluster also hired private insurance to complement social security. This implies a permanent economic investment that most of the time is assisted by their employers. In addition, most services involve copayments that are considered affordable. Also, there are strategies deployed when seeking services at the IESS that allow for strengthening the chances of getting quality care through this institution. Specifically, the interviews revealed that using a ´palanca`, namely knowing someone who works for the social security system or in a medical centre, who can help to get quicker and easier entrance to the provision circuit, is considered the most usual and effective, although using this strategy to facilitate their own access impairs access for who do not have such connections.

In contrast to the first, the **second cluster** of practices involves utilising services delivered by the social security scheme as the first choice complemented by private ones and other strategies to cope with the flaws in the timely attention at the IESS. Those with their practices in this cluster do not hire private insurance and use private services sporadically against direct payments, which operate as a disincentive, because of the economic cost. Nonetheless, some interviewees indicated that seeking private services has become increasingly frequent since 2010, when social security coverage extended to family dependents, as this implied an increased demand for services through the IESS.

Laura explains in the quote below how she uses the strategy of identifying private practices with agreements with the IESS to partially absorb the economic cost of copayments. Others explained that, for those services with long waiting lists at the IESS and if the disease was serious, they would rely on their families or bank loans to cope with the cost of private supply, whilst for simpler problems, they would ask for advice on a health care blog or self-medicate themselves. In turn, similar to cluster one, when they sought services at the IESS, they usually relied on a ´palanca` to ease the process of getting the service.

> *´If something happens to me, the first thing I would say is "take me to the IESS" … because of the change of economic situation that I had in the last year [...] If it is my daughter, I would think a bit more. [...] I have a record of the private clinics that work with the IESS, and I would say "let's go to the International, please*"` (Laura, mother of 1 child, 34 years old).

Those who narrated practices of this cluster have jobs (or their husband/wife´s jobs) that do not offer the benefit of collective private insurance and consider that they cannot afford the cost by themselves. However, none of them pointed out that, if they were able to pay for private insurance, they would choose not to do so. Even those with better opinions about public services, asserted that they would feel more secure by hiring complementary private insurance. Moreover, most of them had had private insurance at some point in their lives.

Lastly, the **third cluster** is the most unusual and comprises more radical withdrawal from social security services. These practices consist of the exclusive utilisation of private services, making every possible effort to avoid services provided publicly, either by the social security scheme or

the MSP. The few participants who narrated this kind of practices paid for more costly private insurance than those in the first cluster to get a more comprehensive health plan. They also expressed their unwillingness to accept public services conditions, such as the waiting times or the impersonal style of communication, even if this implies the need to relying on strategies, such as getting bank loans.

> *´[…] if my brother gets an poisoning, I would immediately take him to an emergency to a private centre. I would not wait to take him to IESS or the Carlos Andrade Marín [public hospital] to see what happens […]. I would find the way to finance that*` (Andres, married, no children, 36 years old).

It is significant that the three clusters comprise several strategies, among them being hiring private insurance, picking-up services from different providers, OOP spending, family support, bank loans, asking health blogs, and self-medication. All of them are individual and not considered by the policy architecture, with the only exception of picking-up services from private practices with an agreement with the IESS.

The responses to the vignettes show practices that are consistent with those that participants described for themselves. That is, those who reported engaging in practices of the first cluster advised the vignette´s future pregnant woman to hire private insurance: *´[…] Thinking that Cristina lives in Ecuador, she should pay private insurance*` (Gabriela, mother of 1 child, 31 years old). However, in the hypothetical situation of no pregnancy, the advice is relativised. The core idea was that, if someone needs to use health services frequently, it is better to invest in private options.

In turn, those who expressed practices of remaining using the IESS´ services and complementing this when seeking specific private services (i.e. the second cluster) also advised the vignettes' characters to keep themselves with the IESS. *´Perhaps in that case, what she needs to take up is additional compensation. I mean, she is there [with the IESS], but she has check-ups with a [private] separate doctor*` (Federico, father of 2 adults, 63 years old).

Finally, participants who indicated the unwillingness to use the social security services (i.e. third cluster) also expressed a coherent position in the vignettes. These interviewees believed that private insurance should be a priority, whether there is a current need for health care or not. *´Yes [private insurance], women's health is not just pregnancy. There are always risks, you need to have some security for health services*` (Alicia, mother of 1 child, 50 years old).

To summarise, it is by adding social insurance and access to private providers, using different kinds of strategies, that the participants were acquiring a sense of greater meeting of their health care needs. *´It´s something you have to do. This is what gives me a little more security. So, that's why I tell you that people choose to have both [types of insurance]. People know that one is not so good, so you take the other for security*` (Felipe, father of 2 children, 36 years old).

There are factual conditions that make the difference regarding the degree of preference for public or private options and the type of strategies used for strengthening health care access.

Holding or not a job that grants private health insurance is the main element that may tip the balance towards private or social security provided services. When private insurance is available, it diminishes the economic barrier and the result is that private options offer more benefits than costs. Other conditions that appeared as being significant were the level of income and health risks (e.g. sex, having children, chronic disease), with a greater predisposition to opt for private services among those with higher income and more health risks.

When participants explained their practices, they appealed to their perceptions about the health care system, which were, in turn, conditioned by their positions as members of the Ecuadorian middle-classes. Thus, their practices were both dynamic (i.e. responding to contingent conditions, such as the severity of the disease, the availability of economic resources, and the availability of services, among others) and enduring (i.e. responding to their position in society).

As is common among Ecuadorians in middle-classes positions, all interviewees worked in the formal economy, and most were employees. Hence, they were compulsorily enrolled in the social security scheme and yet, did not appeal to their enrolment to explain their elections and practices regarding health services. Those holding private insurance mostly got it as a job benefit. They explained that private services allow for timely attention, the possibility of choosing and keeping the same doctor over time, and experience a sense of greater security. Moreover, copayments are cheaper with private insurance. Otherwise, employees without this job benefit usually do not hire private insurance by themselves. Nevertheless, they still pay for private services, arguing that they do not want to waste time waiting: *´it is better to make an economic effort to get immediate attention` (Gabriela, mother of 1 child, 31 years old)*. However, they know that they need to resort to social security for more expensive services.

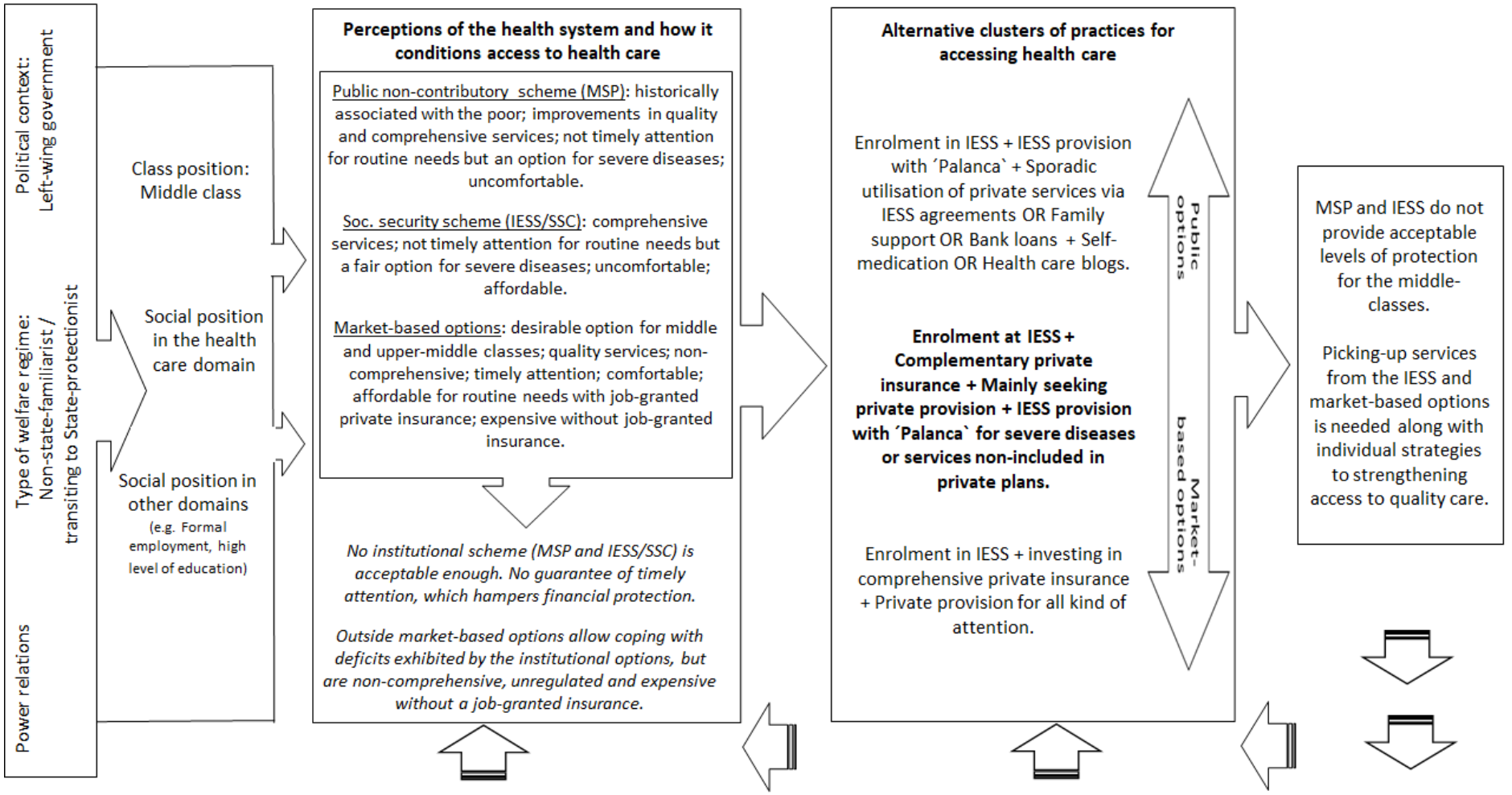
Regarding the self-employed, they explained that they made their voluntary contribution to the IESS, because it offered a fairer cost-benefits balance and presented this enrolment as a reason to use its services. They judged that it is better to use these services, rather than making additional payments for private services: *´I voluntarily joined the IESS. I pay with my own money [...] I don't think I'm going to take private insurance. I do not say never, but it is expensive for me now`* (Gaston, single man, 37 years old). Thus, three of the four self-employed interviewees expressed their disposition to primarily seeking attention at the IESS (second cluster), whilst the one who indicated a different option had private insurance, because of his wife´s job.

Another reason that the self-employed expressed for opting to contribute to the IESS instead of private insurance, was that the former was the option that protected them the most, especially against more serious health needs that would be unaffordable with private insurance. *´I pay for the IESS, because I could only take the most basic private insurance. So, any bigger issue that may happen to me, I can rely on the IESS`* (Dante, married, no children, 30 years old).

An aspect that draws attention is that medical competence was not an argument to explain the preference for private services. Instead, most pointed out that the best doctors and technology are with the MSP due to the high investment since the health reform. Another argument that appeared to explain health-seeking´ practices relates to status. It was often mentioned, especially regarding the vignette that involved the situation of pregnancy, that Ecuadorians from

higher social strata do not use social security health services and that only the poor resort to the services supplied by the MSP. Besides these arguments, the explanation that prevailed in giving meaning to health-seeking practices is that none of the institutional options (i.e. MSP and IESS) provided enough health care protection. Consequently, participants indicated that they need strengthening access to health care by picking-up services from the IESS and outside market-based providers. However, as private options do not offer sufficient guarantees, they need additional strategies (e.g. ´Palanca`) to achieve timely and high quality health care.

Figure 5.2. Middle-classes´ perceptions of and practices when accessing health care in ECUADOR



Source: Own-elaboration

5.6.- Integration and conclusion: iterations between the policy architecture, policy outputs and middle-classes´ practices

The previous pages have shed light on the conditioning of welfare arrangements, policy architecture and policy outputs on the middle-classes´ practices for health care in Ecuador. In turn, the examination of these practices and the perceptions about the health system have unveiled their role regarding universal/segmented access to health care in the country.

First, regarding the welfare arrangements that contextualise the policy architecture and middle-classes´ access to health care, the up to date indicators of the Ecuadorian welfare regime have demonstrated that the country increased decommodification of social welfare and, to a lesser extent, commodification in the labour market. The most substantial improvements occurred regarding the expansion of public social investment, which led to a reduction in poverty and inequality. Nevertheless, the quality of jobs continues to be deficient, thus limiting the expansion and strengthening of the middle-classes. Furthermore, whilst some have claimed there has been a process of reconfiguration of the welfare regime (see Martín-Mayoral, 2009; Minteguiaga and Ubasart-González, 2014, 2015; Ramírez, 2016), others point out that the transformation has been undermined by the preservation of the traditional models of development and accumulation, the lack of labour market improvements, and the pro-poor approach of social policies (see Minteguiaga and Ubasart-González, 2015; Caria and Domínguez, 2016).

According to the sinuosity of transformations in welfare production, the switch in the policy architecture of health care has been subject to debate. The analysis presented has shown that, despite the reform, the health care system remains fragmented and leading to segmented outputs. The 2008 reform allowed significant expansion of coverage underpinned by the notions of universal health care entitlement as a social right, the strengthening of the public sector thanks to higher public investment, and an unprecedented enlargement of services´ generosity. Nevertheless, the system kept separated schemes, with different eligibility criteria, the structure of financing persisted having separated funds, thus limiting the possibilities for redistribution, the ´functional integration` of service delivery has not been undertaken beyond the purchasing of services to private suppliers, and market-based options are excluded from the explicit policy architecture, lacking regulation, despite their extensive utilisation.

Thus, the reported reform may be characterised as one that has prioritised coverage without making similar advances in unification. Such a kind of strategy has been criticised because it is likely to fuel segmentation and is unlikely to encourage cross-class coalitions to endorse the expansion of social policy (Huber and Stephens, 2012). The literature also says that commodified systems (like the case of Chile) push more significant withdrawal towards private options vis-à-vis systems fragmented according to the nature of participation in the labour market (Martínez Franzoni and Sánchez-Ancochea, 2016). Nevertheless, as the analysis of practices has indicated, despite private insurance being lower in Ecuador (around 4%) than in Chile (about 18%), this does not mean a lower utilisation of private services and reduced segmentation in terms of

payment capacity. The available information has shown that private service utilisation has been extended in Ecuador, but rather than the contracting of voluntary private insurance, most of it has relied on direct payments at the moment of attention (this is revealed in the high levels of OOP spending) being required, and that this is not visible in the policy architecture. Moreover, it is not recognised or regulated by the state, thus leading to an underestimation of the real deficits faced by the system (e.g. it is not clear how many people are on waiting lists as many of them solve their needs by relying on private options) and the real magnitude of private provision (Former Vice-minister of Health Service Provision). Therefore, it could be argued that the Ecuadorian policy architecture remains subject to two types of fragmentation, that is, one that is explicit in the policy design founded on the divisions of the labour market (i.e. fundamentally between formal and informal jobs) and a second that is not institutionally recognised, but still exists, which occurs through the extended and unregulated presence of private insurance and service delivery. In other words, access to health care is broadly commodified, but not in an explicit fashion (see Bernales-Baksai and Velázquez Leyer, 2021). These two types of fragmentation enhance the segmentation of the population's access to health care, both according to their participation in the labour market and their ability to pay.

The omission of the private sector of the policy architecture, and thus, its lack of regulation, in circumstances that the shortcomings of the system push people towards market-based options, leave users in greater contact with this sector precisely at the times they are most vulnerable, i.e. when they are in immediate need of health services. However, this omission keeps better-off groups connected with social security as they cannot opt-out from the mandatory enrolment, thus ensuring a minimum of contributions. Moreover, the retention of this connection with social security schemes, as participants explained, provides a sense of protection, at least against more serious health conditions.

As the analysis of the policy outputs has demonstrated, neither the constitutional definition of health as a social right nor formal coverage is enough for guaranteeing sufficient and equitable access, generous benefits, and financial protection in the context of a policy architecture that keeps the system fragmented. Beyond the universal entitlement to health care, there are crucial shortcomings related to the availability of comprehensive services and financial protection. Moreover, despite disparities between schemes narrowing with the increase of resources aimed at the MSP, variations in generosity (i.e. availability and quality of services) from one scheme to another continue to exist, and the efforts to enhance financial protection (e.g. eliminating copayments with the MSP and IESS) have not brought down OOP spending as the primary source of financing.

In sum, the analysis has indicated that the transformations carried out have not been profound enough to curb the segmentation associated with participation in the labour market (i.e. formal/informal employment and job benefits) and payment capacity. A plausible explanation for this failure is the welfare system’s trajectory, with some historically favoured actors exerting their veto capacity to maintain their privileges. The interviews conducted with policymakers directly involved in the health reform support this idea. Another explanation relates to failure in promoting social participation and enhancing a broad social pact to reshape the rationale of welfare production. Criticism in this regard repeatedly appears in the literature (see, for

instance, Martín-Mayoral, 2009; Caria and Domínguez, 2016; Silva, V., 2016; Chang Campos, 2017). While the first explanation underlines the role of policy legacies (Pribble, 2013; Baba, 2015), the second advocates the importance of obtaining the support of the middle-classes, and the formation of cross-class coalitions, to promote generous social policies for the entire population (Esping-Andersen, 1990; Korpi and Palme, 1998).

Furthermore, the examination of the practices for accessing health care has suggested that the health system pushes the middle-classes towards addressing their health needs in an individualised manner. Despite the health reform extended coverage, the trajectory followed by the health system, with the decrease of per capita resources for the IESS and the concomitant perception of lowering the quality of the social security scheme accompanied by a growing presence of the private sector, has been leading to the middle-classes abandoning the traditional mechanisms used to meet their health needs. In their place, they have increasingly been opting for private services, either by investing in private insurance or seeking provision against OOP spending. In turn, this deepening segmentation has been progressively hindering the possibility of building cross-class coalitions that support improvements in the provision of health care.

Participants´ narratives have shown that the middle-classes perceive that none of the existing schemes provides as being sufficient security against health risks. Moreover, the unregulated private sector does not shape an alternative that allows them to satisfy all health needs either. They respond to this configuration with practices of picking-up what they need and can obtain from social security (e.g. attention for severe health conditions) and the private sector (e.g. medical tests and attention for routine health needs), wherever possible holding private insurance, which they further complement with other individual strengthening strategies (e.g. the ´palanca`). The 2008 reform improved equity by strengthening the public scheme. Nevertheless, improvements to the generosity of all the institutional alternatives (i.e. public and social security schemes) have been insufficient, thus limiting the possibilities for tackling the segmentation and favouring individualised practices to face risks and obtain adequate health care.

CHAPTER VI URUGUAY: WELFARE REGIME, POLICY ARCHITECTURES OF HEALTH CARE AND MIDDLE-CLASSES PRACTICES TO ACCESS HEALTH CARE

6.1.- Introduction

The third and last case study addresses Uruguay. Section 6.2 shows that this country has witnessed significant advances in social welfare, especially related to strengthening the capacity of commodification in the labour market and decommodification of social welfare. The latter through social policies with a universal approach relying significantly on the improvements in the labour market. Subsequently, Section 6.3 reviews the trajectory of the health care policy and the milestones in the welfare system. It is pointed out that health care policy was historically featured by fragmentation by occupational categories and privileging the middle-classes. Even so, the structure and practices for health care moulded by this trajectory were used as the basis for a health reform that relies heavily on the contributory scheme and the traditional health providers of the middle-classes from there, seeking universalism. The analysis of the contemporary policy architecture of health care and the policy outputs presented in Section 6.4 points out that, unlike what has been observed in Chile and Ecuador, the policy architecture in Uruguay has advanced the unification of the health system and progressively reversed segmentation by extending social security coverage beyond the middle-classes as well as regulating the participation of the private sector within the system. Hence, the policy architecture has created an incentive structure for the middle-classes to meet their care needs through alternatives that also integrate other social classes.

Consistently with the features of the policy architecture and policy outputs of health care, Section 6.5 shows that, in Uruguay, the middle-classes perceive that the health system allows for acceptable levels of protection and consequently, they mainly engage in practices that do not separate them from the rest of society by resorting to market options, regardless of whether or not they have the resources to do so. Lastly, Section 6.6 puts together all the analysed domains and contends that the country has moved towards a type of welfare regime in which the state has assumed the leadership for promoting universal social welfare with a focus on labour market regulation. Notably, the current policy architecture of health care has substantially advanced unification and improved the sufficiency and equity of coverage, generosity and financial protection, with a strong emphasis on inclusion through the extension of formal employment and the equalisation of benefits. In this scenario, the middle-classes perceive higher protection and so they have not shifted their healthcare-seeking practices and continue to rely primarily on the traditional social security health care providers, i.e. without moving to market-based options. Thus, despite still facing challenges, the health reform has managed to retain the middle-classes at the time of expanded coverage and benefits for lower classes, which constitutes a significant advance for universal health care.

6.2.- The Uruguayan welfare regime in the 21st century: progress and limits in the achievement of social welfare

According to the typology I have been applying throughout the case studies, Uruguay belongs to the cluster of state-protectionist welfare regimes (Martínez Franzoni, 2007, 2008), meaning that: *i.* The achievement of welfare through participation in the labour market is fair, but lower than in the state-productivist cluster of welfare regimes; *ii.* The state plays a significant role in the production and delivery of social welfare, although benefits have been historically stratified by occupational categories (see Filgueira, F., 1998); *iii.* Families continue to play a central role in coping with social risks; and *iv.* Outcomes of well-being and quality of life are high in the regional context, but conditioned by stratification in access to social benefits. The analysis below considers the recent evolution of this country in the four dimensions included in the typology of welfare regimes: commodification in the labour market, decommodification of welfare, defamilisation of welfare, and outcomes.

In the dimension *commodification in the labour market,* the up to date indicators (Table 6.1) show that the rate of economic participation grew since the beginning of this century (2000: 61.2%, 2019: 62.1%), reaching historical maximum above 65% around 2015 (Amarante and Tenenbaum, 2016). Females, especially from the higher strata, entered the labour market *en masse* in the last two decades (Rossel, 2016), but they continue to be under-represented (2015: 54.9%), although to a lesser extent than in Chile and Ecuador (Tables 4.1 and 5.1).

The share of workers in informal jobs dropped drastically (2000: 40.3%, 2019: 24%), which is broadly recognised as one of the core advances in the last few years, and related by several scholars to the comprehensive set of reforms undertaken by Frente Amplio (FA)[34] governments to improve the quality of employment (OIT, 2014; Amarante and Gómez, 2016; Amarante and Tenenbaum, 2016). Also, the percentage of employees in the total employed population recovered to levels prior to a devastating economic crisis in the early 2000s, and unemployment dramatically dropped, reaching 8.9% in 2019.

Regarding economic performance, from 2004 onwards, the country started to recover from the early 2000s downturn (Caetano and Armas, 2012), with the economy growing at higher rates than the average for the last 50 years of the 20th century (Amarante and Tenenbaum, 2016). The GNI per capita increased 49% between 2000 ($12,858) and 2015 ($19,148). In fact, in 2013, Uruguay was the second country in Latin America (after Chile) to attain the status of a high-income economy (WB classification). Economic growth positively impacted on poverty and inequality, with the former reducing to 3% in 2018 and there being a Gini Coefficient of 0.392 in 2019, which is one of the lowest income inequality scores in the region.

[34] Frente Amplio is a coalition of centre-left political parties and social movements created in 1971. The coalition held the presidency of the republic between 2005 and 2020, with Tabaré Vázquez (2005-2010 and 2015-2020) and José Mujica (2010-2015) as presidents.

Table 6.1. Indicators for the dimension commodification in the labour market for Uruguay years 2000 and 2017 (or the nearest year)

Indicator	Year	
Economic participation rate (% of the working-age population) [i]	2000: 61.1%	2019: 62.1%
Employees (% of the total employed population) [ii]	2000: 73.1%	2019: 71.5%
Unemployment (Average annual rate) [i]	2000: 13.6%	2019: 8.9%
Women economic participation rate (% of the working-age women population) [i]	2003: 48.9%	2015: 54.9%
Children in employment, total (% of children ages 7-14) [iii]	--	2009: 7.3%
Share of workers in informal employment (% of non-agricultural employment) [ii] [iv]	2000: 40.3%	2019: 24%
GNI per capita, PPP (constant 2017 international $) [iii]	2000: 13,298.9	2018: 20,091.3
Poverty headcount ratio at $5.50 a day (2011 PPP) (% of population) [iii]	2000: 9.4%	2018: 3%
Gini coefficient [i]	2007: 0.468	2019: 0.392
Personal remittances, received (% of GDP) [iii]	2001: 0%	2019: 0.18%
Rural population (% of total population) [i]	2000: 8.72%	2020: 4.0%

[i] ECLAC (2020), CEPALSTAT
[ii] ILO (2021), ILOSTAT
[iii] WB (2021), World Development Indicators
[iv] ILO (2015), KILM 9th ed. for year 2000

The dimension *decommodification of welfare* also reveals advances (Table 6.2). Social expenditure rose by 8.4% on average between 2004 and 2012 (Rossel, 2016) to reach 17.2% by 2018, which is slightly higher than in Chile (16%) and notoriously above Ecuador (9%) as well as the average in Latin America (11.3%) (ECLAC, 2020). Regarding allocation, social expenditure increased more on health care and education vis-à-vis social security (Rossel, 2016), broadening the previous focus on formal workers contributing to social security (i.e. middle-classes) to include less advantaged groups. Consistently, between 2000 and 2018, households´ final consumption expenditures declined from 76.5% to 66.4%, private expenditure on health from 58% to 27% and OOP spending from 25% to 17%, with the lattermost representing less than half that in Chile and Ecuador. Moreover, the country leads the multidimensional index of social protection when compared to the other two studied cases (Ocampo and Gómez-Arteaga, 2016). Despite these advances, critics have pointed to the endurance of fragmentation (Antía et al., 2013) and the lack of an appropriate welfare system engagement with the new risk structure of the society, in particular, the drop in fertility, new family configurations and cultural patterns as well as changes in the productive model (Rossel, 2016).

Table 6.2. Indicators for the dimension decommodification of social welfare for Uruguay, years 2000 and 2020 (or the nearest year)

Indicator	Year	
Private health expenditure (% of total health expenditure) [i]	2000: 58%	2018: 27%
Out of pocket health expenditure (% of current health expenditure) [i]	2000: 25%	2018: 17%
School private enrolment, primary (% of total primary) [ii]	2000: 14%	2014: 17.8%
Households and NPISHs final consumption expenditure (% of GDP) [iii]	2000: 76.5%	2019: 66.4%
General government final consumption expenditure (% of GDP) [iii]	2000: 12.4%	2019: 15%
Public expenditure on health care (% of GDP) [iV]	2000: 2.1%	2018: 3.6%
Public expenditure on education (% of GDP) [iV]	2000: 3%	2018: 4.9%
Public expenditure on social protection (% of GDP) [iV]	2000: 6.2%	2018: 7.9%
Overall social expenditures (as % of GDP) [iV]	2000: 11.8%	2018: 17.2%
Old-age contribution ratio (% labour force) [V]	2000: 62.3%	2011: 88%
Old-age pensioners recipient ratio above retirement age [V]	--	2011: 76.5%

[i] WHO (2020), Global Health Expenditure Database
[ii] UNESCO (2021)
[iii] WB (2020), World Development Indicators
[iV] ECLAC (2020) , CEPALSTAT
[V] ILO (2016), Social Security Inquiry

In the dimension *defamilisation of welfare*, the analyses of the early 2000s show that families supported a significant part of the production of welfare (Martínez Franzoni, 2007). However, when compared with other Latin American countries, Uruguay currently exhibits higher defamilisation of welfare. Table 6.3 indicates that between 2007 and 2019 the percentage of extended and composite households declined from 16.1% to 15.3%, which is far below the regional average (2019: 26.8%), and the proportion of female heads of household grew from 33.2% to 46.6%. Consistent with this, the percentage of women full-time to household chores declined and the share of those with part-time employment rose. However, some researchers have stressed that females experience more precarious employment (Rossel, 2016) and much greater responsibility for domestic housework than males (Batthyány, 2004; Aguirre and Scuro, 2009; Sojo, 2017).

Table 6.3. Indicators for the dimension defamilisation of social welfare for Uruguay, years 2000 and 2020 (or the nearest year)

Indicator	Year	
Extended and composite households (% of the total number of households) [i]	2007: 16.1%	2019: 15.3%
Domestic servants (as % of total employment) [i]	2007: 7.3%	2019: 3.6%
Women full-time to household chores (% of the population of women aged 15 and over) [i]	2007: 16.8%	2018: 12.5%
Female share of part-time employment (% of total employment) [ii]	2000: 62.8%	2014: 64.9%
Female heads of households (% of the total number of households) [i]	2007: 33.2%	2019: 46.6%
Demographic dependency ratio (children and older persons) [i]	2000: 60.3%	2020: 54.9%

[i] ECLAC, CEPALSTAT
[ii] ILO, KILM 9th ed.

Finally, by the beginning of this century, Uruguay already had a leading position in the region regarding the *outcomes* of quality of life and well-being. Today, the country is exhibiting further improvements surpassing the regional averages in all the indicators reviewed (Table 6.4). Moreover, the country has been experiencing a very high human development (HDI), which reached 0.804 in 2017 and 0.689 when it is inequality-adjusted (IHDI), placing the country in third place (after Chile and Argentina) in the region. Also, the performance in gender equality has been remarkable, so too the reduction in the levels of inequality compared with the regional averages, but there are shortcomings regarding equality of life expectancy (UNDP, 2018).

Table 6.4. Indicators for the dimension outcomes for Uruguay, years 2000 and 2020 (or the nearest year)

Indicator	**Year**	
Under-five mortality rate (Deaths per 1,000 live births) [i]	2000:17.0	2019: 7.1
Expected years of schooling [ii]	2000: 13.9	2019: 16.8
Gender Development Index (GDI) [ii]	2000: 1.000	2019: 1.016
Homicide rate (per 100,000 people) [ii]	2000: 6.4	2018: 12.1
Individuals using the Internet (% of population) [i]	2000: 10.5%	2019: 76.9%

[i] WB (2021), World Development Indicators
[ii] UNDP (2021), Human Development Data Center

Briefly, the up to date analysis shows the country´s dramatic advances in commodification in the labour market (OIT, 2014; Amarante and Gómez, 2016). Different to the previous cases, which based their advances in this dimension primarily on economic performance, Uruguay notably improved job quality along with economic growth and poverty and inequality reduction, thus revealing the choice of its governments, since the early 2000s, of increasing social protection through the expansion of social security. Also, the decommodification of welfare has improved, with significantly greater involvement by the state. Public protection has expanded, there being the generous benefits that reach the middle-classes and vulnerable groups. These two dimensions have progressed in tandem with a lower need to rely on families for improvements in outcomes of wellbeing. Table 6.5 summarises these updated features, unveiling that the scenario where the current architecture of health care is unfolding is that of unprecedented quality jobs and state commitment to extending social welfare throughout all groups of the population. Nonetheless, according to some analysts, benefits, to some extent, continue to be uneven, because they are provided through a structure that separates social security-based protection from social assistance (Antía et al., 2013). Such a structure comes from a particular historical trajectory, which is the centre of attention of the discussion in the following section.

Table 6.5. Updated features of Uruguayan welfare regime by dimensions of the Martínez Franzoni's (2007) typology of Latin American welfare regimes

	URUGUAY
Type of welfare regime	**State-protectionist welfare regime**
Commodification in the labour market	**High in the regional context and balanced** Jobs quality is above regional average and substantially improved from the early 2000s. Economic performance is high, with a significant decrease in poverty and inequality, but the latter remains high (but lower than in the other two focal countries).
Decommodification of welfare	**High and mostly public** Well-developed public welfare system for the whole population, but with traces of stratification. Limited participation of market-based options.
Defamilisation of welfare	**Moderate** Reliance on families slightly declined, which is particularly associated with progress in women´s entrance to the labour market.
Outcomes of well-being	**High performance** sustained over time

Source: Own elaboration based on Tables 6.1 to 6.4

6.3.- Historical trajectory of the policy architecture of health care

Similar to Chile, Uruguay was a regional pioneer in developing social and labour legislation (Mesa-Lago, 1985; Finch, 2005; Palmowski, 2015). In the late 19th century, the country already had some pension schemes for the military forces, public servants, and employees of the educational system (Huber and Stephens, 2012). Nonetheless, it was by the beginning of the 20th century that President Batlle y Ordóñez (1903-1907; 1911-1915) prompted the ´Batllismo`, that is, an ideological project that marked the foundation of the Uruguayan welfare system (Barrán and Nahum, 1983), allowing for inequality reduction, social integration, strong ties between the state and the civil society (Lanzaro and De Armas, 2012) as well as extensive labour legislation (Mesa-Lago, 1978).

Regarding health care, the first attempts at state regulation and provision of services for the poor date back to the creation of the National Council of Hygiene in 1885 (Fuentes, 2013) and the National Public Assistance Board in 1910 (Martínez Franzoni and Sánchez-Ancochea, 2016b). The latter ran in parallel to separated schemes for the military forces and the police (Oreggioni, 2015). By that time, the first non-for-profit mutual aid societies started to operate that addressed organised groups of immigrants and then, expanded to groups of salaried workers (Oreggioni, 2015). In a landscape of limited services provided by the state (Morás, 2000; Setaro,

2013 in Martínez Franzoni y Sánchez-Ancochea, 2016), mutual aid became the most important health care supplier, especially for the urban middle-classes (Oreggioni, 2015).

Between the settlement of the ISI development model in the late 1930s and the coup in 1973, social security expanded among the urban population (Finch, 2005), becoming quite generous and virtually universal for formal workers, but with uneven benefits across occupational categories[35] (Filgueira, C. and Filgueira, 2002; Midaglia et al., 2017). In the health sector, the state started to commit to the middle-classes through the introduction of regulation of mutual aid (Filgueira, F., 1995). However, this effort was ended by reinforcing the role of these private institutions and enhancing segmentation between the sectors of the population able to contribute to mutual aid societies (i.e. formal workers) and those who had to rely on means-tested public assistance (Midaglia et al., 2017).

Scholars have different perspectives regarding the transformations that the civic-military dictatorship (1973- 1985) meant for the development model and social policies. Finch (2005) and Huber and Stephens (2012) emphasise the adoption of a liberal approach, which had the intention of returning to the primary-export model of the first decades of the century. Amarante and Tenenbaum (2016) stress the transformation of the productive structure by decreasing the proportion of workers in the industrial sectors and the growth of less-protected employment. Meanwhile, Castiglioni (2005, 2016) draws attention to the more moderated approach of the Uruguayan dictatorship compared with the Chilean one.

As for health care, the period meant more centralisation, but not the end of stratification. Fees were directed at the National Board of Social Insurance (Dirección de Seguros Sociales por Enfermedad [DISSE]) (Oreggioni, 2015), the National Resource Fund (Fondo Nacional de Recursos [FNR]) started to cover catastrophic diseases (Martínez Franzoni and Sánchez-Ancochea, 2016b), and the state widened subsidies for health coverage aimed at the middle-classes (Filgueira, F., 1995).

With the return to democracy in 1985, the country started a new economic model (later named neo-liberal) following the Washington Consensus principles. In the 1990s, the economy grew, but employment conditions and income inequality worsened (Finch, 2005), whilst the stratification of social benefits intensified (Filgueira, F., 2001). There were several attempts at health reform, but doctors, civil society, unions, and the left rejected the reduction of public subsidies, and so, the path followed by the system did not substantially change (Huber and Stephens, 2012; Sánchez de Dios, 2015). Mutual aid societies, now re-named Institutions of Collective Medical Assistance (Instituciones de Asistencia Médica Colectiva [IAMCs]), persisted as the primary service providers for the middle-classes. A small proportion of better-off citizens

[35] Such mass and stratified coverage is known as ´stratified-universalism`. Whilst this concept may sound peculiar in English, as it involves an internal contradiction, it is widely used by scholars of social policies in Latin America. The concept relies on the empirical findings throughout countries in the region, of broad coverage of social services, but with uneven quality, depending on the occupational category of the beneficiary (Midaglia et al., 2017). As it involves coverage without considering the generosity of benefits/ services or equity in the distribution of those benefits/services, it does not qualify as universalism within the conceptualisation adopted for this thesis, as discussed in Chapter II.

paid for private insurance, whilst the poor were granted a *free-services card* to receive treatment at public hospitals managed by the State Administration of Health Services (Administración de los Servicios de Salud del Estado [ASSE]) (Filgueira, F., 1995; Oreggioni, 2015; Martínez Franzoni and Sánchez-Ancochea, 2016b).

By the late 1990s and early 2000s, the country had been plunged into a deep economic crisis that dramatically increased poverty, unemployment and informality of employment (Antía et al., 2013). Health coverage via social security declined, and the need for publicly provided services increased, which escalated the financial pressures on the public sector (Fernández Galeano and Benia, 2013-2014). In turn, those who remained covered through social security faced difficulties in affording copayments (Huber and Stephens, 2012; Martínez Franzoni and Sánchez-Ancochea, 2016b).

The crisis was the catalyst for the political turn that started in 2005, when the FA came to power, beginning a reformist agenda of pre-distributive and redistributive policies (Filgueira, F. and Hernández, 2012). The FA was committed to redistribution and universalism (Huber and Stephens, 2012), calling for a more progressive tax system, further regulation of the labour market, and the extension of social benefits (Midaglia and Antía, 2007; Antía et al., 2013; Amarante and Gómez, 2016; Amarante and Tenenbaum, 2016; Rossel, 2016).

Focusing on health care, up until this time there were two main detached systems: a general revenues-based public one managed by the ASSE and a private not-for-profit sector in the hands of the IAMCs, with fragmented occupation-based schemes (Midaglia et al., 2017). This division allowed for significant disparities with regard to the quality of care (Pribble and Huber, 2013). In 2005, the FA recognised health as a ´legal right and a public good` and, in 2007, started a profound reform towards the construction of the Integrated National Health System (Sistema Nacional Integrado de Salud [SNIS]) (Laws 17.930 and 18.211), increasing fiscal investment in the public sector and creating a single National Health Fund (Fondo Nacional de Salud, FONASA-Uruguay) (Law 18.131) (González and Triunfo, 2020) to enhance progressivity in revenue collection and resources allocation (Fernández Galeano and Benia, 2013-2014; Olesker, 2015; Oreggioni, 2015).

Regarding the conditions underpinning the health reform, Pribble (2013) shows that the co-existence of several IAMCs, heterogeneous in terms of size, type of beneficiaries, and geographical location gave the government room to negotiate. Also, the worsening of the IAMCs´ financial situation associated with the early 2000s economic downturn and their increasing dependence on resources provided by the state (Fuentes, 2010) accompanied by their non-for-profit character (Martínez Franzoni and Sánchez-Ancochea, 2016b) are identified as factors that contributed to their disposition to support changes in the system. Others emphasise the role played by the progressive ideas and broad based political support of the government, the strong ties between the ruling coalition and social organisations, the unprecedented good performance of the labour market (see Fuentes, 2010; Pribble and Huber, 2013; Rossel, 2016), as well as the efforts of the FA in persuading a broad range of stakeholders to become engaged. The lattermost manifesting itself in the creation of the National Board of Health (Junta Nacional de Salud [JUNASA]) as the main governing body of the SNIS, with

representatives of the Ministry of Public Health (Ministerio de Salud Pública [MSP]), the Ministry of Economic Affairs (Ministerio de Economía y Finanzas [MEF]), the Social Welfare Bank (Banco de Previsión Social [BPS]), organisations of health care workers, and users (see Fuentes, 2013; Fernández Galeano and Benia, 2013-2014; Olesker, 2015; Oreggioni, 2015).

In short, this revision indicates that the Uruguayan welfare system, and health care in particular, was featured since their foundation by fragmentation and stratification. Until the reform in 2007, the public sector had played a residual role in health care provision, delivering services to the poor and informal workers through the ASSE. Otherwise, the not-for-profit private sector, represented by the mutual aid societies, later renamed IAMCs, became increasingly protagonist in providing services to workers in the formal economy and the middle-classes (Midaglia et al., 2017). The reform, started in 2007, encompassed the most significant transformation of the health care policy ever in the country, being aimed at the unification and comprehensiveness of the system (Pribble and Huber, 2013; Bernales-Baksai, 2020). Even though the examination of the policy architecture in the next section shows that the current health care policy has involved more profound advances in some components, others have only experience slight adaptations that still impose challenges for the unification of the system and the advance of universal health care.

6.4.- The contemporary policy of health care

6.4.1) Policy architecture of health care

6.4.1.1. Eligibility - Under what criteria do people benefit?

From the settlement of the health reform in 2007, all residents in Uruguay are entitled to receive health care through the SNIS, as contributions were complemented with residency as eligibility criteria (Fuentes, 2015; Martínez, 2015; Oreggioni, 2015). Nonetheless, the distinction between contributory and subsidised populations remains. Those in the contributory scheme participate in FONASA-Uruguay and can access any type of provider[36]. In contrast, the subsidised scheme restricts the choices of service supply to the ASSE and functions as a residual option. The armed forces, the police and other small occupational groups keep separate schemes (Fernández Galeano and Benia, 2013-2014; Olesker, 2015; Oreggioni, 2015).

Regarding private insurance, FONASA-Uruguay holders are entitled to this option against the payment of extra premia. Thus, as in Chile, for-profit private institutions can cream off the population according to their ability to pay and health-related risks (Bernales-Baksai, 2020). Hence, the primary eligibility criterion is payroll contributions, whilst residency is a subsidiary criterion, and the ability to pay is required in order to take up private for-profit insurance. This means that, the reform was not intended to steer the middle-classes away from the contributory scheme and kept the IAMCs as primary deliverers. The efforts were centred on keeping the

[36] Before the 2007 reform, those enrolled in the contributory scheme only could be covered through private not-for-profit providers (IAMCs) (Olesker, 2015).

IAMCs and expanding the population that could access health care through them by relying on the increasing formalisation of jobs and improvements in employment conditions. Hence, despite the model remaining centred on social security, advancing unification was still feasible grounding on the improvements in the labour market.

Moreover, despite being limited to the contributory scheme, the creation of FONASA-Uruguay signalled a noteworthy advance for unification by suppressing the former possibility of IAMCs rejecting certain individuals or providing only partial coverage (i.e. by excluding some services) (Huber and Stephens, 2012). Also, FONASA-Uruguay extended coverage to pensioners and formal workers´ family dependents, who before the reform were excluded unless additional payments were made (Fuentes, 2013; Ballart and Fuentes, 2018). As a result, currently, the majority of the population and virtually the whole middle-classes are eligible.

6.4.1.2. Funding - Who pays and how?

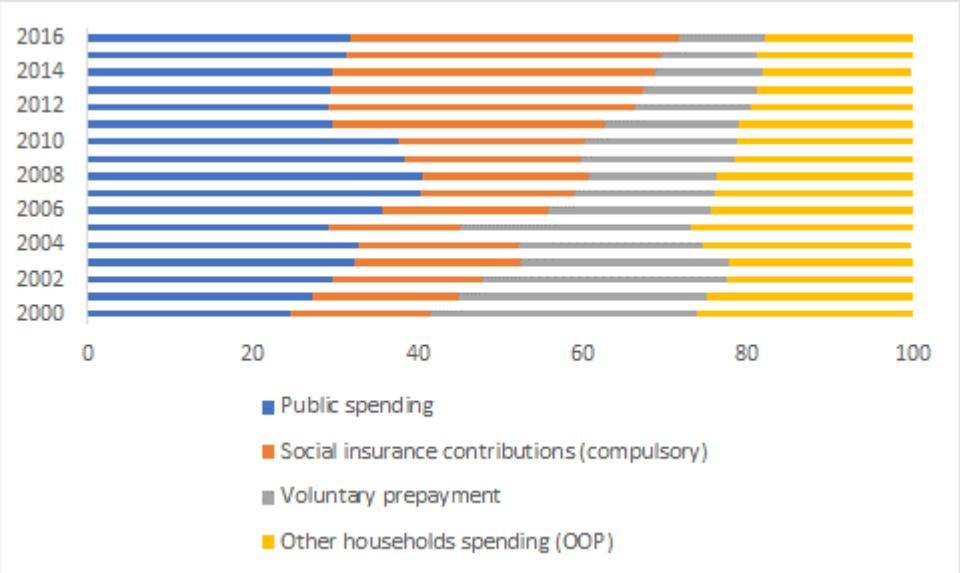
With the health reform, FA governments increased resources to strengthen the public sector and subsidised scheme (Pribble and Huber, 2013). Public spending from general revenue (excluding social insurance contributions) increased from 25% to 33% of the total health expenditure between 2000 and 2018 (WHO, 2020a) and grew from 1.4% to 3.6% of GDP between the beginning of the reform in 2007 and 2018 (ECLAC, 2020), with a significant proportion of this increase being aimed at the ASSE (Fernández Galeano and Benia, 2013-2014). Moreover, as in Chile, Uruguayan total public expenditure (general revenues + compulsory contributions) is above the average in Latin America, attaining 6.6% of GDP in 2017 against a regional average of 3.7% (OECD/WB, 2020), which also relates to the growing participation of payroll taxes in health care financing. Indeed, payroll taxes grew up from 17% to 40% between 2000 and 2017, which places compulsory contributions as the primary revenue source of the reformed health system. The remaining 23% of the total health expenditure in 2017 was private expenditure (WHO, 2020a).

The 2007 health reform significantly transformed the financial arrangements by creating FONASA-Uruguay (Bernales-Baksai and Solar-Hormazábal, 2018; Bernales-Baksai, 2020). This fund pools the resources of the contributory scheme and then allocates a per capita amount, based on the risk profiles (e.g. sex and age) to the health care providers of the SNIS (Pribble and Huber, 2013; Olesker, 2015), thereby enhancing progressivity in resource allocation and reducing the historical gap of resources between the ASSE and the IAMCs (Rodríguez Buño, 2014). All workers and pensioners contribute between 3% and 8% to FONASA-Uruguay, depending on their income level and number of dependents, which is complemented by state revenues and 5% of employers´ contributions (Olesker, 2015). In turn, the subsidised scheme is financed by general revenue, which allocated to the ASSE. Additionally, the FNR covers catastrophic diseases as a separate fund, although some argue that it should be included in the integrated model of financing (Olesker, 2015).

The advances in financial unification through FONASA-Uruguay along with the increase in resources for the public sector have allowed for the transition from a structure that, before the

health reform, strongly relied on voluntary prepayments and OOP spending, to one where payroll contributions[37] and general revenues are the primary sources of financing (Graph 6.1). FONASA-Uruguay has favoured solidarity and progressivity within the covered population, namely formal workers and the middle-classes, and reduced the gap between the public (ASSE) and private not-for-profit (IAMCs) providers. Nonetheless, some disparities in resources allocation remain between FONASA-Uruguay holders, on the one hand, and informal workers, who are covered by the subsidised scheme, on the other (Bernales-Baksai, 2020). Moreover, only those included in FONASA-Uruguay can choose either the ASSE, IAMCs or private insurance, whilst the subsidised population can only seek services from the ASSE. Finally, there also are differences regarding direct payments. The ASSE does not charge copayments, whereas the IAMCs request moderation fees within the thresholds of price defined by the MSP and the MEF, whilst private for-profit providers request copayments and charge extra premia (Oreggioni, 2015). All this creates barriers for less advantaged groups when seeking attention outside the ASSE.

Graph 6.1. Health care expenditure distribution type source, Uruguay 2000-2016



Data source: WHO (2020a)

6.4.1.3. Benefits - Who defines them, and what are they?

The creation of the SNIS had important implications for the equalisation of benefits. Since the reform, all providers included in the SNIS, namely those receiving resources from FONASA-Uruguay and/or general revenues, have to guarantee the Comprehensive Benefits Plan (Plan Integral de Asistencia a la Salud [PIAS]) for everybody, independently of whether they are covered through FONASA-Uruguay or through subsidisation by the ASSE (Fernández Galeano and Benia, 2013-2014; Olesker, 2015). The PIAS includes services of all levels of attention (i.e.

[37] It should be noted that the growing importance of payroll contributions as a revenue source has happened contemporaneously with a dramatic increase in formal employment, which was an explicit aim of FA governments.

primary, secondary and tertiary care) and medicines and does not contemplate an exclusion list (Oreggioni, 2015).

6.4.1.4. Delivery - Who does what?

Despite the advances in the unification of financing and benefits, service delivery has remained fragmented. The SNIS comprises three main types of comprehensive providers: the public (ASSE), private not-for-profit (IAMCs) and private for-profit (private insurance). Other institutions, such as the BPS, the University Hospital (Hospital de Clínicas), and medical centres of the municipalities, complement the offer when required, whilst the Institutes of Highly Specialised Medicine (Institutos de Medicina Altamente Especializada [IMAEs]) deliver services of the highest complexity (Oreggioni, 2015). JUNASA is responsible for regulating, controlling and purchasing the services from all providers included in the SNIS (Olesker, 2015). Furthermore, mobile emergency companies (Servicios de emergencia móvil) offer partial insurance; providing domiciliary emergency and non-emergency services on a voluntary basis. These companies became a popular option over the decades before the reform, because of the health system's shortcomings, especially at the first level of provision (Fernández Galeano and Benia, 2013-2014).

The ASSE is the main state provider and delivers services to subsidised and FONASA-Uruguay holders. Moreover, the 29 IAMCs distributed throughout the country are the primary supplier and the main recipients of resources of the SNIS. The IAMCs provide care to over 80% of the FONASA-Uruguay holders and more than 60% of the population. Lastly, market-based insurers deliver services to about 2.4% of the population belonging to the highest-income groups , especially those in Montevideo (Oreggioni, 2015).

FONASA-Uruguay holders are entitled to choose coverage and service supply from the ASSE, the IAMCs or private insurance (González and Triunfo, 2020), but the subsidised are only covered through the ASSE. Moreover, there are differences in payments across providers: ASSE does not charge copayments, IAMCs charge moderation fees and for-profit private insurers require the payment of extra premia and copayments (Oreggioni, 2015). Therefore, the fragmented organisation of service delivery still favours segmented access of the poor (ASSE), the middle-classes (IAMCs), and the upper-class (for-profit private providers).

6.4.1.5. Outside Options - How do governments manage market-based alternatives?

The Uruguayan system comprises a large number of outside options. The distinction between the IAMCs and market-based private alternatives is crucial to understanding how this system works.

As discussed above, the IAMCs (formerly called Mutual Aid Societies) have been central in the Uruguayan health system practically since its foundation. These institutions were born from mutualism and took charge of health social security and care for the middle-classes. They are private, but not market-based, have had a large public role, and became powerful actors (veto players) in the system. The 2007 health reform kept the IAMCs at the centre of the SNIS, but

established regulations, such as the prohibition of rejecting any FONASA-Uruguay holder, the thresholds for moderation fees, the equalisation of the per capita premia between the IAMCs and with respect to the ASSE, and its adjustment according to the risk profile (Oreggioni, 2015) as well as the regulation of the waiting time for services (Pribble and Huber, 2013).

Market-based private insurance started to be part of the architecture of health care with the 2007 reform, but remain small in terms of number and covered population. As they are now part of the SNIS, market-based insurance can receive FONASA-Uruguay´s per capita revenues for those who choose this option, but in a lower amount than the IAMCs and the ASSE. Yet, private insurers are less regulated than the IAMCs, being allowed to negotiate premia and copayments with the covered population, which permits risk-creaming. Moreover, there are no temporal restrictions for enrolment, that is, any person can opt for contracting private for-profit insurance at any moment (Fuentes, 2015), whilst mobility between the ASSE and the IAMCs is restricted to one month every two years (Olesker, 2015).

Regarding partial private insurers (e.g. mobile emergency services, dental insurance), they are not included in the SNIS and cannot replace coverage at the ASSE, the IAMCs, or comprehensive private insurance. They are not recipients of FONASA-Uruguay´s revenues (Oreggioni, 2015), are barely regulated (Former General Secretary of JUNASA and Director of the SNIS), and conflicting practices are frequent since most of these institutions are managed and even owned by physicians (Oreggioni, 2015).

In sum, private options are heterogeneous and unevenly regulated. The 2007 reform retained the IAMCs as core actors of the health system and deepened their regulations. Comprehensive private for-profit insurance started to be part of the policy design but remained less regulated than the IAMCs, whilst partial private insurance remained poorly regulated.

6.4.2) Health Care Policy Outputs

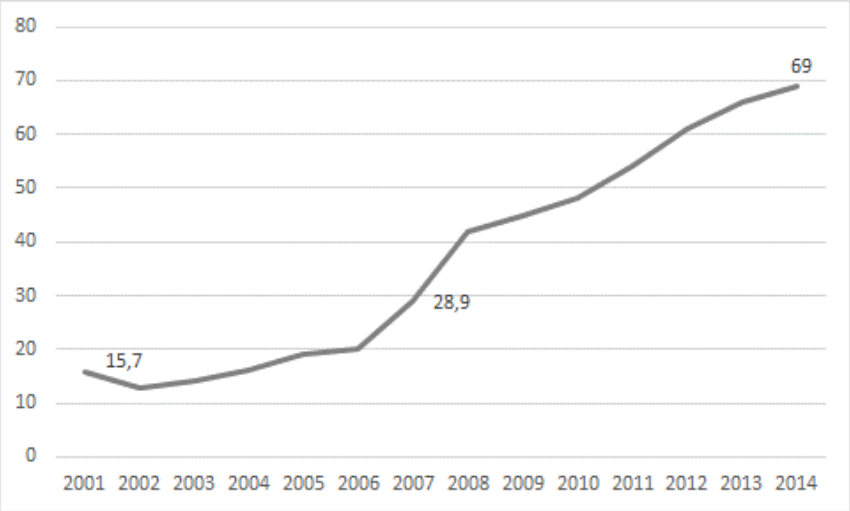
6.4.2.1. Population coverage

Similar to Chile, Uruguay has historically shown the highest levels of health coverage in Latin America. Among urban salaried workers (15 years and over), coverage reached 98.2% in 2002 and 99.1% in 2013, whilst for the self-employed, it increased from 95.2% to 96.1% in the same period (Sojo, 2017).

The health reform allows Uruguayans to get coverage either through social security (i.e. FONASA-Uruguay), subsidisation or special schemes (e.g. armed forces and the police). From 2007 onwards, social security coverage has expanded the most of all, reaching not only the formal workers, but also, extending coverage to workers´ family dependents and pensioners. In 2014, 69% of the population held FONASA-Uruguay, with more than half being family members and pensioners (Oreggioni, 2015). Graph 6.2 shows the relevance that social security has gained

since the launch of the reform, which also coincides with the boost given by the FA governments to formal employment.

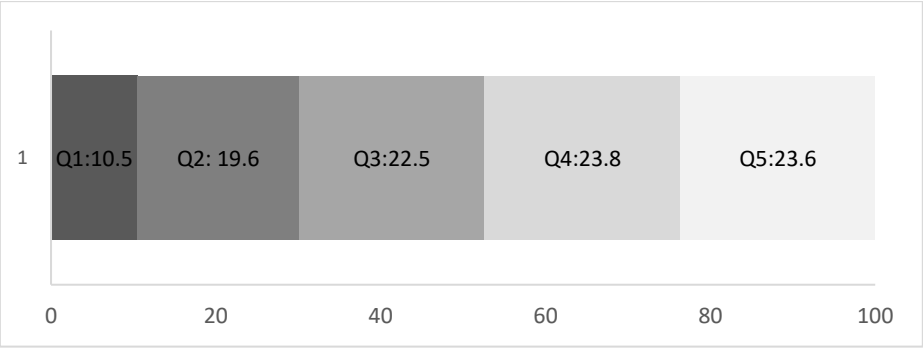
Graph 6.2. Evolution of population with health coverage through social security (DISSE/FONASA), 2001-2014 (percentage of the total population)



Source: Martínez (2015) based on JUNASA, MSP

Nevertheless, not all groups are equally included. Regarding income level, the creation of FONASA-Uruguay was supposed to foster the increased incorporation of lower-income groups. The proportion of social security coverage in the first, second and third deciles grew from 3%, 8% and 12% to 16%, 40% and 50%, respectively (Oreggioni, 2015). Nonetheless, the gap by income is still significant (Graph 6.3). Differences by sex and age are not marked (Carrasco, 2015b), but men are more represented than women (63% vs 56%) and the working-age population is more signed up than the younger and older people (MIDES, 2013).

Graph 6.3. Distribution of population with health coverage through social security (FONASA-Uruguay) by income quintile, 2011 (percentage of FONASA holders)



Source: Oreggioni (2015) based on ECH 2011

In turn, as explained earlier, holding or not of FONASA-Uruguay implies different entitlements for choosing service providers. That is, while all the subsidised must seek the services from the

ASSE, holders of FONASA-Uruguay can obtain health care from the IAMCs, the ASSE or market-based private insurance. The majority of those entitled to FONASA-Uruguay opt for the IAMCs (80% with IAMCs vis-à-vis 17.6% the ASSE, and 2.4% had private insurance in 2014) (Oreggioni, 2015). Also, considering the whole population, coverage at the IAMCs expanded from 47.5% to 63% between 2000 and 2016, while coverage with the ASSE dropped from 36% to 30% for the same years and private insurance remained at around 2.5% between 2008 and 2016 (Ballart and Fuentes, 2018).

Furthermore, there are different requirements between the IAMCs (regulated moderation fees), the ASSE (no copayments) and private insurance (extra premia and copayments), which enhance access to some groups and hinder others. These conditions have led to the uneven composition of the groups that obtain health care with each type of provider. The middle-classes prioritise the IAMCs, and the lower classes mainly attend the ASSE. Differences are clear in a study carried out in 2011 that examined health coverage by different levels of welfare[38] (Table 6.6).

Table 6.6. Health coverage of groups with different levels of welfare for Montevideo and urban areas of the rest of the country (percentages)

	IAMCs	ASSE	Private (for-profit) insurance	Military /Police hospital	Other	Total
High welfare	81.5	3.2	10.3	4.4	0.4	100
Moderate welfare	76.7	13.8	0.6	7.0	1.9	100
Potential vulnerabilities in welfare	47.4	42.3	0.9	3.6	5.8	100
Extreme lack of welfare	32.5	53.9	0.0	4.2	9.5	100
Total	67.5	19.9	4.7	4.9	3.0	100

Source: Midaglia et al. (2012) based on ECH 2011

This study shows a positive relation between coverage by non-public providers (i.e. IAMCs and private insurance) and higher levels of welfare. Coverage by IAMCs predominates for the cluster with the highest level of welfare (81.5%), followed by private for-profit insurance (10.3%). IAMCs also prevail for the group of moderate welfare (76.7%), but here the public provider (ASSE) is the second most frequent (13.8%), and private insurance is marginal (0.6%). The cluster with potential vulnerabilities and that with extreme lack of welfare exhibit the opposite trend, especially in the latter, which is predominantly covered by the ASSE (53.9%) (Midaglia et al., 2012).

Despite there being a gradient, coverage at IAMCs currently is more evenly distributed across different income groups (Oreggioni, 2015). Coverage by the ASSE also shows transformations, as the percentage of FONASA-Uruguay holders grew from 1.4% in 2007 to 32.2% in 2014, expressing the inclusion of less advantaged groups into social security. However, most holders

[38] Levels of welfare were determined by a cluster analysis that included indicators on housing, comfort, education, and employment.

(67.8% in 2014) continue to be entitled via subsidies (Setaro, 2016).

6.4.2.2. Generosity

Like in Chile and Ecuador, since the reform, public investment in health has grown in Uruguay, leading to the expansion of coverage and benefits. Currently, both total and public expenditure in health are above the regional average (ECLAC, 2020), which is expected to favour the quality and comprehensiveness of health services. Moreover, the settlement of FONASA-Uruguay came hand in hand with the progressive allocation of resources per capita (health risk-adjusted) to the public provider and the IAMCs (Olesker, 2015). Meanwhile, the fees transferred from FONASA-Uruguay to private comprehensive insurance are lower (Oreggioni, 2015), which prevents the draining of the highest contributions to the private sector.

From 2005 onwards, the budget for the ASSE increased on a sustained basis enabling new investments in equipment, human resources, and the strengthening of the primary level of provision. Hence, the reform promoted greater equalisation of quality regarding the IAMCs (Fernández Galeano and Benia, 2013-2014; Setaro, 2016); lowering the gap from 3.5 in 2005 to 1.3 times in 2012 (Oreggioni, 2015). Nevertheless, the budget managed by public hospitals is still 20% lower than the per capita allocated by FONASA-Uruguay, which is primarily channelled to the IAMCs (Former General Secretary of JUNASA and Director of the SNIS).

Finally, from a regional perspective, analyses indicate that Uruguay performs high in generosity, exhibiting the highest levels of public resources on health, when social security contributions are considered (Martínez Franzoni and Sánchez-Ancochea, 2018). This has meant the availability of resources to offer comprehensive benefits for all, with greater resources for the system, but especially for those entitled through FONASA-Uruguay. In this way, the middle-classes have continued with their advantages in accessing health care, whilst the lower classes have been progressively included by virtue of both their entrance into the social security system and an increasingly generous subsidised scheme. In other words, despite the reform having kept fragmentation by maintaining separated funds, insurance and providers, there have been efforts made to equalise generosity.

6.4.2.3. Financial protection

The current arrangements of health care involve at least two types of subsidies that foster financial protection: Free service cards to support coverage in the ASSE for those who lack social security and the FNR for financially protecting all social groups against catastrophic diseases (Fernández Galeano and Benia, 2013-2014; Fuentes, 2015). Moreover, whilst it is not a direct subsidy, progressivity in revenue collection, as stated by the health reform, has translated into a decrease, and even the suppression of, premia paid by lower-income households (Carrasco, 2015a).

Financial protection also has to do with the direct expenses incurred by households, either as prepayments or at the time of receiving care (OOP spending). In this regard, the definition of the per capita paid by FONASA-Uruguay and the benefits guaranteed by the PIAS, have meant the

drastic reduction of prepayments, which formerly were requested by the IAMCs and scarcely regulated (Oreggioni, 2015). Thus, prepayments decreased by more than 7% between 2010 and 2017, whilst in most of the region the opposite trend was evidenced (OECD/WB, 2020).

Likewise, financial protection significantly improved by the reduction in OOP spending, which currently is half of such spending exhibited by Chile and less than a half than in Ecuador. With 17% of the total health expenditure, OOP spending in Uruguay stands notoriously below the 34% average share in Latin America and even lower the almost 21% average of OECD countries (OECD/WB, 2020). On the one hand, the reduction of OOP spending relates to the elimination of copayments at the ASSE, wich especially benefits to less resourcefull groups. On the other, to the regulation of moderation fees requested by the IAMCs for services (i.e. órdenes), tests and medicines (i.e. tickets) included by the PIAS, which meant about a 60% reduction in prices in real terms between 2005 and 2012 and has favoured the financial protection for the middle-classes (Carrasco, 2015a).

Nevertheless, households still have to deal with moderation fees, which are not adjusted by payment capacity (Oreggioni, 2015) and differ, within the allowed thresholds, across IAMCs (Fuentes, 2015). Consequently, to some extent, with the current payment structure there remain income-related gaps for accessing health care. Indeed, some analyses of the financial performance of the health reform indicate that moderation fees primarily moderate the demand for services of the low-income earners (Carrasco, 2015a; Cetrángolo, 2015). Moreover, copayments for services not included in PIAS and for services in private market-based insurance remain unregulated (Arbulo et al., 2012), which indicates that financial protection has not improved in the same fashion for the upper-middle and upper classes.

Another indicator that allows for capturing financial protection is service utilisation. In this regard, analyses indicate that, overall, service utilisation is high and unmet health care needs are similar whether under the ASSE or IAMCs (Oreggioni, 2015). However, further examination reveals a horizontal inequity in the quality of access by socioeconomic status (Balsa, Rossi and Triunfo, 2011), with pro-rich inequality, being the type of health insurance the main explanatory variable: private is pro-rich whilst public is pro-poor (González and Triunfo, 2020).

In sum, the available information indicates that the health reform has improved financial protection, especially for lower-income groups and the middle-classes. However, the latter still face copayments for services not included in the PIAS. In contrast, those upper and upper-middle classes that opt for seeking private market-based services have to cope with unregulated copayments and therefore, may be more at risk of financial hardship.

6.4.2.4. Sufficiency and equity of policy outputs

Similar to the analysis presented in the study of Chile and Ecuador, here, I briefly summarise the effects that the current policy architecture has had in terms of sufficiency and equity in coverage, generosity and financial protection. The analysis presented makes visible the favourable outputs in terms of sufficiency of coverage, generosity and financial protection, as

well as important advances in equitable outputs. These observations concur with previous studies that place Uruguay in the cluster of the best performers for universal health care in the region (Martínez Franzoni and Sánchez-Ancochea, 2018).

The policies aimed at the labour market applied by the FA enhanced the expansion of coverage through social security meanwhile the increase of public investment in health has allowed subsidising the coverage of the rest of the population through the ASSE. In so doing, in recent years, there has been high sufficiency and equity in the coverage reached throughout the population. Nevertheless, coverage with FONASA-Uruguay has not been the same for income levels and employment conditions (i.e. the share of FONASA-Uruguay holders is higher among the highest income quintiles and formal workers).

As discussed earlier, holding or not of FONASA-Uruguay implies different entitlements for choosing service providers. Currently, most of the population is covered at the IAMCs, and such coverage distributes more evenly than before the reform. Nonetheless, the population remains segmented, not only relying on the people´s participation in the labour market and their ability to contribute to FONASA-Uruguay, but also, on income level owing to differences in the requirements of premia and copayments across the suppliers included in the SNIS. In this scenario, the middle-classes are in an advantageous position since most of them have FONASA-Uruguay and therefore, can choose any type of provider. In contrast, a substantial part of the poor does not have FONASA-Uruguay nor the same possibilities of choice and must rely solely on the ASSE.

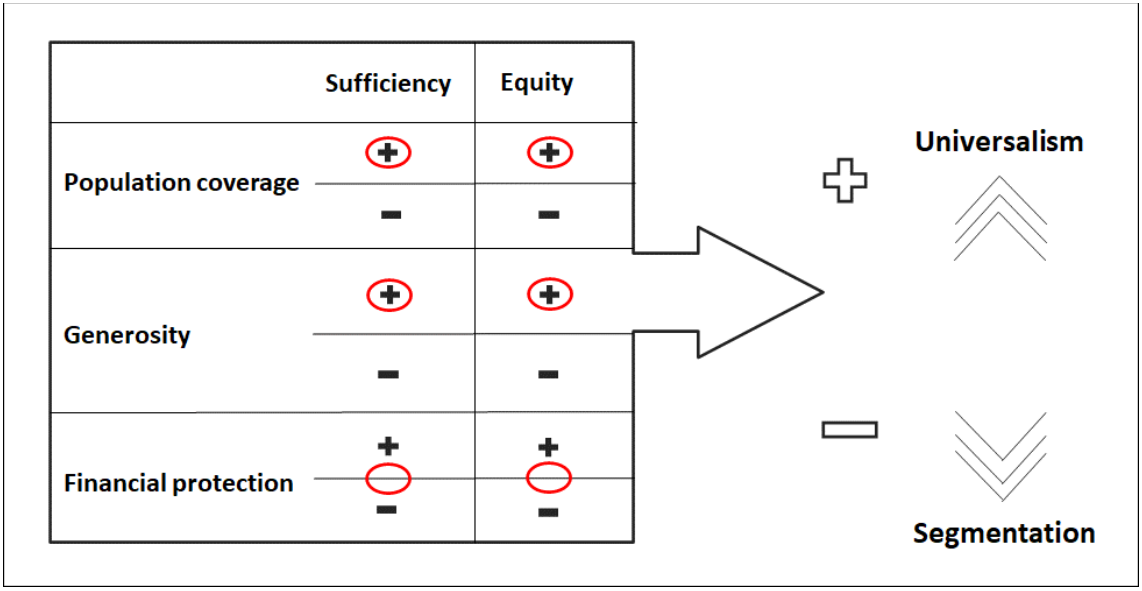
Regarding generosity, the PIAS and progressive resource allocation improved sufficiency and equity. The PIAS is comprehensive and offered to all independently of the participation in the contributory or subsidised scheme. Regarding resource allocation, whilst risk-adjusted per capita limits to FONASA-Uruguay and resources for the subsidised population are lower, redistribution goes beyond FONASA-Uruguay holders, because these resources also reach the ASSE, where they are pooled with the general revenues assigned to the subsidised population, thus contributing to decreasing the gap in resources per capita.

As for financial protection, the decrease in OOP spending indicates significant advances in sufficiency, especially for the lower and middle-classes. Moreover, there are direct (i.e. FNR and free cards) and indirect mechanisms of subsidisation (i.e. progressivity in revenue collection) that together favour horizontal and vertical equity. In turn, reductions in prepayments owing to the settlement of per capita payments by FONASA-Uruguay have especially promoted financial protection of the middle-classes. Nonetheless, the lack of regulation of copayments and premia in the private insurance implies that financial protection for the members of the upper and upper-middle classes who choose this alternative has not improved to the same extent. Moreover, it must be borne in mind that, despite being the lowest in the region, OOP spending continues to be high and further advances are needed to this dimension actually contributing to universal health care.

To sum up, the analysis indicates that progress made in the unification of the architecture of the health system has allowed the country to advance in the path towards overcoming

segmentation and advancing universalism (see Figure 6.1). In this scenario, the middle-classes seem to be more protected than ever before. However, there are some areas, such as service delivery, in which labour market-founded fragmentation remains and may involve unequal chances to access health care for different sectors of the population. However, attempts have been made to address this through the guarantee of generous services of the PIAS.

Figure 6.1. Outputs for universal health care by dimensions, Uruguay



Source: Own elaboration

6.5.- Middle-classes´ access to health care

So far, this chapter has discussed the development and current features of the health system within the context of the Uruguayan welfare regime, the policy outputs and some implications for the middle-classes´ access to health care. The analysis has unveiled remarkable advances towards universalism, although more efforts are needed to tackle segmented health care in some areas. This section begins by profiling the middle-classes in the country, followed by the focus being on the implications that the current arrangements for social welfare as well as the policy architecture and outputs of health care bring for the middle-classes, their practices of health care seeking and the consequences regarding segmentation and universalism in this area.

6.5.1) The middle-classes in Uruguay

Historically, Uruguay has been identified as a middle-class society looking comparatively at the region (Lanzaro and De Armas, 2012; Carbajal and Rovner, 2014). Initially pushed by Batllism

and then, by the economic and industrial development of the ISI period, the middle-classes grew sustainedly from the beginning of the 20th century to the late 1960s.

In 1956, Solari drew attention to the intense vertical mobility of the Uruguayan society and estimated there being around 75% of middle-classes against 20% of the working class and 5% of the upper-class. The author considered that public employment was one of the fundamental pillars for the middle-classes´ expansion and subsequent estimations have supported this idea, showing a steady increase in public jobs, from about 10% of the active population in 1940 to 20% over 1965-1975, to then falling to 15% in the 2000s, when all Uruguayan society became impoverished owing to a profound economic crisis (Lanzaro and De Armas, 2012). Solari also examined the economic situation, patterns of organisation, and political role of the middle-classes, concluding that their income did not significantly differ from the proletariat. He also argued that, due to their heterogeneity, the middle-classes remained disintegrated, in contrast with the advanced organisation and class consciousness reached by the upper-class and the working class. This was despite the middle-classes greatly benefiting from state protection thanks to their electoral clout -as the largest sector of the population- and ties with the parties that traditionally ruled the country (Solari, 1956).

Later studies show that, once the ISI model had become exhausted and regardless of the growth in income inequality throughout the 1980s and 1990s, the middle-classes (defined as certain employment situations or groups of occupations) kept on representing around 50% of the working population. Erradonea (1989) estimated 52% of workers were in middle-classes occupations for 1985, whilst Boado and Fernández (2005), applying the Goldthorpe schema, estimated that the middle-strata increased from 49.4% in 1998 to 56.3% in 2004 (cited by Lanzaro and De Armas, 2012). Over this period, the middle-classes continued receiving the state´s support regardless of the civic-military dictatorship and the 1990s neoliberal reforms (Castiglioni, 2005; Huber and Stephens, 2012; 2016).

Income-related approaches, however, show different findings. Using measures of income polarisation, Borraz, González and Rossi (2013) show that the middle-classes declined to 37% over the period 1994-2004 along with the economic downturn and the increasing inequality. Whereas Riella et al. (2006), applying a multidimensional index of socioeconomic level, estimate that middle-class´ households recovered to 52% in 2006 (cited by Lanzaro and De Armas, 2012), which aligns with the recovery of the economy, the decrease in poverty and inequality as well as the introduction of redistributive policies from 2004 onwards by FA governments. Also, Ferreira et al. (2013) stress the high social mobility in the 2000s, when 30% of people changed socioeconomic strata vis-à-vis 10% in the 1990s. Such mobility was, to a significant extent, towards the middle-classes, where between 17% and 20% of households entered this group (Colafranceschi, Leites and Salas, 2018).

Following the approach proposed by Lopez-Calva and Ortiz-Juarez (2014), Carbajal and Rovner (2014) calculated thresholds of 20 USD and 50 USD a day for the Uruguayan middle-class, concluding that the group slightly increased between 1992 and 2002 (from 16.3% to 19.7%), whereas it grew sharply between 2002 and 2012 (30.5%). The poor increased substantially from 1992-2002 (from 21.7% to 28.4%) and then, fell even more dramatically 2002-2012 (9.6%).

Moreover, the vulnerable group declined during 1992-2002 (from 57.4% to 45.5%) and then rose towards 2012 (51.8%). This means that the period 1992-2002 was featured by a significant transit from vulnerable to poor, whereas the period 2002-2012 exhibited the opposite trend. This study also found a positive correlation between the perceptions of well-being with higher class positions. Finally, analyses based on self-perception indicate that 51% of people perceived their belonging to the middle-classes in 2016/17 (Colafranceschi, Leites and Salas, 2018), whilst in 2018 6.5%, perceived themselves to be in the upper-middle-class, 49.7% in the middle-class, and 30% in the lower-middle-class (Latinobarómetro, 2018c).

As for political preferences, from 2004 and for three presidential periods, most of the middle-classes supported the progressive governments of the FA and showed favourable attitudes towards redistributive policies, with explicit objectives of social equity (Carbajal and Rovner, 2014). Nonetheless, those attitudes have turned to being less progressive in recent years (Colafranceschi, Leites and Salas, 2018).

Lastly, concerning access and satisfaction with health care, cross-country analysis conducted by Solís, Chavéz Molina and Conbos (2019) shows that there are no significant gaps between the middle-classes and lower-classes´ enrolment in health insurance (all above 95%). Moreover, currently, the health care system has broad legitimacy, with over two-thirds of the population supporting the health reform process (Olesker, 2015). Still, the valuation of the IAMCs declined among the middle-classes. Before the reform, the IAMCs fundamentally covered the middle, upper-middle and upper sectors, but the reform meant the expansion of the covered population, and they were no longer a status symbol. Thus, the prestige previously enjoyed by the IAMCs may have gradually shifted towards private insurance (Méndez, 2019).

The examination of the levels of satisfaction with the health system and each type of provider after the health reform shows high overall scores and similar levels of satisfaction between the IAMCs and the ASSE in several dimensions, meanwhile private market-based insurance holds a better evaluation. Toledo Viera (2017) analysed a survey conducted in 2017 by MSP-Uruguay and makes comparisons with others conducted in 2014 and 2010. The author calculated for 2017 an overall satisfaction score of 8.2, within a scale from 2 (low satisfaction) to 10 (total satisfaction), with an average score of 8.1 for the IAMC, 8.0 for ASSE, and 9.0 for market-based insurance, thereby registering no significant variations compared with 2014 and 2010. The analysis by dimensions indicates that the IAMCs and ASSE score similar regarding satisfaction according to the availability of medical hours for specialities, timely attention, waiting times, and comfort. In all these dimensions, private options scored higher, whilst ASSE scored lower than the IAMCs regarding paperwork and direct interaction. Again, market-based insurance scored better than the other types of insurance in these two dimensions. Lastly, in the dimension of economic accessibility, IAMC holders faced more difficulties in purchasing tickets for medical tests (7.3%), medical consultation (4.3%), and medicines (3.1%) vis-à-vis holders of private insurance. This is despite the lower and regulated prices of tickets for the IAMCs. Economic accessibility was not evaluated in ASSE, as this institution does not charge any ticket or copayment.

However, the surveys conducted by the MSP-Uruguay do not investigate practices for health care. Neither it was possible to identify any study analysing this in a way that allows for the differentiation of the middle-classes. Similar to the analysis undertaken for Chile and Ecuador, the next pages address this gap of information through the analysis of the interviews conducted with members of the Uruguayan middle-classes.

6.5.2) Middle-classes´ practices for achieving health care

This analysis draws upon 18 in-depth interviews conducted with members of the middle-classes between March and May of 2018 in the Uruguayan Capital, Montevideo. Participants were divided evenly by sex (nine women and nine men), ranged between 29 and 57 years old and were diverse in terms of family status (single and married, with and without children), employment category (salaried and self-employed), household income, participation in social movements and the type of university (public or private) attended. At the time, all of them held FONASA-Uruguay, sixteen were enrolled with IAMCs and two had comprehensive private insurance (Appendix 2).

6.5.2.1. The perceived health system

Interviewees stressed the advances reached since the beginning of the health reform and did not complaint regarding the mandatory contribution to FONASA-Uruguay: *´[…] you pay a lot of taxes, it's true, but the middle-class and the rich are, undoubtedly, the social classes that benefit the most from state services`* (Alvaro, single man, 29 years-old). They are aware of the different options of providers and know that they can opt for directing their contributions to the IAMCs, the ASSE or private for-profit insurance. Moreover, all participants pointed out that the quality of professionals and services is similar across the three types of comprehensive providers. Ida (mother of two children, 43 years old), who is enrolled with an IAMC, clearly summarises what interviewees perceive in common and different regarding private insurance: *´[…] I think it is not very different. They are all good. The private [insurance] gives you more comfort, but regarding clinical competence, it does not add anything`*.

The perception of an acceptable medical quality across providers and the knowledge about the PIAS allow the middle-classes to feel protected against health risks, even if they fall into a more disadvantaged situation (e.g. losing their job) and have to rely on the publicly subsidised scheme. Nevertheless, this does not imply that they consider all options to be the same. Alvaro, a civil servant enrolled on an IAMC, illustrates this point:

> *´The PIAS, the catalogue of benefits, is for all providers of the SNIS. They have to deliver these benefits. But, in the mutualistas [IAMCs], in ASSE, and in private suppliers, it is delivered differently [...] In ASSE you have to share the room with three or four people and formerly it was with eight or even twelve. It does not happen in*

the mutualista, and with private insurance you are alone. So, the right to hospitalisation exists, but it is not the same` (Alvaro, single man, 29 years old).

Delving into the IAMCs, participants recognised them as the historically most important actor in health services delivery for the middle-classes, especially in the capital Montevideo. They explain that the IAMCs allow for meeting the health needs with no luxury, but with quality enough. Moreover, despite moderation fees varying in terms of differences across IAMCs, participants consider that services through these are affordable for the middle-classes. On the negative side, there are some complaints regarding the waiting times for specialities: ´*Since the reform, you suffer in terms of the time, except for general medicine [...], and this creates discomfort*` (Felipe, father of three children, 40 years old)*; ´[…] before [the reform], there were fewer people, and you could get a doctor in a day or two. It is obviously much better now, but there are many delays*` (Eliana, married without children, 29 years old). However, it is also known that the timing for critical health needs is defined by a protocol: *´[…] if you are receiving treatment for cancer, and your oncologist believes that he has to see you in a week, he will see you in a week […] If you need urgent surgery, the regulation defines that it must be done within 48 hours*` (Alvaro, single man, 29 years-old).

There also are differences across IAMCs regarding moderation fees, number of people enrolled, waiting lists to get attention, and supplementary services (e.g. domiciliary attention): *´The mutualista that I have, COSEN, from the point of view of services, is very good [...] you call in the week, and within ten days you have the appointment. My wife´s mutual is not the same, that has two months of waiting time […]*` (Fabian, father of three children, 44 years old). These differences translate into differences of status between IAMCs, with a couple of higher status ones that concentrate their provision in the areas of residence of the upper-middle classes, whilst others include a more diverse spectrum of affiliates and locate throughout the city, and a third group that has historically served blue-collar workers (Scholar at the Universidad de la República, Expert on Uruguayan health system).

Regarding the ASSE, most participants have had no direct experience, which unveils that the historical trajectory of the health system has kept the middle-classes at a distance from the public sector. Therefore, the interviewees´ perceptions relate to the experiences of others at public hospitals and their ´general knowledge`. Narratives expressed that the government has made a big investment in the public sector, which, according to what they know, has translated into unprecedented improvements in the technology and quality of services, even surpassing the quality of the IAMCs and private hospitals for treatment of severe diseases.

However, they also believe that public services involve large waiting times and other situations of discomfort. In this regard, participants are particularly sensitive to the idea of sharing a room with people *´who are sometimes not very polite*` (Francisca, single woman, 47 years old), even expressing the view that, *´nobody who is not poor seeks attention at ASSE, at least in Montevideo*` (Alvaro, single man, 29 years-old). These two quotes reveal how the perspectives of the ASSE are coloured by the preconceptions that participants have about ´the type` of people who seek care there. It is, therefore, also a question of status, since being middle-class is unfailingly associated with the IAMCs.

Lastly, concerning market-based insurance, most participants pointed out that it is quite expensive and thus, an elite option. The amenities were identified as being the main advantage: *´Ahhhh, they are a pleasure. It's like going to a hotel. The waiting room is bicolour, it's music, silence, nice service. But it's very elite because it´s very expensive`* (Antonia, mother of one child, 38 years old). However, most interviewees considered that such amenities did not counterbalance the cost: *´If you want a private room, you can pay for it at the mutua [IAMC], but I wouldn't pay for private insurance [...] the only thing you would achieve is a little more comfort, but nothing else`* (Ida, mother of two children, 43 years old). The few who did have private insurance remarked about the advantage of choosing the doctor and getting immediate attention, but still considered that there were no differences regarding medical quality.

In sum, the narratives reveal that, for the middle-classes, none of the options that the health system currently provides seem totally unacceptable nor inaccessible. The perception of similar medical quality allows them a sense of protection that, in theory, makes it feasible to remain or move to any of the three types of providers and decide according to their preferences as well as their assessment of the costs and benefits offered by each one. Participants expressed being aware that the system is capable of responding to their health care needs. Nonetheless, they also distinguished advantages, limitations and costs of each option of provider as well as status issues that translate into a stratified perception of these options, with the ASSE at the bottom and private insurance at the top, and the IAMCs in the middle and being this latter option that best represent the middle sectors of society.

6.5.2.2. Practices to achieve health care

The previous subsection showed that, currently, the middle-classes perceive that the health system offers a range of possibilities when seeking services. However, as I will discuss next, only some materialise in their practices. Middle-classes´ practices for health care actualise the interaction of the contemporary policy architecture with other long-term conditionings from past architectures as well as the implications that they perceive of their position in the Uruguayan social structure and regarding the health care domain. Next, I examine the three alternative clusters of practices that came to the fore through the interviews.

Starting with the practices most typical among the participants, the **first cluster** encompasses opting for enrolling in an IAMC and using its services exclusively without resorting to private options nor hiring any kind of additional services. This cluster of practices is deployed by more than a half of participants, including different employment situations (i.e. self-employed and salaried in the private and public sectors) and income levels, but they all have in common having studied in the public university and a political position to the left. Also, most of them use facilities (e.g. domiciliary attention) offered by their IAMCs, at no extra cost, that are not part of the benefits included in the PIAS, that is, not being available at all IAMCs nor through the ASSE. This happens because they are enrolled in IAMCs that offer greater benefits, timely attention and enjoy a higher status. Despite the premium that FONASA-Uruguay transfers to these IAMCs

being the same, the difference is that their moderation fees are higher and therefore, they also attract groups from higher socioeconomic strata.

> *´I can choose a mutualista [IAMC]. I chose that one that provides you with the mobile emergency as part of its portfolio of benefits`* (Alvaro, single man, 29 years old).

The **second cluster** of practices is to opt for enrolling in the IAMCs and paying, to the same IAMC or to a separate institution, for additional amenities or services, such as accessing services at specific private providers, getting a private room for inpatients services, or mobile domiciliary services. Thus, different to the previous cluster, in this one, participants add supplementary benefits to those granted by the enrolment with the IAMC in order to get health care according to the standard they seek.

Five participants expressed practices belonging to this cluster; most of them coming from an upper-class background in terms of family of origin, having studied at private universities and being closer to the liberal right ideological matrix. The only interviewee, Daniel, within this cluster, who comes from a different background, has the particularity of being enrolled in an IAMC that, despite being the tradition of the upper-middle classes, has been declining in quality.

> *´When my daughter got sick [panic crisis], she went to the mutualista ... She was in the emergency. There they reassured her, all good. Then, we realised that it was better to continue the treatment with the same psychiatrist of the mutualista, but in her private practice. We paid privately, because those consultations are more regular there`* (Daniel, father of two children, 52 years old).

Finally, three participants, all women, narrated practices that shape a **third cluster**. However, in one case, Antonia, these practices are for her child, and she herself accesses health care through practices discussed in the second cluster. Practices in this cluster consist of hiring private insurance and accessing health services through private suppliers. In doing so, they opt for directing their FONASA´s contributions to private insurance and making extra payments to reach the higher premia requested by market-based alternatives. These three women have children, studied at private universities, come from upper-middle-class families, and have income levels that are not notably different from other interviewees. Celeste´s narrative illustrates the practices within this cluster.

> *´We have it very easy. You call the doctor and that is it. We find it difficult to think every month that we have to pay a lot for it. There are times when we doubt, but when something happens, a detail, the girl breaks down at school and you run to the health practice, well [...] thankfully we are paying`* (Celeste, mother of two children, 41 years old).

When asked about the stories presented in the vignettes, most interviewees supported the idea of choosing the IAMC or even the ASSE:

´I don't know, no private insurance, it makes no sense. I don't see what you can obtain by getting private insurance` (Ida, mother of two children, 43 years old).

´[…] First, I would try ASSE, and then, I would change if necessary. If I take a chance, I try ASSE first` (Isidro, father of three children, 57 years old).

Diana (third cluster), Eliana and Enrique (second cluster) replied differently and advised hiring private insurance. Also, Antonia (second and third clusters) expressed the view that either the IAMC or private insurance may be a good alternative.

´I know many friends who did that [change to private insurance when they were pregnant], and it is fundamentally because of a theme of comfort [...] Moreover, they receive a lot of things, gifts, when the childbirth is in a private hospital [...]. For a woman who has to go frequently it is much more practical. Without a doubt, I would recommend that [private option], if she can` (Enrique, single man, 32 years old).

Concerning strengthening strategies, unlike what happened in Ecuador and in Chile, they are described more as an option than as a need. Participants expressed that it is a good practice to investigate the antecedents and portfolio of benefits offered by each IAMC, to be informed about the patients´ rights, and to hire additional services (e.g. private room and domiciliary attention) in case of need. In fact, domiciliary attention is an enduring long-term tradition among the middle-classes in the country. Currently, some IAMCs include this benefit in their portfolios for free and in other cases, participants pay external institutions for it. Nevertheless, all these strategies take place within the institutional framework laid out by the ruling architecture of health care, which ensures that institutional mechanisms are responsive to the needs and preferences of middle-classes.

Lastly, regarding the meanings that participants give to their practices, those in the first cluster explained their decision of remaining with the IAMCs and not moving to private insurance or the ASSE was due to the appraisal of the costs and benefits of each alternative. As for private insurance, the differences that persist across the IAMCs, allow, at least partially, for the middle-classes to continue to belong to the more prestigious ones. Furthermore, it is usual for them to benefit from domiciliary attention, which is considered a mechanism to cope with the overcrowding and limitations of timely attention of the IAMCs. Hence, private insurance has very little to offer to them beyond the amenities and the status, which does not counterbalance the economic effort involved.

These participants did not express dispositions to move from the IAMCs to the ASSE either, despite their awareness of the improvements in quality and absence of copayments regarding the latter. They indicated that payments at the IAMCs are affordable, unveiling that the current system provides levels of financial coverage that are acceptable for the middle-classes. Also, they acknowledged the role of historical shortcomings in quality and stigmatisation of the ASSE as being the service for the poor in preventing them from trying the public option:

> *´[…] I also come from a generation that [...] going for public services was … you see, only those who had the card of the poor were there. It was, so-called, the card of poor […] so, I have it very associated with the fact that services were terrible […] But I think my children might decide to go to the ASSE in the future`* (Isidro, father of three children, 57 years old).

This quote illustrates that, despite the middle-classes being able to acknowledge the transformation of the health system, and even a generational change, they have not necessarily integrated this shift into their practices. This is a middle-class that historically coped with a deficient health system. Since the foundation of the system, they have satisfied their health needs without the support of the state, through mutualism, which is neither public nor private, but rather, an expression of the organisation of civil society. This historical experience remains in their current practices, in spite of the leading role assumed by the state since the health reform.

In contrast, those interviewees who were more likely to prefer some market options (second cluster) reported that, in recent years, the state has targeted benefits at the poor whilst overdemanding the middle-classes, which makes them feel dissatisfied. However, as the quote below reveals, this feeling of dissatisfaction is not about being exposed to financial hardship or not receiving the care they need, as it was so in the analysis of the practices in Chile and Ecuador. In this case, this refers to the possibility of not meeting their health care needs to the standard they used to have.

> *´I think that the state has many assistance mechanisms [...] I do not say that it is wrong, it is very good [...], but that makes neglecting the workers who are pushing for the economy to work [...] there is a middle-class sector that is super demanded, in taxes [...] we feel more at risk. If I get sick, health insurance cannot cover the middle-class standard of living`* (Eliana, married without children, 29 years old).

Finally, participants who opted for private insurance (third cluster) recognise that it involves a high economic cost. Even though they justify their choice, explaining that they value the amenities and comfort that they can obtain in private practices: *´When I gave birth, I had a private room in a hospital that is like a five-star hotel. The shared room is not the same. That is a place where I don´t know if I could be so happy`* (Diana, mother of two children, 41 years old).

In sum, the narratives unveil that the middle-classes in Uruguay feel mostly protected against health risks. Even those who pay for private market-based options explained that they could meet their health care needs through the IAMCs, because their medical quality is similar to private insurance. Even they stated that may seek care in the ASSE, but they know that this would imply less comfort. The affirmation of Diana clarifies this point: *´[...] I do not have blind confidence, but I feel that if we did not have the resources, if I had to depend on the state, I would have much less comfort, but I would not feel abandoned [...]`*.

Furthermore, participants relate their sense of protection to their social position. This quote from Isidro (father of three children, 57 years old) illustrates what several interviewees pointed

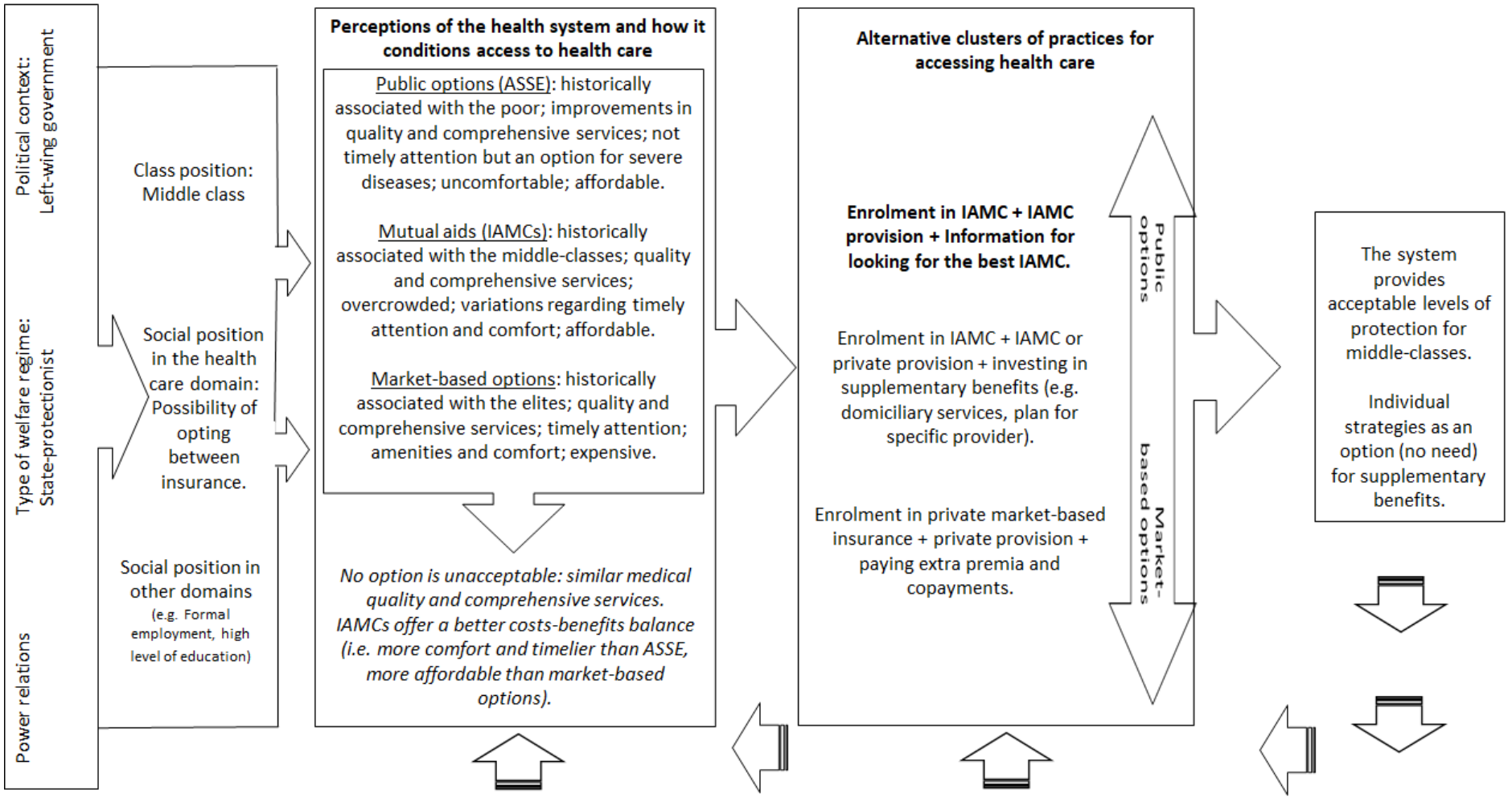
out, namely that the middle-classes are, and always were, in a privileged position to use the benefits offered by the health system:

> *´[…] I was always protected, the Uruguayan system always protected me […], I was in a class, the Uruguayan middle-class, which allowed me to always be very far from falling […] Currently, I think, there is much more protection than before […] the rural workers in places that had never been historically protected, domestic workers […] I think that there is much progress`*.

In this scenario, in which the middle-classes feel mostly protected, it is worth asking, then, what makes the difference in the practices? In other words, what difference, if any, is there between those interviewees that narrated practices from the first, the second, or the third cluster? In fact, those who have opted for private insurance (Antonia, Celeste and Diana), as well as those who, although they remain with the IAMCs, show more favourable dispositions towards market options (Eliana and Enrique), come from upper-middle-class families of origin, studied at private universities and present an ideological matrix closer to the liberal right. In contrast, those who rely on the IAMCs and support this choice come from what could be called the most traditional Uruguayan middle-class, that is, public servants, professionals who studied at the public university, and are ideologically closer to the left. Moreover, it is noticeable that, despite the often mentioned high cost of private insurance, there were no differences between the income level reported by participants that opted for them vis-à-vis those with practices of the other two clusters.

Thus, it seems that in this case, the difference lies in more subtle aspects, such as status, unlike that observed in Chile and Ecuador where differences in the practices performed predominantly relied on objective conditions. Given that in Uruguay all health care options meet the basic conditions, symbolic aspects would appear to gain relevance. This may also explain why there is no cluster of practices for meeting health care needs through the ASSE, despite the middle-classes recognising its quality. The middle-classes are in an advantageous position. They have different options for health care provision, all of which are above the minimum standard of quality. The risk, however, is that different social groups satisfy their health needs with different providers and this, as discussed in previous chapters, entails the shortcoming that not all these groups have the same capacity to demand high quality care.

Figure 6.2. Middle-classes´ perceptions of and practices when accessing health care in URUGUAY



Own-elaboration

6.6.- Integration and conclusion: iterations between the policy architecture, policy outputs and middle-classes´ practices

As with the analyses carried out for Chile and Ecuador, in this chapter, the different conditions that impact on the middle-classes´ access to health care have been identified. In this, they have been shown to have contributed to advancing universal health care in Uruguay more so than in the other two cases. Moreover, in order to have a complete picture, the policy analysis has been complemented by inquiry into the middle-classes´ perceptions of the health system and their practices for health care.

Regarding the welfare regime in which the current policy of health care is embedded, it is evident that the country went from being a highly stratified welfare regime to one that redistributes resources much more than ever before. Nowadays, the Uruguayan state has assumed the role of guarantor of social welfare, prioritising social protection by inclusion into the regulated labour market and providing assistance to those who, for any reason, are excluded. This strategy has resulted in substantial advances in decommodifying social welfare and the outcomes of wellbeing, as well as improvements in the defamilisation of welfare.

The rationale of the social welfare arrangements translated into the reform led to a policy of health care coherent with the type of welfare regime. In fact, the SNIS notably relies on the inclusion of people through formal employment. This has been complemented with a scheme of social assistance that has become sufficiently generous, because, thanks to the successful commodification in the labour market, increasingly, the majority of the population have been participating in the contributory scheme, while public investment has also grown.

Moreover, by unifying the previously fragmented schemes of social security, the country has advanced the equalisation of benefits, thus promoting more equitable access to health care. Thus, the reform was capable of overcoming some of the most pernicious constraints imposed by the policy legacies inherited from the 20th century. Certainly, this was favoured by some contextual factors, such as the mass social support for the FA government, the economic crisis of the IAMCs (Fuentes, 2010), strong ties between the ruling coalition and social organisations (Pribble and Huber, 2013) as well as the unprecedented performance of the labour market (Rossel, 2016), among others.

Policy outputs demonstrate that the country has been progressively capable of providing sufficient and equitable coverage and generosity and advancing financial protection. This progress has been enhanced by the unification of the resources of the contributory scheme into FONASA-Uruguay and the settlement of the PIAS to guarantee high quality services for all. Nonetheless, labour-market founded fragmentation persists in the eligibility criteria and service provision, which maintains the segmentation of the population, although to a lesser extent than previously. The public provider delivers services almost exclusively to the poor or informal workers, whilst the middle-classes

continue to primarily seek health care with the IAMCs, and a small group opt for market-based options.

The health reform kept the IAMCs at the centre of the health system, which is consistent with the rationale that governs the welfare system as a whole. Moreover, the strengthening of IAMCs´ regulation regarding moderation fees, services covered and protocols of attention, among others, has pushed for greater financial protection and equity, thus contributing to advances in universalism.

In turn, the integration of market options in the system has also been accompanied by the strengthening of regulations, but these remain less strict than those for the IAMCs. Nevertheless, it is significant that despite the current architecture offering the possibility of directing contributions to comprehensive private insurance, it limits such an alternative, thereby avoiding the presence of commodification-led fragmentation. Of particular relevance, is the fact that private insurers cannot have separated funds and the transfers that they receive from FONASA-Uruguay are lower when compared to those of the ASSE and IAMCs. Moreover, they have to cover the same services as the other suppliers of the SNIS. These regulations avoid the draining of resources from higher incomers towards the private sector and limit extra premia requested by private insurance to supplementary amenities.

So, whilst the policy of health care allows for opting-out towards market options, by integrating actions in the different components of the architecture, this makes it a less attractive proposition. In other words, it creates an incentive structure that prevents the mass exit towards market-based options and decreases the risk of segmenting the population. The result, as expressed by the participants, is that the middle-classes mostly opt for meeting their health needs through the IAMCs. Furthermore, the reform has resulted in enough legitimacy and support, even among those holding private insurance as this is also part of the system, to continue strengthening the system in providing generous services to all.

Turning to a diachronic perspective, the current architecture has not been particularly disruptive for the middle-classes, as it did not lead to breaking with the long-lasting tradition of the IAMCs. The middle-classes were able to meet their health needs through mutualism without the direct support of the state over most of the past century. The situation changed, however, with the economic downturn at the beginning of this century that seriously impacted on the IAMCs´ performance and impoverished the middle-classes (Fuentes, 2010, 2015). This disrupted the system and triggered the alliance of the middle-classes with the lower-classes that led to the election, for the first time in history, of the progressive governments of the FA and, associated with this, the health reform that placed the state as the guarantor, even if retaining the fragmentation of providers.

Nowadays, near fifteen years since the beginning of the health reform, material differences between providers have decreased and definitely, are not as marked as they are in the other two cases studied. However, the legacy of the stratified health system appears to be more durable in

matters of status. The narratives examined show middle-classes that continue to observe the health system in a stratified way, i.e. middle-classes historically privileged and aware of these privileges. Participants´ narratives seem to indicate that the middle-classes´ practices of health care have not substantially shifted, as the new architecture has allowed them to continue to seek health care through the IAMCs and in some cases, to start seeking private insurance, but they do not seek services with the ASSE.

Nonetheless, because of the expansion of the population that receive services in the IAMCs, a social mix has been taking place, and most of the middle-classes have remained without withdrawing and moving towards private insurance. Different to what was the observed in the analyses of Chile and Ecuador, health care practices seem less elaborated, that is, they tend to continue the tradition and prioritise the lowest cost, instead of resorting to intricate individual strategies to increase their chances of obtaining acceptable health care. Moreover, the practices of the Uruguayan middle-classes would appear to be less dependent on contingent conditions, such as the severity of the disease, the availability of economic resources or the availability of services, being more related to enduring conditions, such as their position in society.

CHAPTER VII COMPARATIVE ANALYSIS

7.1.- Introduction

The three previous chapters delved into the policy conditions behind segmented health care and the middle-classes´ perceptions of the health system and practices to meet their health care needs in Chile, Ecuador and Uruguay. Thus, each chapter has provided a comprehensive picture that allows making relevant linkages between macrosocial and institutional conditions, on the one hand, and the perceptions and practices of the middle-classes, on the other.

Throughout the analysis, cross-country commonalities as well as substantive differences became evident. Even so, it is essential to undertake a systematic comparison of the areas analysed and their reciprocal interactions to address the research questions stated for this thesis, namely: *How does the policy architecture of health care contribute to universal or segmented health care?, What kind of practices for health care of the middle-classes are conditioned by the policy architecture?* and *What are the generative mechanisms which connect policy architectures, middle-classes practices and outputs of health care policy in Chile, Ecuador, and Uruguay?*. In the next pages, I undertake this comparison through four main sections.

First, in Section 7.2, I focus on the welfare regimes that frame the health care policy, discussing the differences and commonalities of the arrangements for reaching social welfare in the three countries. Following this, in Section 7.3 the countries´ policy architectures of health care are compared, considering both their respective trajectories and current disposition to create a picture of their fragmentation/unification. In addition, in this section, I start to establish linkages between the policy architecture and how universal are the policy outputs, in terms of the sufficiency and equity of coverage, generosity and financial protection of health care as well as the most significant characteristics of the respective welfare regime. Taking the elements together, we can delve into the aspects of the policy architecture that contribute to segmented/universal health care (first research question) and push the middle-classes towards certain practices (second research question), the latter being the focus of Section 7.4. To conclude, Section 7.5 builds upon the previous discussion to address the mechanisms that connect the policy architectures, the middle-classes´ practices, and the policy outputs of health care (i.e. the third research question).

7.2.- The welfare regimes that frame the policy architectures of health care

The previous chapters have shown that Chile, Ecuador and Uruguay have exhibited notable differences in the arrangements for social welfare production over the last two decades, although they do have in common the effort of making public investment to extend social welfare. Table 7.1 presents a comparative overview of the current state of these welfare regimes, which make up the context of the health care policy in each country. This comparison considers the four dimensions

used by the typology of welfare regimes of reference: commodification in the labour market, welfare decommodification, welfare defamilisation and outcomes of wellbeing.

Table 7.1. Updated features of welfare regimes in Chile, Uruguay and Ecuador by dimensions of the Martínez Franzoni's (2007) typology of Latin American welfare regimes

	CHILE	ECUADOR	URUGUAY
Type of welfare regime	**State-productivist welfare regime**	**Non-state familist welfare regime**	**State-protectionist welfare regime**
Commodification in the labour market	**High in the regional context but uneven** Jobs quality is above the regional average but stagnated from the early 2000s. Economic performance is high with a significant decrease in poverty and inequality, but the latter remains high.	**Similar to regional averages** Low jobs quality with no significant improvements since the early 2000s. Progress in economic performance with substantial decline in poverty and inequality, but the latter remains high.	**High in the regional context and balanced** Jobs quality is above the regional average and has substantially improved since the early 2000s. Economic performance is high with a significant decrease in poverty and inequality, but the latter remains high (but lower than in the other two countries).
Decommodification of welfare	**Limited and dual** Well-developed public welfare system for social assistance. Strongly market-based system for the non-poor	**Limited and dual** Progress of the public welfare system, but improvements are still restricted. Market-based options fulfil the gaps of publicly provided social services.	**High and mostly public** Well-developed public welfare system for the whole population, but with traces of stratification. Limited participation of market-based options.
Defamilisation of welfare	**Moderate** Reliance on families has slightly declined, being associated with decline of the dependency ratio and progress in women´s entrance to the labour market.	**Low** Reliance on families remains high.	**Moderate** Reliance on families has slightly declined, particularly associated with progress in women´s entrance to the labour market.
Outcomes of well-being	**High performance** sustained over time	**Low performance**, but marked improvements from the early 2000s onwards.	**High performance** sustained over time

Own elaboration. Detailed information on indicators and sources of information is provided in Tables 4.1 to 4.4, 5.1 to 5.4, and 6.1 to 6.4.

As it can be seen in Table 7.1, whilst the three countries progressed in the dimension of commodification in the labour market (see also Table 4.1, Table 5.1 and Table 6.1), only Uruguay reached this in an even way, whereby it significantly improved jobs quality along with making advances in economic performance, whilst Chile and Ecuador's advances were based on economic growth and a decrease in poverty (WB, 2021), without significantly improve the quality of jobs. Most notably, Uruguay reduced informality by 16% between 2000 and 2019, meanwhile in Chile the reduction was just 4%, and in Ecuador informality even increased over the same period (ILO, 2015, 2021). Thus, unlike what was observed in the early 2000s, currently, Uruguay presents higher commodification in the labour market than Chile, reflecting the decision by governments to regulate jobs better as the basis for advancing social welfare. The stumbling block shared by all three countries, however, continues to be high levels of inequality, although these are lower in Uruguay (ECLAC, 2020).

These countries also vary in relation to their level of social welfare decommodification. Notwithstanding the fact that they have all increased public investment for social protection (ECLAC, 2020), the policy designs and institutional capacity of their welfare systems substantially differ (Franco Chuaire and Scartascini, 2014). In Chile and Ecuador, decommodification has been limited, and the welfare system is dual. Regarding the former, Chile has extensive publicly provided social services, on the one hand, accompanied by with commodified social services for the middle and upper classes, on the other. In Ecuador the welfare system remains limited and market-based options fill the gaps of publicly provided social services for the middle and upper-classes. A key difference between both countries is that, in Chile, the welfare system is designed to include explicitly market-based options, whereas in Ecuador they are not part of the welfare system design, but still play a significant role in the provision of services (see Bernales-Baksai and Velázquez Leyer, 2021). In contrast, Uruguay has strongly advanced the decommodification of social welfare and has a more unified welfare system.

As for the defamilisation of welfare, Chile and Uruguay have advanced in this regard. However, they present differences regarding the drivers of this change. In Chile, it has been primarily enabled by demographic transition (ECLAC, 2020) whilst in Uruguay, consistent with the FA governments´ efforts to foster social welfare relying on the strengthened labour market, the change has notably relied on the robust entrance of females to the formal labour market (ILO, 2015). Ecuador, in contrast, has not exhibited improvement in this dimension since the early 2000s.

Finally, on outcomes of wellbeing, both Chile and Uruguay are the best performers within the region. As the analysis of the other three dimensions has demonstrated, these outcomes have been achieved through different pathways. Chile has significantly relied on its economic performance and the households´ ability to invest in accessing welfare, complemented by social policies subsidiary to the market. Whereas the Uruguayan state has adopted a more proactive role in driving greater decommodification, although the outcomes still rely significantly on the labour market performance and the maintaining of some degree of stratification.

As for Ecuador, since the beginning of this century, the country has made remarkable advances and substantially improved its outcomes of wellbeing within the regional landscape.

Nonetheless, it embarked from a more disadvantaged starting point when compared to the other two focal countries and indicators of wellbeing continue to be inferior (UNDP, 2021; WB, 2021). As in Chile, the market plays a considerable role in welfare provision. Nonetheless, in the Ecuadorian case, it responds to the limited state capacity to provide social welfare rather than the explicit introduction of the market into the social policy design. Moreover, the low levels of defamilisation indicate that families remain critical to achieving wellbeing outcomes.

The aforementioned differences also have implications for the effects on stratification. The limited decommodification achieved in Chile and Ecuador has restricted the welfare regimes´ redistributive capacity as well as tending to reproduce social inequalities. In Uruguay, on the other hand, indicators and the design of welfare policies have signalled a greater redistributive potential.

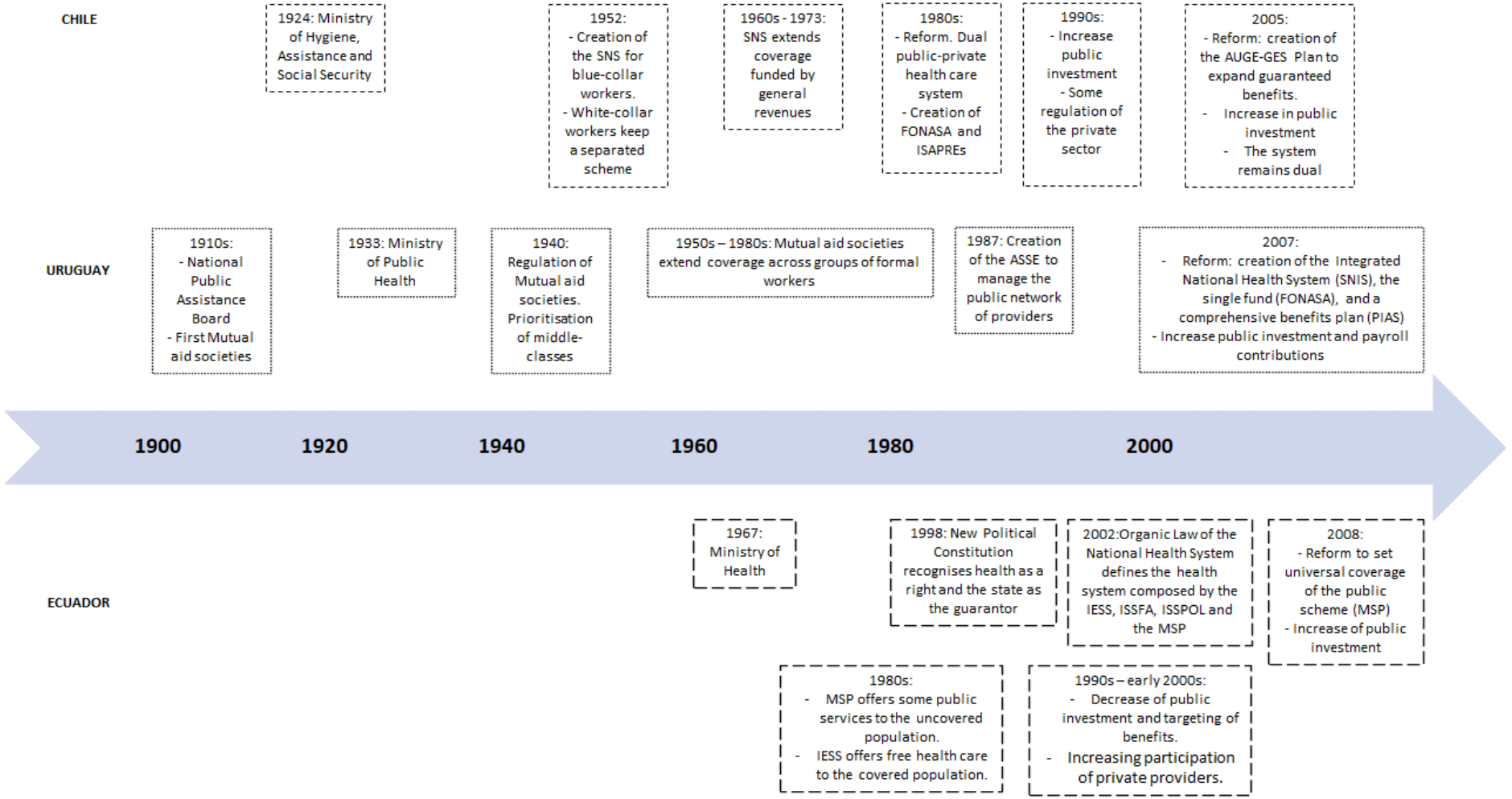
The overall view of the dimensions of social welfare shapes a context that, as thoroughly analysed in the case studies, is more conducive to the commodification of health care in Chile and Ecuador, whilst being more favourable towards greater state involvement in Uruguay, thus promoting universal outputs. These areas are comparatively considered in the next section.

7.3.- Policy architectures and their contribution to universal / segmented health care

7.3.1) Health policy trajectories

The enquiry of the historical trajectory into the health care policies in the case study countries has shown that all three started from a similar policy design. However, Chile and Uruguay pioneered the development not only of health care policies, but also, of welfare systems (1910s – 1920s) in the region, while Ecuador was a late-comer to welfare policy in general (Mesa-Lago, 2000) and the last to create a Ministry of Health, in 1967. Figure 7.1 presents the milestones of the trajectory of the health care policy in the three countries.

Figure 7.1. Historical milestones related to the policy of health care: Chile, Ecuador and Uruguay (1900 - to date)



Own elaboration

Up until the 1970s, the health care policy in Chile, Ecuador and Uruguay featured fragmentation and stratification by occupational categories, with the middle-class (i.e. formal employees) being prioritised. Faced with the shortcomings of their public schemes and the contributory arrangements for less advantaged occupational groups, the three countries steadily made efforts to expand coverage and benefits, whilst market-based options were not formally included in their policy architectures.

The trajectory followed by Chile, however, differed the 1980s, when the country introduced pro-market reforms that shaped a dual public-private health care system that offered commodified health care to those with the ability to pay and an underfunded public system for the others. While Ecuador and Uruguay continued with the occupational-based model that involved social security schemes for formal workers and social assistance for the rest of the population. The sudden and radical differentiation of Chile's trajectory has to do, as mentioned, with the dictatorial regime. In fact, several scholars have argued that there was an inverse relationship between the degree of commodification of social policies and the degree of democratisation in countries of Latin America (Mesa-Lago, 1999; Barrientos, 2004; Huber and Stephens, 2012; Castiglioni, 2016). Despite Ecuador and Uruguay also applying pro-market reforms during the 1990s (i.e. post dictatorship),, these reforms did not significantly impact on the health care realm, which remained ´protected` by the corporative interest of the most privileged groups of workers and providers of social security health care.

In the 2000s, significant shifts took place in the three countries, this time, according to a similar trend. Pushed by the pro-universalist international environment (Huber and Stephens, 2012), the countries increased public investment in health, broadened the principles of eligibility, extended coverage to formerly excluded groups, and enlarged the generosity of services. Nevertheless, the reforms exhibited different scopes. Whilst Chile expanded coverage, benefits, and financial protection, it mostly kept the previous policy architecture. Ecuador substantially increased coverage by strengthening the public scheme, applying transformations to the previous policy architecture regarding broadening eligibility and benefits, but keeping the other policy instruments without significant changes. Finally, Uruguay deployed a more profound transformation, especially regarding the model of financing and benefits, tackling the fragmentation among social security schemes, but the system remained fragmented between the social security on the one hand, and the social assistance schemes, on the other. Meanwhile, the proportion of the population in the latter decreased substantially.

The conditions behind differences in the scope of these pro-universal efforts relate to both the previous policy trajectory and contingent circumstances. Unlike the other two countries, Chile incorporated private actors in a privileged position within the policy architecture for several decades, which made them powerful veto players. This hindered the strengthening of the public sector and installed a rationale of health care on an individual basis, rather than a collective issue, all of which have substantially limited the possibilities of universalist reforms even during centre-left governments (Pribble, 2008, 2013). Also, the political scenario of the country, with centre-left parties with an elite-focused character and weak ties with unions and social organisations, have favoured moderate rather than structural transformation (Pribble and Huber, 2013; Castiglioni, 2016). These conditions have meant that the current policy

architecture continues maintaining a significant participation of private actors, thus remaining fragmented and stratified.

In Ecuador the health policy has portrayed significant historical continuity. From its foundation to the present, the health system has been fragmented according to occupational position, which has been associated with differences in the generosity of the services accessed by different sectors of the population. This trajectory implies that the actors that provide social security health care have kept enough veto power to combat structural transformation and the unification of the system (Vice-minister of Governance and Public Health Surveillance). Thus, despite the health reform started in 2008 representing an important turn, as for the first time the state took significant responsibility for those who could not obtain access to health care through their participation in the labour market, fragmentation endured between social security and social assistance related to eligibility, financing and service delivery. Moreover, market-based options continued to be unregulated, in spite of their being extended in terms of private insurance and supply.

In Uruguay, the pro-universalist reform that began in 2007 was more profound and meant greater unification of the policy architecture than in the other two countries. As in Ecuador, social security health care providers had been influential, but in the early 2000s an economic crisis created contingent circumstances in which these actors became weakened and hence, were more likely to accept structural changes (Fuentes, 2010, 2013). Uruguay kept a model centred on social security, where advancing unification still was feasible, as the improvements of the labour market enabled the majority of the population to be included in the social security system (Amarante and Gómez, 2016). This is a notable difference when co compared to Ecuador, which also relies on a social security centred model but this is embedded in a highly informal labour market.

The less radical reform of the Chilean system is associated with the policy legacies of several decades of market rules included in the system that increased the veto power of private actors and weakened the public sector. Following the scope, the Ecuadorian reform has implied deep transformations in the public scheme but remaining the old division between this and the social security scheme. The veto capacity of the social security actors kept this division, hindering the unification of the policy architecture. As discussed in Chapter V, this prevented the possibility of advancing further improvements in areas such as the availability of primary health care and financial protection. The latter owing to the shortcomings of the public and social security schemes resulted in private insurance and providers playing a significant role in health care, even though it was not formally included in the policy architecture. Lastly, the reform in Uruguay is the most advanced in terms of pro-universal structural transformation. In this country, favourable contingent conditions permitted more profound changes in the policy architecture, which, in turn, have now generated new legacies that can change the direction of the policy. These conditions included the greater room for manoeuvring that the progressive government had to undertake the health reform (Fuentes, 2015) and the achievement of a more formal, inclusive and regulated labour market than ever before in the country´s history (Amarante and Gómez, 2016; Amarante and Tenenbaum, 2016).

7.3.2) Contemporary policy architectures and outputs of health care

Moving from the historical view to a contemporary perspective, Table 7.2 compares the instruments that make up the policy architectures of health care across countries. Here, it is relevant to analyse whether these policy instruments contribute to creating a unified or fragmented health care policy, considering that, as mentioned, the literature concurs about the obstacles that fragmentation brings for universal policy outputs. Subsequently, Table 7.3. presents the different components and dimensions of policy outputs considered in this comparison.

Table 7.2. Current policy architecture of health care, Chile, Ecuador, and Uruguay

Components	Chile	Ecuador	Uruguay
Eligibility criteria	Payroll contributions: Formal workers and family-dependents are eligible for the social security scheme, which allows coverage either for public (FONASA-Chile) or private (ISAPREs) insurance. Nonetheless, ISAPREs can require the payment of extra premia. Need: Vulnerable groups and the poor are eligible to enrol in the subsidised scheme of FONASA-Chile.	Payroll contributions: Formal workers and family-dependents are eligible for the social security scheme, which allows for coverage by the IESS or the SSC depending on the occupational category. Residency: All residents are eligible for the public scheme and coverage through the public provider (MSP).	Payroll contributions: Formal workers, pensioners, and family-dependents are eligible for the social security scheme, which allows for coverage by any provider of the SNIS (i.e. ASSE, IAMCs or Private insurance). Nonetheless, private insurance can require the payment of extra premia. Residency: All citizens not covered through social security are eligible for the public scheme and covered through the public provider (ASSE).
Funding	<u>Revenue sources</u> • General revenues • Payroll contributions (only workers) channelled either into public or private insurance (´opt-out`). • Voluntary premia for ISAPREs (complementary) • Copayments progressive in FONASA and unregulated in the private sector. <u>Pooling of resources and solidarity</u> FONASA-Chile: single fund (general revenues + contributions), revenue collection is the same percentage for everybody, and solidarity in resource allocation. ISAPREs: multiple funds, no progressivity nor solidarity (individual insurance).	<u>Revenue sources</u> • General revenues • Payroll contributions (workers and employers) <u>Pooling of resources and solidarity</u> Social security: two funds (IESS, SSC), progressive revenue collection, and solidarity in resource allocation within each fund. No solidarity between social security and public sectors.	<u>Revenue sources</u> • General revenues • Payroll contributions (workers, employers and the state) • Voluntary premia for private insurance. • Copayments: ASSE does not charge copayments, IAMCs charge moderation fees determined by the MSP, and private insurers charge unregulated copayments. <u>Pooling of resources and solidarity</u> Social security: single fund (FONASA-Uruguay) with all contributions, progressive revenue collection, and solidarity in resource allocation. Exclusion of non-contributors of FONASA-Uruguay limits solidarity.

Benefits	Definition of benefits: Ministry of Health Benefits included: FONASA: All services ISAPREs: Minimum package + others according to the health plan.	Definition of benefits: Ministry of Public Health Benefits included: All services (in theory)	Definition of benefits: Ministry of Public Health Benefits included: All services (PIAS)
Service delivery	Fragmented Public providers: mainly population enrolled in FONASA-Chile (poor and lower-middle-classes). Private providers (for-profit): enrolled in ISAPREs (upper-middle and upper classes) and FONASA-Chile (middle-classes by the ´Free Choice Modality`) + services included in the AUGE-GES Plan purchased by FONASA-Chile.	Fragmented Public providers (MSP-Ecuador): population not contributing to social security (poor and lower-middle-classes). Social security (ESS/SSC): population of the social security scheme (middle-classes). Private (for-profit): mainly holders of private insurance (upper-middle and upper classes).	Fragmented Public providers (ASSE): mainly population not contributing to social security (poor). Social security (IAMCs private not-for-profit): population of the social security scheme (middle-classes). Private (for-profit): population of the social security scheme and holders of private insurance (upper-middle and upper classes).
Outside options	A large number of largely unregulated market-based options (insurance and providers). Outside market-based options integrated into the system.	A limited, but increasing, number of unregulated market-based outside options (insurance and providers). Outside market-based options not formally integrated into the system.	A large number of regulated not-for-profit providers (IAMCs). A limited number of moderately regulated market-based providers. Outside not-for-profit and market-based options integrated into the system.
Overall Unification / Fragmentation	**Commodification-led fragmentation**	**Labour market-founded fragmentation + Implicit-commodification-led fragmentation**	**Advances to unification with leftovers of labour market-founded fragmentation**

Own elaboration based on Bernales-Baksai (2020), MSP Ecuador (2012); Cid et al. (2014); Malo-Serrano and Malo-Corral (2014); Oreggioni (2015); Frenz et al. (2018); BPS (2019)

Table 7.3. Policy outputs of health care for Chile, Ecuador and Uruguay

	Population coverage	Generosity	Financial protection
Chile	95.2% of the population covered in 2017 [I] Coverage is even throughout population groups Segmentation of the population [i]: FONASA: 78% of the population Poor, lower-middle and middle classes: 92% of people in the 1st income-decile vs 25% in the 10th income-decile. Higher health risks: 80.6% of females vs 75.2% of males; about 85% of 60 or more years vs. near 74% of the working-age population. ISAPREs: 14.4% of the population Upper-middle and middle classes: 2% of people in the 1st income-decile vs 68.2% in the 10th income-decile. Lower health risks: 13.1% of females vs 15.7% of males; about 8% of 60 or more years vs near 16% of the working-age population. Other (e.g. Armed forces, Police): 2.8% of the population.	Allocation of resources per capita by calculation of health risks (progressive) within the public sector (FONASA and public providers). Less availability of resources per capita for the public sector vis-à-vis private options [ix].	State subsidies for the poor and vulnerable population (enrolment in FONASA and services with public providers), for everybody holding public insurance for health problems included in the AUGE-GES Plan, and for all against catastrophic diseases. Overall OOP spending reached 32% in 2015 [x]. It is lower within households enrolled in FONASA vis-à-vis those holding private insurance [xii]. Overall, service utilisation is high. Unmet health needs increase as income level decreases and are higher for FONASA vis-à-vis holders of private insurance.
	Sufficient and Equitable (+, +)	**Sufficient but Inequitable (+, -)**	**Insufficient and Inequitable (-, -)**
	Moderate universalism		

Ecuador	100% of the population covered from 2008 Coverage is even throughout population groups Segmentation of the population: <u>MSP</u>: 61.1% of the population [ii] Poor and lower-middle classes: 88% of people in the 1st income-quintile vs 37% in the 5th income-quintile [iii]. Higher health risk: 70% of females vs 66% of males [iii]. <u>IESS / SSC</u>: 38% of the population [ii] Middle and upper-middle classes (formal workers and family dependents). <u>Private insurance (supplementary)</u>: between 4% [iv] and 9% [v] Among them 38% have higher education vs 1.2% with no formal education. The majority (93%) live in urban areas, and are professionals (20.5%) or technicians and associate professionals (18.9%) [iii]. <u>Other</u> (e.g. Armed forces, Police): 2% of the population [iii].	Allocation of resources is independent for the public and social security sectors. Less availability of resources per capita for the public sector (MSP) vis-à-vis social security (IESS). The public sector has a broader network for primary health care, but deficits for secondary and tertiary services [ii].	State subsidies for the poor and informal workers (enrolment and services at the MSP) [ii] and for some cases against catastrophic diseases [v]. Overall OOP spending reached 40% in 2018 [x]. Overall service utilisation is moderate. Unmet health needs increase as income level decreases [xiii]. The income gap of service utilisation of curative services decreased after the reform [xiv]. Unmet needs are higher for the public scheme vis-à-vis holders of social security and supplementary private insurance [xiii].
	Sufficient and Equitable (+, +)	**Insufficient and Inequitable (-, -)**	**Insufficient and Inequitable (-, -)**
	Low universalism		

Uruguay	98.4% of the population covered in 2014 [vi] [39] Coverage is even throughout population groups Segmentation of the population: <u>ASSE</u>: 30.3% of the population [vii] Poor, lower-middle: 42.3% of people with potential vulnerabilities in welfare vs 3.2% of people with high welfare (urban areas) [viii]. <u>IAMCs</u>: 63% of the population [vii] Middle and upper-middle classes: 47.4% of people with potential vulnerabilities in welfare vs 81.5% of people with high welfare (urban areas) [viii]. <u>Private for-profit</u>: 2.3% of the population [vii] Upper class: 10.3% of people with high welfare vs. 0.6% of people with potential vulnerabilities in welfare (urban areas) [viii] . <u>Other</u> (e.g. Armed forces, Police): 4.9% of the population [viii]	Allocation of resources per capita by calculation of health risks (progressive). Still, slightly fewer resources per capita are allocated to the public sector (ASSE) [vii] [x] than the per capita allocated for FONASA holders.	State subsidies for the poor and informal workers (enrolment and services with the ASSE) and for all against catastrophic diseases. Overall OOP spending reached 16% in 2014 [viii] . It is lower within households with ASSE vis-à-vis those in IAMCs or private insurance. Overall, service utilisation is high. Unmet health care needs are similar for ASSE and the IAMCs [xi].
	Sufficient and Equitable (+, +)	**Sufficient and Equitable (+, +)**	**Moderately sufficient and equitable (+/-, +/-)**
	Moderate-High universalism		

Source: Own elaboration based on:

[i] Observatorio Social CASEN (2018); [ii] MSP Ecuador (2012); [iii] Encuesta Nacional de Empleo, Desempleo y Subempleo (2021); [iv] Jiménez-Barbosa et al. (2017); [v] Lucio et al. (2019); [vi] Martínez (2015); [vii] Ballart and Fuentes (2018); [viii] Midaglia et al. (2012); [ix] Frenz et al. (2018); [x] (WHO, 2020a); [xi] Oreggioni (2015); [xii] MINSAL-Chile (2015); [xiii] Armijos Bravo and Camino Mogro (2017); [xiv] González and Triunfo (2020).

[39] Although formally everyone is covered, this figure is based on self-reports.

7.3.2.1. Eligibility - Under what criteria do people benefit?

Beginning with the criteria that designate who is eligible for what, it is clear that fragmentation is still the reality in the three studied countries. They all continue to rely on compulsory payroll contributions as the primary criterion, which provide full entitlements. This is complemented with assistance schemes, the benefits of which are granted by different eligibility criteria, that is, the need in Chile and residence in Ecuador and Uruguay. In turn, in Chile and Uruguay, private insurance, which is included in the system and can request extra premia for coverage and hence, although not explicit, the ability to pay becomes another eligibility criterion.

Despite fragmentation between schemes, in the three countries, population coverage overall is en masse and even across social groups. Therefore, it could be said that coverage is sufficient and equitable and contributes to universalism (Table 7.3). However, the population covered remains segmented between schemes or insurance by their position in society (income level, occupational status, etc.) and health risks. This, as discussed in the individual cases, can translate into inequities in the outputs of generosity and financial protection and thus, despite contributing to extending coverage, the eligibility criteria that separate different social groups may hinder universalism.

In the three countries, the population covered by different insurance/schemes have markedly variable socio-demographic profiles. The public sector gathers the groups with higher health risks and lower income. At the other extreme, by requesting extra premia, private insurance, cream off the population according to health risks and income level. Despite, the social security in Uruguay and the public sector in Chile achieve a certain unification, which is not the case in Ecuador. In Uruguay, the population covered through the IAMCs is increasingly heterogeneous because of the expansion of formal employment. While in Chile, FONASA-Chile provides public insurance to both the subsidised population and a large percentage of contributors.

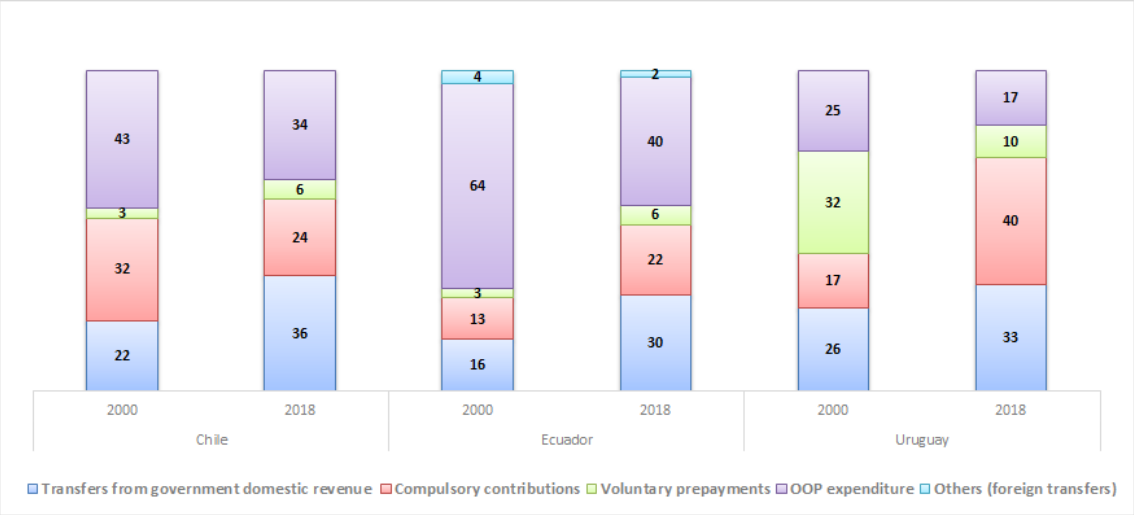
As for the middle-classes, their coverage differs by country. In Chile, the largest proportion is covered by FONASA-Chile, but the upper-middle sectors usually opt-out of the public sector, with a high proportion choosing to invest in market-based private insurance. In Uruguay, the middle-classes are almost completely covered through the IAMCs, and a small proportion holds private insurance. In Ecuador, similar to Uruguay, most of the middle-classes are covered by social security through the IESS, but, unlike Uruguay, a non-neglectable proportion holds parallel private insurance, which is not a coverage option formally recognised by the policy architecture.

7.3.2.2. Funding – Who pays and how?

Regarding financing, a first commonality to note is that the relationship between public investment, payroll contributions and households spending on healthcare changed with the reforms applied in the first decade of the 2000s in the three countries. However, the resulting configuration of revenue sources has been somewhat different, unveiling the dissimilar routes of reform chosen by each of them. As Graph 7.1 illustrates, all three countries, but especially

Chile and Ecuador, increased public investment in health. This allowed for the expansion of subsidies, favouring the abovementioned advances in the outputs of coverage.

Graph 7.1. Health care expenditure distribution by source, Chile, Ecuador and Uruguay, years 2000 and 2018



Source: Own elaboration based on WHO Global Health Expenditure Database

Payroll contributions, in contrast, followed uneven trends. On the one hand, Chile decreased its participation in total health expenditure, whilst on the other, Ecuador and Uruguay increased their weight. Nonetheless, similar to Chile, in Ecuador, payroll contributions were behind general taxes and OOP spending, whereas in Uruguay, they became the primary source of financing, which is coherent with the general strategy adopted by this country of grounding access to social welfare on inclusion in the labour market (see Chapter VI and Section 7.2).

Another noteworthy difference between Uruguay and the other two cases is the marked reduction and overall much lower level of household payments either as voluntary prepayments or OOP spending (Graph 7.1). This is consistent with the measures considered in the reform discussed in the case study: the restructuring of the financing mechanisms, the creation of a unique contributory fund, the regulation of copayments in service delivery as well as the expansion and equalisation of benefits within the health system. Ecuador and Chile also targeted financial aspects through the elimination of copayments in the former (see Chapter V) and the regulation for the AUGE-GES´ health conditions in the latter (see Chapter IV). However, the progress has been limited, and OOP spending has remained very high; double the figure for Uruguay. It is especially striking that, despite the wide expansion of assistance coverage and the elimination of all copayments in Ecuador, OOP spending continues to be extremely high (although considerably lower than in 2000). This indicates that the measures implemented have been insufficient to guarantee access and the population continues to seek health services outside the system being exposed to financial risks.

Differences are also remarkable regarding the possibilities offered by the financing arrangements for solidarity and redistribution. The coexistence of separate resource funds for

different population groups is an obstacle from the redistributive point of view in all three countries.

In Chile, the situation is ambivalent since there is broad solidarity in the public sector that has a single fund, but in the private sector solidarity is not feasible. Resources are doubly fragmented. First, between the public and private sectors, and second, among those who opt for private insurance, since these insurance arrangements are individual. Hence, the whole financing structure that enables people to ´opt-out` and channel contributions to private insurance imposes institutional restrictions for redistribution. As discussed, these arrangements lead to less availability of resources in FONASA-Chile vis-à-vis private options, thus raising significant inequities in the generosity of services. In Ecuador, progress has been even more limited, since, in addition to the separation between the assistance and social security funds, there have also been separated coexistent funds in the latter. In this way, solidarity is restricted to relatively homogeneous groups, thus hindering advances in equity. This financing structure, along with insufficient resources in the public scheme, has hampered the possibility of equalising the generosity of services across the schemes (Table 7.3). Thus, in both countries, the redistribution of risks and resources across social groups is limited by fragmented financial arrangements, which maintains the middle-classes as being separated, with their advantages and disadvantages, from the rest of the population.

In a different fashion, in Uruguay, the pooling of all payroll contributions into a single fund has created the institutional conditions for a greater mix of people with different backgrounds within the IAMCs, but it is still limited to those who participate in the social security scheme. FONASA-Uruguay (i.e. the contributory fund) allocates resources progressively by calculation of health risk, which has narrowed the former gap of resources per capita between the public and social security providers, thus reaching, to some extent, the population that lacks social security. Hence, the current financial arrangements in this country are those that most favour solidarity and redistribution, allowing advancing horizontal and vertical equity, although the endurance of separated contributory and assistance schemes has resulted in some limitations for redistribution.

7.3.2.3. Benefits – Who defines them, and what are they?

Benefits are possibly the policy instrument for which the three countries have more in common. In all of them, the state defines the benefits that must be provided. The public sector of the three countries (FONASA-Chile, the MSP Ecuador and the ASSE Uruguay) as well as social security providers in Ecuador (IESS/SSC) and the non-public providers of the SNIS in Uruguay (IAMCs and comprehensive private insurance) grant comprehensive benefits, including all kind of services. The exception is private insurance in Chile, in which the services included depend on the individual plan purchased.

However, it is necessary to be cautious regarding the apparent similarity of benefits since their formal inclusion does not mean that they are actually available in a timely manner for the entire population. This was evident in the analysis of the outputs of generosity, among them waiting

times in the public sector in the case study of Chile and especially the lack of availability of services in Ecuador. In fact, in these two countries, differences between the formal entitlement and actual access may also explain the deficits in the outputs of financial protection, since, as discussed, people end up seeking care and making direct and unregulated payments in the private sector. In Uruguay, whilst it is not possible to rule out that this phenomenon also occurs, the reduction in OOP spending (see Graph 7.1) indicates progress in financial protection and thus, a lesser presence of this problem.

Regarding the middle-classes, the fact that in Ecuador and Uruguay all providers have to include similar services gives them greater formal protection compared to what happens in Chile, where a significant proportion of the middle-classes opt for private insurance with no guarantee of service coverage. However, considering the limitations of the availability of services for Ecuador, the middle-classes would also appear to be exposed, since, in practice, they end up contracting unregulated private insurance to compensate for the shortcomings in the social security provision of services.

7.3.2.4. Delivery - Who does what?

The fragmentation and stratification of service delivery is a commonality of the three cases studied. In Chile, despite public providers delivering most services and a substantial part of the middle-classes having public insurance, those with the ability to pay resort to private providers when meeting their health needs. The fragmentation and stratification of service providers as well as their differences of resources lead to the segmentation of social groups and generates inequities in quality, for example, in terms of timely care. Whilst the AUGE-GES Plan implemented with the health reform in 2005 has partially contributed to overcoming these differences, inequities persist in the health conditions that are not included in the package of guarantees (Frenz et al., 2018; Bernales-Baksai, 2020).

In Ecuador, the fragmentation and stratification of provision are also very clear. As in Chile, most services are delivered by public providers, but practically all the middle-classes receive health care from social security (IESS/SSC) and private providers, while the poor (most of them informal workers) get theirs from public providers of the MSP. Although the 2008 health reform proposed to integrate the health services of the IESS/SSC and the MSP, this has not materialised so far. Furthermore, there is a significant number of heterogeneous, unregulated and stratified private providers that also deliver services in a segmented fashion. Uruguay, meanwhile, has a history of significant fragmentation and segmentation of service access since the middle-classes have always satisfied their health needs through mutualism, which also had heterogeneous statuses, whilst the poor have resorted to the state. Currently, the mutualists, renamed IAMCs, deliver most services, and segmentation has decreased: now it is possible to find a higher proportion of people with low socioeconomic status attending the IAMCs, whereas the ASSE continues to provide services almost exclusively to the poor. In this country, private for-profit providers represent a much smaller percentage of the total health services provided. Moreover, the settlement of the PIAS allowed for considerable progress in the standardisation of service delivery across providers included in the SNIS. Nonetheless, like in Chile, the model of delivery

involves some barriers for equitable access, as contributors have the possibility to get services either through the ASSE, the IAMCs or private insurance, while the subsidised population only can rely on the former option, which may hamper their accessibility and timely attention. Moreover, whilst the reform regulated moderation fees for all services included in the PIAS, non-PIAS services continue to be offered on a voluntary basis by the IAMCs, thus remaining unequally accessible (Carrasco, 2015a; Bernales-Baksai, 2020).

In sum, the fragmentation of service delivery in the three countries implies that the middle-classes usually engage with providers other than those that the most disadvantaged groups use to meet their health care needs. In Chile and Ecuador, given that differences in quality and timely care between providers are significant, this usually implies that the middle-classes must deal with market options and therefore, financial risks. In Uruguay, there is greater evenness in the generosity of services, which enables more financial protection to all groups, including the middle-classes.

7.3.2.5. Outside options – How do governments manage market-based alternatives?

Finally, in all three countries, outside options exist. However, their number, type (market-based or not-for-profit), degree of regulation, and the way in which they are linked to the health system varies substantially. In terms of number and type, Chile and Uruguay have the greatest proportion of non-public options. In Chile, they are market-based, while in Uruguay the majority are not-for-profit mutual aid providers (IAMCs) and a smaller proportion are market-based. In Ecuador, on the other hand, the proportion is much lower, although, as revealed in the case study, there are signs that their presence has been increasing.

Regarding their articulation with the health system and regulation, Chile has the longest trajectory in explicit incorporation of market options as part of the policy architecture (Bernales-Baksai and Velázquez Leyer, 2022). Regulation has increased over the years; however, it continues to be insufficient and allows for practices that transgress the social security principles of providing support in moments of greater vulnerability. This is despite these private institutions receive social security resources (Sojo, 2017).

Uruguay also has a long trajectory of public-private articulation in health care, but mostly limited to the relationship with mutualism, which is not market-based. Nonetheless, with the reform, Uruguay included explicitly market-based private insurance within the health system, allowing, like in Chile, that social security resources are channelled to these institutions. The difference, however, is that Uruguay set a higher level of regulation and fundamentally, did not allow them to have separate funds, instead all SNIS providers receive the assignment from FONASA-Uruguay. Furthermore, in the case of market-based private insurance, the allocation from FONASA-Uruguay is lower. In this way, the regulation prevents the draining of social security resources towards the private sector and the arising of quality differences.

Lastly, in Ecuador, the situation is completely different since the private sector is not recognised by the policy architecture. Nevertheless, as discussed, it does have a presence in practice and

has led to the generation of the implicit commodification of health care. The lack of formal or explicit recognition of the role that the private sector plays, in turn, implies a prominent lack of regulation, leaving people fully unprotected when they need to resort to private options.

Hence, although to varying degrees, regulation still is insufficient in all three countries. As shown by the OOP spending of households, this is especially significant in Ecuador and Chile, where it is much more common for the middle sectors to rely on the market to meet their health care needs, and the private sector is less regulated than in Uruguay. So that the lack of regulation of outside options ends hampering the middle-classes´ chances of accessing quality health care.

7.3.2.6. Overall unification / fragmentation of the policy architecture

According to the previous analyses, the overall view of these instruments in the three countries illuminates that fragmentation persists in all of them. Nonetheless, it also became evident that the extent, mode and implications differ between them. Hence, it is appropriate to rely on a more refined depiction of the fragmentation that predominates in each country, rather than just defining whether a health system is fragmented or not.

The kind of fragmentation that exists in Chile is one fundamentally created by the significant presence of the market-based private sector and the commodification of health care. This kind of fragmentation, as with the other forms, led to the segmentation of the population, but it has the particularity that segmentation is primarily grounded in the households´ ability to pay. Ecuador and Uruguay, for their part, have in common a type of fragmentation based on the participation in the labour market. However, in Ecuador, fragmentation remains present in all the policy instruments (i.e. eligibility criteria, funding, benefits, delivery and outside options), while in Uruguay, it has been suppressed in some (e.g. benefits) and reduced in others (e.g. financing). In addition, and perhaps here is the central feature of the fragmentation in Ecuador, it occurs on two levels. At the first level, it is explicit, where, as mentioned, fragmentation is associated with the people´s participation in the labour market (e.g. formal/informal employment or agricultural employment), which takes place in the abovementioned five policy instruments and, as reviewed in the case study, significantly expresses in the outputs of generosity. Then, there is the other level of fragmentation, implicit, which occurs through double insurance and the health care seeking of private services outside the institutional framework of the health system. This segments the population according to their ability to pay and is expressed in inequities in the outputs of generosity and deficits of financial protection deficits.

Finally, Uruguay has decreased fragmentation and by this, achieved the growing inclusion of people in the same scheme (contributory). Moreover, the type of fragmentation that the country has exhibited is one that segments the population by participation in the labour market and is not based on the ability to pay, even though the market-based private sector has been included in the system. Hence, as discussed in the case study, the greater unification in the policy instruments of benefits, financing and regulation of outside options seem to have been crucial In the country´s advances towards universal outputs.

In short, the comparison makes evident that beyond identifying whether or not countries have fragmentation in their health systems, it is also necessary to consider the type of fragmentation. In the analysed cases the type can be commodification-led as in Chile, labour market-founded as in Uruguay or having both as in Ecuador, which brings different implications in terms of the generation of segmented or universal outputs of health care, as previously discussed.

7.3.3) The policy architectures´ contribution to universal or segmented health care and their implications for middle-classes

7.3.3.1. Incentives created by the policy architecture of health care

Beyond the mentioned commonalities and differences, it is central to identify the most distinctive characteristics of the policy architecture in each country and their implications for the middle-classes´ access to health care and universalism. In Chile, efforts to deliver universal health care have focused on eligibility, financing and benefits. This has translated into the expansion of coverage, through the broadening of eligibility criteria for subsidies for coverage, and the delivery of increasingly comprehensive services. However, the commodification and significant presence of the market-based private sector have fragmented the system and created a barrier that seems insurmountable under current conditions, as commodification, per se, segments the population according to their ability to pay.

In such a landscape, the current architecture provides to the middle-classes two main institutional mechanisms for opting-out of the public sector. The first of these is the possibility of channelling compulsory social security contributions to private insurance. The second one is the utilisation of private provision supported by vouchers (i.e. the Free Choice Modality) supplied to the non-subsidised holders of public insurance. These mechanisms along with the shortcomings of the public sector, not only allow for, but push the middle-classes and groups with the payment capacity into meet their health care needs by relying on private options, leaving them exposed to the market rules. Moreover, the institutional mechanisms for opting-out strengthen the private sector and indirectly, impair the public sector owing to the public-private interactions that the current architecture allows regarding insurance[40], availability of per capita resources[41] and health care provision[42] (for a more detailed analysis of the Chilean public-private health care mix see Bernales-Baksai and Velázquez Leyer, 2022).

[40] The ISAPREs gather the population with less health risk and higher income meanwhile the public sector gathers those rejected by the ISAPREs and more disadvantaged groups in general.

[41] The public insurance subsidises the poor and promotes solidarity, whilst the ISAPREs attract the better-off groups and exclude solidarity.

[42] Contracting-out of private services with public resources and the option given to FONASA-Chile holders to obtain privately delivered services using vouchers.

Therefore, the Chilean policy architecture, fragmented between the public and private, creates the conditions for the withdrawal of the middle-classes towards outside market-based options and the segmentation of health care access. Segmentation takes place at multiple levels: splitting those who can from those who cannot afford private insurance, which in turn, associates with disparities of resources and benefits (e.g. timely attention, availability of specialists); private insurance (ISAPREs) splitting those who can pay more expensive health plans (i.e. with more benefits and financial coverage) from those who hold basic plans; and public insurance (FONASA-Chile) splitting those who can contribute from the subsidised population, allowing the former to opt-out towards private service delivery. As the previous analyses have shown, the middle-classes are at the centre in all these types of splitting, as the policy design has placed them as being tightly tied to the market.

In Ecuador, the 2008 reform marked a relevant turn, as for the first time in history, the state assumed the leading role in advancing universal health care, entitling the whole population to be covered by the public scheme. Nevertheless, the continuation of independent contributory and public schemes, with separated funds and providers as well as differences in resources and service availability, has undermined the reform´s goals, whereby it has led to the endurance of a fragmented system and segmented health care.

There is an inconsistency between the declared universalist principles and the policy instruments set by the reform, as social-rights-based eligibility is inconsistent with maintaining separated funds and providers. This inconsistency erodes the unification of the policy architecture and thus, the ability of the health system to achieve universalism. The policy architecture maintains the middle-classes outside the public scheme of the MSP, which had the greatest investment of resources and improvements in the policy outputs from the beginning of the 2008 health reform. This means that the reform did not comprehensively reach the middle-classes, as social security health care did not benefit of greater investment and quality improvements, which has pushed them into seeking private alternatives. Moreover, the formal exclusion of the private sector has translated into a lack of regulation, which is inconsistent with the purchasing of private services by the MSP and social security institutions. In fact, this purchasing implies the acknowledgement that a part of the population meets their health needs through private options. Thus, despite the architecture not involving the explicit commodification of health care, the policy design implicitly drives it, exposing the population to financial hardship by failing to provide sufficiently generous services. Nonetheless, it is difficult to capture at first sight the impact that this implicit commodification has been having. The ´implicitness` involves the lack of reliable data and the blindness to the degree to which the population relies on outside options as well as the deficits faced by the public sector.

On the positive side, through the lens of universalism, the exclusion of the private sector suppresses the possibility of opting-out and funnelling off social security contributions to private insurance. Hence, this involves the advantage of keeping the contributions of the upper and middle-classes in the social security schemes, thus benefiting their financial sustainability. Also, this maintains the links between the middle-classes and social security, favouring their protection, as they retain the option of drawing upon these schemes independently of whether they have or not parallel links with the private sector.

Finally, the 2007 reform in Uruguay can be considered as a turn towards universalism, as, despite maintaining separated contributory and assistance schemes, the system allows for quality access to health care for the entire population. Moreover, the pooling of resources into FONASA-Uruguay meant the unification of the formerly fragmented schemes of social security, thus tackling the historical segmentation that existed even between members of the middle-classes. However, in spite of the unprecedented efforts to extend social security throughout the population, the reform has kept fragmentation by maintaining separated funds, insurance, and providers for those not participating in the social security scheme. However, there have been efforts to avoid this fragmentation being translated into segmented health care. In particular, the equalisation of benefits provided by social security and the public scheme was aimed at suppressing differences in generosity across population groups. Nonetheless, the persistence of a gap of resources between the IAMCs and the ASSE has hindered the efforts made at eliminating inequities in the services accessed and thus, risking maintaining some level of segmentation.

Despite these remaining differences, the possibility for those holding social security of opting for provision in the ASSE, the IAMCs or private suppliers without abandoning the social security scheme operates as a tool for stimulating the upper-middle-classes to stay within the system, for even those who prefer private options do not need to opt-out from the social security scheme and support public investment (social legitimacy). As in Chile, the Uruguayan reform allowed the market-based private insurance to receive social security resources. Nonetheless, unlike Chile, by adopting a different approach and perhaps more importantly, given the substantially different starting point, the configuration of the policy instruments, especially in financing and regulation, has involved higher protection.

Moreover, the unification of all resources into a single fund avoids private insurance capturing the highest contributions. This implies, firstly, that the system ensures that resources are not drained to the private sector, thus impairing quality in the public sector. Secondly, despite the policy architecture incorporating market-based options, it poses significant barriers to adopting them, as households have to invest significant additional resources to opt for private insurance. Hence, at least in terms of resources, the current architecture generates an incentive structure for the middle-classes to remain within the system and to continue satisfying their health needs through the IAMCs, as they have historically done, thus preventing segmentation. This can be seen clearly in the percentage of affiliation to private insurance, which has remained steady at around 2.5% (Ballart and Fuentes, 2018).

7.3.3.2. Understanding the policy architecture of health care in light of the welfare regime

The examination of the policy architectures presented in Subsection 7.3.2, indicates that in the three countries, the policy of health care reflects the observed differences in the respective welfare regime.

In Chile, the dual health system reproduces the discussed subsidiary role of the state, here represented by the public insurance FONASA-Chile and the public network of providers that assume the responsibility for assisting the neediest. The middle-classes usually meet their health care needs dealing, at some point, with the market, sometimes represented by the ISAPREs, but most of the time by private providers, with both being explicitly included in the policy architecture. It could be argued that, as FONASA-Chile covers more than 70% of the population, health care is mostly in the hands of the public sector. Nevertheless, the analysis of the architecture and policy outputs has shown that, whilst a public basis indeed exists, an important part of those insured in FONASA-Chile access health services through market-based providers, thus incurring OOP expenses. This implies that, in the end, most of the middle-classes are exposed to the market, either because they pay for private insurance (upper-middle sectors) or because, despite being publicly insured, they seek private services (middle-middle and even lower-middle sectors).

In the Ecuadorian case, the health system also reflects what is observed in the welfare regime as a whole. That is, a state that attempts to deliver services to the entire population, but makes this fragmentedly, dividing assistance, as provided by the MSP, from social security, delivered by the IESS/SSC and other smaller schemes. Moreover, the state has not enough institutional capacity (Franco Chuaire and Scartascini, 2014) to actually provide all the services, so the upper and middle-classes end up relying on the market and the poor on the family support. Similar to what was discussed regarding the comparison of the welfare regimes, the Ecuadorian policy design of health care does not explicitly include the private sector. However, owing to the limitations of the public sector, it plays a significant part in health care delivery, such as that evidenced by the OOP spending, either through private insurance, private practices or less formal instances, such as pharmacies, blogs and healers (Chapter V).

Even though the 2008 health reform decreased the exposition to the market and family support. As for the Ecuadorian middle-classes, as the interviews for the case study revealed, when they face serious disease, they perceive themselves as less at risk of financial hardship than the observed in the interviews of their Chilean counterparts, as Ecuadorians always can draw on the IESS/SSC, as there is no a formal opt-out.

Also, the current health care policy in Uruguay mirrors the prevailing welfare regime, namely one that sees social welfare as involving the population´s inclusion in a regulated labour market, complemented by a robust state. Despite the Uruguayan system not being totally unified and, like in Ecuador, adopting a social security-based model, the success of its outputs relates to the coherence between this design of health care policy and the welfare regime´s performance in terms of the commodification in the labour market. This is markedly different from Ecuador, where health policy keeps social security in the leading position, relying on a labour market that does not meet the conditions for it.

In sum, the above discussed features of the policy architectures in the context of the prevailing welfare regime in each county provides understanding of the observed advances and limitations in the path towards universal health care. Chile can be seen as delivering good results in terms of sufficiency of coverage and generosity of health services thanks to public investment and the

institutional capacity of the public sector, which manifest themselves on extended public basis. However, the results are much less encouraging from the point of view of the equity of the generosity of services and financial protection, which has to do with the fragmentation of this dual and importantly commodified health system. In the same vein, in Ecuador, the fragmentation of the health system along with the limitations of the public sector has led to substantial shortcomings in the sufficiency and equity of the generosity, which in turn, has affected the financial protection of households. In Uruguay, the progress in the unification of the previously fragmented contributory schemes in tandem with the efforts to equalise resources and benefits between the contributory and subsidised schemes have set the ground for this country to witness progress, not only in the sufficiency of coverage and generosity, but also, in financial protection and equity in health care access. The next section considers, from a comparative perspective, how the middle-classes deal with the prevailing conditions and what they imply for their access to health care.

7.4.- Middle-classes´ perceptions and practices for health care

Before focusing on the comparison of the perceptions and practices for health care, it is helpful briefly to recall that Chile and Uruguay are among the countries with the most extended middle-classes in the region, whereas in Ecuador, they historically were a small proportion of the population, although they have expanded considerably since the 2000s. From an economic definition, the middle-classes currently reach 44% in Chile, 26.6% in Ecuador, and 30.5% in Uruguay. From an occupational perspective, in Chile and Uruguay, they exceed 60%, while in Ecuador they are below 30%. Finally, considering self-definition, more than 75% of the population in Chile define themselves as middle-class, while in Ecuador and Uruguay, the figures surpass 80% and 85%, respectively.

It is also salient to underline that given the different characteristics of the three countries not only in terms of what is expected, that is, the economic, sociodemographic and cultural conditions, but also, in terms of their arrangements for social welfare, the meaning of being middle-classes can embrace important differences. According to the case study presented in Chapter V, the middle-classes in Chile have had the experience of living in a country with several decades of economic prosperity and political stability, high inequality, commodification of welfare provision, precarious employment, a history of neoliberal policies and a state that has remained subsidiary to the market for more than forty years. Furthermore, these middle-classes were demobilised and heavily left behind by the state in a period of deep economic crisis during the years of military dictatorship and neoliberal policies. In contrast, as revealed in the following two chapters, in Ecuador and Uruguay, the middle-classes have been historically privileged by social policies designed with a pro-formal employment model. However, in Ecuador, despite being a privileged group, their economic prosperity has been at a slower pace than in the other two countries, and the institutional capacity of the state to deliver social welfare has, historically, been limited. Hence, in this country it is not appropriate to suggest that belonging to the middle-classes guarantees security against the risks associated with unemployment, old age, disease, among others. In Uruguay, on the other hand, the context might be more favourable for the

middle-classes, since the country has experienced important economic progress in recent decades. The state has continued to protect the welfare of these groups, as has been the tradition since the beginning of the social state, and the labour market is providing greater security than ever before.

7.4.1) Middle-classes´ perceptions of the health system

Focusing on the perceptions about the health system, the previous chapters unveiled that, in the three countries, the middle-classes perceive the health system as stratified. That is, a system that offers different options for accessing health care to different population strata, depending on their performance in the labour market and resources.

A second commonality across the three cases is the stigmatisation of those public options that cover the subsidised population. Public providers in Chile, Ecuador, and Uruguay (i.e. excluding the IESS and IAMCs that are part of social security) are seen as residual alternatives for the disadvantaged sectors of society. Hence, as long as interviewees define themselves as middle-classes, they do not consider these as good alternatives for seeking health care, at least not as the primary choice. This stigmatisation is slighter in Chile since the public insurance includes both subsidised and contributors and therefore, the population covered is more heterogeneous (i.e. not only the poor), although many of the contributors seek services with private providers. Still, in all the three countries stigmatisation relies on a real basis, as for long periods the public sector was underfunded and had quality deficits, especially regarding the availability of services and timely services. Thereby, participants' perceptions express the legacies of the historical trajectory followed by health systems. However, they are aware that the public sector has advanced to offer similar medical quality to the social security and private alternatives, but they also consider that shortcomings remain, especially regarding the chances to get timely care as well as in terms of comfort.

Regarding the traditional providers of social security in Ecuador (i.e. the IESS/SSC) and Uruguay (i.e. the IAMCs), in both cases, they are associated with the middle-classes. However, the valuation is different depending on the case. The Ecuadorian middle-classes perceive IESS´ providers as a feasible option, especially for severe health conditions, but not the most desirable, because of its limitations in terms of timely attention and overcrowding. While Uruguayans mostly hold a positive appraisal of the IAMCs and consider that they offer the best cost-quality balance for the middle-classes. In Chile, however, the middle-classes do not identify a traditional provider for them, as there is none specifically linked to formal workers, occupational groups or any other category that may be related to the middle-classes. The distinction in this country is different, that is, those who can pay more than the compulsory contribution (i.e. most of the consolidated and upper middle-classes) go private and those who cannot do so rely on the public sector. Moreover, in this country, the option also depends on the type of need. Thus, the public sector seems more acceptable for routine needs (i.e. primary health care), whereas for speciality services the middle-classes prefer to make an effort and go private.

Regarding market-based private options, participants expressed that they offer timely care, comfort and good amenities along with the possibility of choosing the desired professionals and services. Nonetheless, in all three countries, for-profit providers are considered as having a medical quality that is not superior to public options and involving the effort of economic investment. Nonetheless, the middle-classes in Chile and Ecuador perceive private provision as necessary, as it allows them to overcome the limitations of the public and social security sectors, respectively.

In Chile and Ecuador, the middle-classes have extensive experience of seeking care with the market-based private sector. In Chile, such experience, however, is not always positively evaluated because of the distrust towards private institutions. The narratives show a negative valuation of the profit orientation of private insurance and suppliers, but the middle-classes continue to consider them as a kind of ´mandatory option` to meet their health care needs adequately. In Ecuador, contrarily, participants positively value private options, especially concerning their comfort and timely care. However, in this country, the middle-classes rarely rely exclusively on private supply since formal workers are required to participate in the social security scheme. Hence, their multi-insurance arrangements may offer a sense of security by raising less-demanding perceptions and appraisals of the private sector. Unlike the closeness expressed by the Chilean and Ecuadorian participants, in Uruguay, private options did not appear as a widespread aspiration for the middle-classes. The narratives of those who identify themselves with the traditional Uruguayan middle-class (i.e. the class that accesses public education, is made up of professionals with formal jobs and lives in Montevideo) report that private options are unfamiliar to them. Moreover, they consider that the cost of market-based alternatives is high when considering the advantages they offer compared with the other provider of the SNIS. Instead, private options seem closer and highly valuated for the status they grant, in the narratives of those who follow the lifestyles of the most privileged classes (i.e. those who attend private education, live in the more exclusive neighbourhoods of Montevideo, and are self-employed professionals), but still consider themselves as middle-classes. To summarise, narratives concerning market-based options are as follows: a necessary, yet not trustable option in Chile, a necessary and desirable option in Ecuador, and a non-necessary and elite option in Uruguay.

In short, the analysis has indicated that the perceptions and evaluations of the various alternatives that make up the health system give rise in Chile and Ecuador to an overarching perception of a health system that does not provide any completely satisfactory option for the middle-classes, as none of them simultaneously provides high quality health care and protection against financial hardship. In contrast, the Uruguayan middle-classes perceive the health system as one that provides greater security, as they consider that they can access quality health care without being exposed to financial risk. Even the public option, despite being stigmatised and considered uncomfortable, gives them confidence from the medical point of view. Then, whilst they are tilted towards choosing the traditional option (i.e. the IAMCs), the other options remain open to them.

Table 7.4. Summary overview of middle-classes´ perceptions of health systems in Chile, Ecuador and Uruguay

Chile	Ecuador	Uruguay
Stratified health system		
Stigmatisation of public options that include the subsidised population (i.e. FONASA-Chile, MSP Ecuador and ASSE Uruguay)		
Public providers may be a viable option for routine health care needs	Social security providers (IESS) perceived as a viable option for severe health problems	Social security providers (IAMCs) are a viable option for all kinds of health care needs
Market-based private options are perceived as the necessary alternative for the middle-classes, despite the high cost		Market-based private options are not so desirable since their advantages do not counterbalance the high cost
Overall, the health system does not protect the middle-classes against health risks. No option guarantees quality while protecting against financial hardship		The health system provides security. While there is a stratified perception of the system, all options allow for getting quality health care in case of need, without being exposed to financial risk

Source: Own elaboration

7.4.2) Middle-classes´ practices for health care

Focusing on the practices for health care, the examination of the cases studies has shown that, within and across the three countries, the middle-classes´ practices can be clustered and placed in a continuum that ranges from more individualised and linked with the market repertoires of action to practices closer to the traditional middle-classes patterns of action linked to social security and risk-sharing. In Chile, the clusters of practices are more heterogeneous, namely, the middle-classes display a broader range of repertoires of action. This relates to a health policy design that offers multiple choices (i.e. type of insurance and providers), but is not fully explained by this design. This is also due, as can be seen from the analysis of the perceptions about the health system (Subsection 4.5.2), to the experience of lack of support that implies that they have to seek, with their individual or family resources, options to get greater security. In Uruguay, the possibilities of choice are institutionalised (i.e. between providers of the ASSE, the IAMCs or private insurance) too, but the middle-classes are much more homogeneous in their practices because they feel protected with what the system offers to them.

In Ecuador, unlike in Chile and Uruguay, the policy design formally restricts the possibilities of choice, but the middle-classes´ practices still show variations. As revealed in the case study, the middle-classes´ clusters of practices are fundamentally characterised by the shaping of different public-private mixes of insurance and providers. As in Chile, the Ecuadorian middle-classes are

forced to seek alternatives to achieve greater security in their health care. However, as the private sector is outside the policy architecture and the services covered are not comprehensive, while the design of the policy requires maintaining the enrolment in social security institutions, there is no complete opting-out. Hence, they pick up the most convenient from social security scheme and combine it with external private options obtained through their jobs or individually.

In Uruguay, despite the transformations in policy architecture during the last decade, the middle-classes´ practices to achieve health care have not experienced major shifts. The vast majority continue just to rely on the services supplied by the IAMCs, as has been their tradition. Even the level of income does not seem to make a difference in these practices, their being only for contracting some supplementary services in the same IAMCs in which they are affiliated. Hence, those who opt for private insurance are atypical. Their income level is not different from that of those who opt for the IAMCs, but all of them share the characteristic of having studied at private universities and following lifestyles that in a certain sense distance them from what the participants described as the traditional Uruguayan middle-class, despite their defining themselves as members of the middle-class. The difference then, as discussed in the case study chapter, would appear to be related to the ideological position and perceived status.

Conversely, in Chile and Ecuador, those who seek private services are not atypical, but rather, the core of the middle-classes. Whilst the form and degree of the linkage with the private sector vary depending on the particular circumstances, it is usual that the access to health care is, at least, to some extent, dependent on private institutions. In the analysis carried out, certain circumstances were identified that make a difference regarding how close the link is with the private sector and the degree of contact they have with the public sector in Chile and with social security in Ecuador. In Chile, the narratives indicate that deploying practices belonging to one or another cluster depends on the health status, the income level and the previous experience with public and private supply. Thus, on the one hand, those without health problems, with higher income levels and with no previous experience of public supply tend to strongly rely on market-based options, both for insurance and provision of services. On the other hand, those with some health condition, lower-income and/or who were once in public insurance are more likely to mix public and private supply. While in Ecuador the circumstances that make the difference for adopting practices within one or another cluster mainly relate to holding or not job-granted private insurance and the income level. Typically, those with job-granted private insurance primarily rely on private supply and occasionally use social security, whereas only those with high income can exclusively seek care with private suppliers.

Another relevant commonality in the middle-classes´ practices in Chile and Ecuador, is that, in both countries, they deploy strategies that are important to strengthen their chances of obtaining what they consider acceptable health services. In Chile, participants described individualised strategies, some of which deepen the market rules, such as identifying those providers with a preferential agreement with their ISAPREs or contracting supplementary private insurance to boost the financial coverage granted by the ISAPRE's plan and thus, cope with the fear of not being able to afford the economic cost over time. Ecuadorian middle-classes also deploy strategies that they use to deal with the fear of not getting the necessary services or sufficient quality health care. However, unlike those described in Chile, several of these

strategies are informal, that is, they are not considered in the regular course of action contemplated by the policy architecture. Examples of this are double insurance, the utilisation of ´palanca` to get timely attention, and direct payments for private services.

Table 7.5. Summary overview of middle-classes´ practices for health care in Chile, Ecuador and Uruguay

Chile	Ecuador	Uruguay
Practices range within a continuum from enrolling in FONASA-Chile and attending public facilities (less frequent), at one end, to enrolling in an ISAPRE and relying exclusively on private practices (more frequent), at the other, with some combinations of public and private care-seeking in between.	Practices range within a continuum, from seeking attention at the IESS or MSP (less frequent) facilities, at one extreme, to attending exclusively private practices, at the other, with several combinations of social security and private delivery in between (more frequent).	Practices concentrate on seeking service delivery in the IAMCs (more frequent). Some opt for market-based providers (less frequent).
Individual and institutionalised strengthening strategies deepen into the market mechanisms to achieve more acceptable services.	Mass utilisation of individualised and frequently informal strengthening strategies to achieve more acceptable services.	Strengthening strategies are not essential to get acceptable services and instead, their aim is to accrue supplementary benefits.

Source: Own elaboration

Differently, in Uruguay strategies occupy a peripheral position, that is, they are an option more than a need and are oriented towards benefits that are not essential components of a health service considered acceptable. Most of these strategies are limited to getting information to choose a supplier and investing in supplementary benefits, such as a private room for inpatient services or domiciliary attention.

In conclusion, the case studies have shown that the middle-classes´ practices in Chile and Ecuador have in common linkages with market-based options. The commodified policy architecture in Chile and the shortages of the system in Ecuador drive the middle-classes of both countries to rely on the market to achieve health care that they consider acceptable. Nevertheless, these practices do not give them security against financial risk and the certainty of being able to continue obtaining health care with the same characteristics in the future. Hence, they move between the fear of not receiving quality health care and that of not being able to afford the economic cost to obtain quality care in the private sector.

The lack of support from the Chilean policy design for the middle-classes, and the lack of capacity of public and social security providers to meet their expectations of health care in Ecuador push them into seeking individualised alternatives that involve relying on their own resources. This results in practices that end up deepening the segmentation created by the fragmented policy

architectures of health care. The middle-classes make efforts to keep themselves separate from the poor and not to receive their health care in public facilities. With this aim, they resort to the resources they have at hand and end up being segmented from each other as well, since the private sector works on the basis of market rules and segments according to investment capacity. Hence, they also access uneven health care and do not have a meeting point for generating joint demands to improve their protection and access to health care.

In Uruguay, the health reform extended the options of coverage for the middle-classes from the IAMCs to include the ASSE and private insurance. Nonetheless, the narratives of the interviews indicate that the middle-classes have not integrated that shift into their practices and continue choosing the same options (i.e. the IAMCs) as before the reform. Most of them have remained in what they consider the traditional middle-classes´ alternative. In turn, the stability and greater homogeneity in the practices of the Uruguayan middle-classes reveal a lesser need to look for alternatives, because the system offers them more guarantees of protection against health risks when compared with those described by interviewees in Chile and Ecuador.

The options they adopt through their practices keep them away from the public provision (i.e. the ASSE) and thus, from the subsidised population represented by informal workers and the poor. Nonetheless, the expansion of the population covered by the IAMCs, due to the reasons discussed earlier, implies that the social mix has still occurred. This is not because the middle-classes have approached the position of the rest of society, but because the policy design has been leading the rest of society to the place of the middle-classes, and the latter have mostly remained where they were. They have not opted-out, despite having the institutional possibility to do so and thus, their practices have been contributing to the efforts that the country is making to advance universal access to health care.

7.5.- Integrated analysis and conclusions: the generative mechanisms that connect the policy architectures, the middle-classes practices and the policy outputs of health care

The analysis of the country case studies was focused on depicting the policy architectures, middle-classes practices and their relations with universal/segmented health care within the context of a given welfare regime. This chapter has revisited these issues from a comparative perspective. In short, I have concluded that, despite being similar initially, the current policy architectures of Chile, Ecuador, and Uruguay have diverged, leading to different policy outputs, which also relate to the welfare regime of each country. Whilst fragmentation remains a feature of health systems in the three countries, it has dissimilar scope, is of a different type across them and has varying impacts regarding the universal/segmented policy outputs.

In Chile, fragmentation has been driven by the explicit introduction of the market in health care. Policy outcomes in this context are uneven, with quite sufficient and equitable population coverage as well as sufficient generosity, on average, but noteworthy limitations in the equity of generosity as well as regarding financial protection. In Ecuador, fragmentation is between public and social security schemes as well as between the schemes of social security (e.g. the

IESS and the SSC). However, there is a second level of fragmentation, because here the policy architecture also leads to the commodification of health care, but it takes place implicitly. As for outputs, this country exhibits the poorest results of the three, for despite advances in coverage and generosity, deficits in the sufficiency and equity of that generosity as well as important shortcomings in financial protection remain. In contrast, the policy architecture in Uruguay has exhibited higher levels of unification since the beginning of the reform that created the SNIS and pooled all social security funds into FONASA-Uruguay. Moreover, the transformations undertaken by the reform have delivered significant advances in the sufficiency and equity of coverage and generosity as well as higher financial protection.

The commodification of health care in Chile and Ecuador, either it unfolds in explicit or implicit modes, along with disparities between the different options that shape the health systems produce segmented access to health care and go hand in hand with the middle-classes´ individualised practices that maintain or even deepen such segmentation and increasingly withdraw from the public/social security sector towards market-based options. In Chile, the subsidiary state and the market logic demand from the middle-classes a corresponding rationalisation, namely this enforces market-oriented rationality, which undermines values of solidarity, social support for redistribution and reproduces segmentation. However, protection cannot be achieved through individualised strategies. Hence, there is tension: the middle-classes know that through their practices, they are reproducing a system that brings them unsatisfactory results, but they do not identify feasible alternatives to replace the precarious protection they obtain on their own. In Ecuador, there are fewer institutionalised choices in the hands of the middle-classes, because of the limitations for directing contributions to market-based options, which, in turn, diminish the experience of self-reliance and risk-taking. Nevertheless, individualised and even informal practices are widespread, because the middle-classes perceive that they only can achieve acceptable quality service by collecting services from different suppliers, as none of the options provides all services with sufficient quality. It is by assembling individual, family, and public resources that they build up quality care precariously, and their demands for more generous public benefits are contained.

Meanwhile, the Uruguayan architecture, despite still being fragmented, has advanced the equalisation of benefits and quality, promoting more equitable access to health care across the different providers of the Integrated Health System (SNIS). The renewed architecture has allowed the middle-classes to remain without having to resort to market options and continuing to deploy practices that may enable further transformations of the system towards universalism. In fact, the middle-classes practices have not changed their behaviour significantly. Instead, the new policy architecture has mixed them with groups traditionally excluded, who now can get services from the IAMCs, and the middle-classes have remained without substantially moving towards market options. Furthermore, the middle-classes perceptions regarding the health system and the chances to meet their health care needs satisfactorily have shifted towards a greater experience of security related to the improvements in the generosity and financial protection reached by the reform.

Table 7.6. Summary of the main domains analysed by the case studies of Chile, Ecuador and Uruguay

	Chile			**Ecuador**			**Uruguay**		
Type of welfare regime	State productivist			Non-state familist			State protectionist		
Foundational policy architecture	Fragmented (based on formal employment, several schemes by occupational category and basic social assistance for the poor)			Fragmented (based on formal employment, two main social security schemes and basic social assistance for the poor)			Fragmented (based on formal employment, several schemes by occupational category and basic social assistance for the poor)		
Current policy architecture	Fragmented public / private (commodification-led)			Fragmented several social security schemes / social assistance (labour market-founded and implicit-commodification-led)			Advances to unification with leftovers of fragmentation between social security / social assistance (labour market-founded)		
Universalism of policy outputs		Sufficient	Equitable		Sufficient	Equitable		Sufficient	Equitable
	Coverage	+	+	Coverage	+	+	Coverage	+	+
	Generosity	+	-	Generosity	-	-	Generosity	+	+
	Financial protection	-	-	Financial protection	-	-	Financial protection	+/-	+/-
	Moderate universalism			Low universalism			Moderate-high universalism		
Middle-classes´ practices for health care	Significant withdrawal towards market-based private options. Maintenance of segmentation.			Double insurance and significant withdrawal towards market-based private options for service provision. Maintenance of segmentation.			Remaining with traditional social security providers without resorting to the market. Supporting advances towards universalism.		

Source: Own elaboration based on the analyses presented in Chapters IV, V and VI

So far, I have discussed comparatively the policy architecture´s contributions to universal/segmented health care and the practices for health care of the middle-classes deployed in the context of the three studied countries. Drawing on all the previous analyses, it is possible to address the generative mechanisms that conduct the relationship between the policy architectures, the middle-classes practices, and the policy outputs of health care in these countries. I identify three main generative mechanisms, which are explained below.

7.5.1) The market entrance to health care provision

The cases of Chile and Ecuador demonstrate two different policy architectures embedded in different welfare regimes that converge in segmenting access to health care. Indeed, the policy architectures in these two countries show significant differences in the five policy instruments (see Table 7.2). Nonetheless, what both have in common is that the architecture strongly drives entry into the market and that such a process suffers from a lack of regulation or has that which favours the private sector. In Chile, the presence of the market is defined by the policy architecture itself, which further to fragmenting the system gives advantages to market-based options over the public sector. While in Ecuador the market´s presence may be considered an unintended consequence of a policy architecture that generates insufficiently generous services and does not regulate the outside options. Both policy architectures, one directly and the other unintendedly, lead to the commodification of health care, inequities in the generosity of the accessed services and shortcomings in financial protection. All of this ends by creating segmentation across different sectors of the population, because health care access -the comprehensiveness and quality of services and financial protection for meeting health care needs- is strongly dependent on payment capacity. The Uruguayan policy architecture, like the Ecuadorian one, is labour-market-founded fragmented, but has two significant differences, namely, recent advances towards unification of some policy instruments -especially financing and benefits- and the welfare regime where the health policy is embedded.

In addition, the Chilean and Ecuadorian policy architectures also converge to give rise to middle-classes practices of opting-out from the public/social security sector in pursuit of private options, ending in reproducing or even deepening segmentation. In these two countries, the middle-classes have to cope with health risks with insufficient state support and thus, resort to dealing with the market. This leads to individualised practices and strengthening strategies in which those who can withdraw from the public/social security and go to the private relying on their own resources. Differently, as previously discussed, the Uruguayan middle-classes have remained opting for meeting their health care needs through the traditional social security providers and without significatively turning towards market-based health care. But, does this mean that a policy architecture that explicitly pushes the middle-classes towards market alternatives, as it happens in Chile, causes the same effect in terms of withdrawal towards the private sector, and universalism/segmentation of health care than a policy architecture that, at least formally, does not open such possibility, as observed in Ecuador? The analyses presented in the case studies indicate that the commodification of the Chilean system has led to the greater withdrawal of the middle-classes to private insurance and provision than their Ecuadorian

counterparts (see Subsections 4.4.2.1, 4.4.2.3 and 5.4.2.1). Nonetheless, this system is still capable of achieving higher levels of universalism in the policy outputs than that found in Ecuador (see Table 7.3). In Ecuador, there is a notable lack of information regarding the hiring of private insurance and private service delivery. Hence, it is difficult to gauge accurately how significant the withdrawal towards market options is. Moreover, indicators such as the OOP spending and the participants´ narratives suggest that, despite not having an explicit opening to the market, private delivery is frequent, because of the deficits of health services´ generosity. Moreover, Ecuadorian households are substantially exposed to financial hardship when seeking to meet their health care needs. Hence, whilst the preference for private options remains hidden at first sight, it does not mean that they are directly related to the policy architecture´s degree of explicit openness to market options.

To summarise, a policy architecture, such as the Chilean one, fragmented between the public and private sectors and with important participation as well as weak regulation of the latter, generates the explicit commodification of access to health care, especially for the upper and middle-classes. This consolidates segmentation, particularly in terms of generosity inequities and financial protection deficits, despite the country's advances in universalism, in terms of coverage and sufficiency of average generosity, through greater public investment along with the expansion of health care benefits. For its part, in Ecuador, a fragmented policy architecture, according to participation in the labour market and with important deficits in its performance, given that it takes place in a welfare regime with a predominantly informal labour market, generates important deficiencies in the generosity of health services, which pushes the middle-classes towards market options, thus giving rise to the implicit commodification of access to health care. Added to this, are the totally unregulated market options that leave households at financial risk. The result of all this is a greater degree of health care segmentation than that observed in Chile, with explicit commodification. In Uruguay, advances in the unification of the long-standing labour-market-led fragmented policy architecture, within the context of a protectionist welfare regime along with improving performance of the labour market and decommodification of social welfare, have prevented commodification of health care from occurring. This has kept the middle-classes at a distance from market options, thereby leading to higher outputs of universalism in health care.

The conclusion that arises from these analyses is that there is not a single type of policy architecture that drives segmentation, for this policy output can result from different configurations of its five components. Nevertheless, the conspicuous and insufficiently regulated entry of the market is a sufficient condition, a generative mechanism, for segmentation to be spurred directly by the policy architecture itself, through commodification-led fragmentation and by the conditioning of practices that maintain or intensify segmentation. Moreover, when the commodification is the result of deficits of the public and social security sectors in delivering the needed health services (e.g. Ecuador), it leads to more significant shortcomings in terms of universalism/segmentation of health care, than the commodification that takes place accompanied by more robust public and/or social security options, despite the explicit incorporation of the market into the policy architecture (e.g. Chile).

The first part of the statement in the preceding paragraph concurs with the argument unfolded by Martínez Franzoni and Sánchez-Ancochea (2016b) about the negative impact of unregulated outside market options on universalism, as this promotes the fragmentation of the policy architecture, even if there are efforts to move the other components of the architecture in the direction of unification and universal outputs. Based on my findings and drawing on the analyses presented elsewhere (see Bernales-Baksai and Velázquez Leyer, 2021), I call attention to the fact that this can also happen implicitly, that is, when the architecture does not formally include market options. Furthermore, I argue that the mechanisms through which the conspicuous entrance of the market in health care promotes segmentation do not limit to the direct effects generated by the policy architecture, for they also act by conditioning the practices for health care, regardless as to whether the market entrance takes place explicitly or implicitly. Therefore, in those countries where the market has penetrated more extensively, the conditioned middle-classes practices for health care are more likely to contribute to keeping or intensifying segmentation, as they are prone to cope with health risk in an individualised manner that separate them from the rest of the population and even from the other members of the middle-classes.

7.5.2) Generous services delivered by non-commodified options

Moving now to the conditions for advancing universalism in health care, the comparison of the case studies unveils the centrality of the availability of sufficiently generous services (i.e. quality, timely and comprehensive) delivered by non-commodified options aimed at including the middle-classes. This enhances middle-classes´ practices regarding health care that give space of manoeuvre to pro-universalist reforms, creating a positive feedback effect that allows for deepening universalism. In other words, the greater the generosity of health services (i.e. the policy output) supplied by non-commodified providers (i.e. a feature of the policy architecture), the less the willingness of the middle-classes to move to market-based options and the greater the support for undertaking further improvements as well as extension of these non-commodified options. Uruguay and Ecuador clearly illustrate the two sides of this statement.

Uruguay and Ecuador had similar foundational policy architectures (although in different historical periods) and followed fairly similar trajectories up to the current reforms. However, historically, their health care outputs were different, with the former presenting a higher performance. The Uruguayan model has traditionally resulted in more generous services for the middle-classes delivered by non-commodified providers associated with occupational groups (i.e. the mutualists now renamed IAMCs). Meanwhile, the Ecuadorian policy architecture, whilst also defining that the services for the middle-classes are to be supplied by non-commodified providers (the IESS and SSC), has failed in the outputs of generosity.

In previous chapters, it has been suggested that such differences in the policy outputs delivered by similar policy architectures relate to the level of development of the social state (i.e. the capacity of the state and its institutions to provide social welfare), the type of welfare regime and the coherence of the policy architecture with the latter. Thus, the greater development of

the social state and a welfare regime with high levels of commodification in the labour market and consistent with the policy architecture model contribute to explaining the superiority of policy outputs in Uruguay compared to Ecuador, where the social state is more limited, and the policy architecture relies on a model based on formal employment in circumstances that the country has a labour market with very high informality. In other words, this means that, in order to be able to provide generous public services, the policy architecture needs to be supported by enough public institutional capacity and by a welfare regime that is consistent with the model adopted by the policy.

For its part, Chile, despite the dual public-private health system, has made significant progress in the capacity of the public sector to generate generous health services, although there are still deficits. In addition, this country has an institutional capacity of the public sector similar to that achieved by Uruguay with the public and social security sectors, and much higher than that of Ecuador. However, there is an issue regarding relative generosity. As discussed above, the commodified design of the policy architecture in Chile implies that, despite the public sector generosity having improved, it offers less generous outputs to the middle-classes compared to what they can obtain in the private sector if they can pay for it.

Summing up, Uruguay offers higher generosity of services to the middle-classes provided by non-commodified options. Moreover, there are high levels of generosity equalisation between non-commodified and commodified options considered within the system. Ecuador displays generosity deficits in all the institutional alternatives (i.e. public and social security), whilst Chile presents better levels of generosity than Ecuador in the public sector, but lacks equalisation concerning the for-profit private sector, thus spurring the middle-classes towards the latter whenever they can afford the costs.

Therefore, a second conclusion and generative mechanism is that a non-commodified provision with sufficiently generous services, thus being more attractive to the middle-classes than market options, is a necessary condition to promote universalism. This is facilitated or hindered by the welfare regime and public institutional capacity, being associated with practices that can trigger transformations towards more unified architectures and therefore, continue boosting pro-universalist efforts. Hence, the policy architecture and the welfare regime interact with each other, together pushing for practices that can trigger further transformations towards the unification of the health system and positively feed back universal health care.

7.5.3) <u>The policy legacies</u>

Lastly, there is a broad corpus of literature that explains the path-dependent policy trajectory, in general and in the region, in particular (see Mahoney, 2000; Pierson, 2000; Pribble, 2008; Mahoney and Thelen, 2010; Pribble, 2011). The relevance of policy legacies in explaining why Uruguay has advanced further universalist reforms than Chile is highlighted by Pribble and Huber (2013). They point out that the neoliberal reforms of the Chilean dictatorship strengthened the role of private providers in such a way that they became resistance forces that that have

seriously impeded social democratic reforms[43]. The case studies presented here, corroborate these ideas in the health care domain, showing that the introduction of the market in Chile has prevented the, structural reforms for making it possible to decommodify access to health care. In Ecuador and Uruguay, the interests of actors associated with social security and privileged groups of workers have also undermined the health systems' unification and universalism, although recently the latter has achieved deeper transformations supported by favourable contingent conditions (see Chapter VI) (Fuentes, 2010; Pribble and Huber, 2013; Rossel, 2016).

Thus, in agreement with the arguments presented by Filgueira, F. (2007), Pribble (2013), Pribble and Huber (2013) and several others who have studied the effects of past policies on subsequent ones in the region, the examination of the Uruguayan case suggests that advances in unifying the policy architecture have been favoured by policy legacies less harmful than those present in Chile. In the case of the former, this has been without the presence of powerful market-based actors with close ties to right-wing parties pushing towards a commodified health system (Castiglioni, 2005). This is not to deny that the policy legacies in Uruguay did not impose obstacles to reforms. In fact, as in Ecuador, the actors linked to social security constituted the greatest obstacle to undertaking the transformation of the policy architecture. Nevertheless, the contingency created by an economic crisis was taken advantage of by the government to break with the corporativist legacies (see Fuentes, 2010, 2013). In a different way, in Ecuador the initial design of reform experienced setbacks that could not be overcome in subsequent years owing to the strong opposition of powerful veto players involved in social security provision (Vice-minister of Governance and Public Health Surveillance).

In addition, I argue, and this is the third generative mechanism, that in the health care realm, the effects of policy legacies are not limited to the possibilities of subsequent policy reforms, for they also shape the perceptions, experiences and day-to-day practices of people, which in turn, reinforces the policy legacies' effect on the policy design. Thus, for example, despite in Ecuador and Uruguay the reforms having introduced the possibility (but did not incentivise) for the middle-classes to seek services in the public sector (the MSP and the ASSE, respectively), this did not happen at all. The participants' narratives were clear in stating that these options are not suitable for the middle-classes, being just for the poor. Their perceptions and practices have continued as they have been conditioned by the historical fragmentation and stratification of the health systems. In fact, the change in Uruguay in terms of the greater mix of social classes in the IAMCs has not occurred because the middle-classes changed their practices, but rather, it was the reform that made it possible to drive forward progressively most of society to engage in the traditional providers of the middle-classes. For their part, the middle-classes have remained in the IAMCs, and because of this, it has been feasible to move towards universalism,

[43] The authors lay out three other reasons behind the divergences in the transit towards redistribution and universalistic policies in these two countries: i) Ideology of the leadership: members of the Chilean governments, even those more to the left, have been more sceptical about state intervention than those ruling Uruguay; ii) Organisational characteristics of the left parties: Chilean leftist parties have weak ties with civil society organisations, whereas the FA in Uruguay is featured by its strong ties to civil society, thus enabling a greater involvement of social actors in the policymaking process; and iii) Strength of the opposition: centre-left governments in Chile have faced strong right-wing opposition well-related with the business community, whereas the opposition to the Uruguayan FA is exercised by two traditional parties less cohesive than the Chilean opposition that have weaker ties to the business community.

because it was considered by the design of the reform. Hence, the Uruguayan reform has relied on policy legacies and the practices that these promote to generate changes in the policy outputs. In this case, policy legacies can be understood as generators of trends, but changes in the policy design or the practices or both, can cause disruptions to the system and thus make a difference.

The opposite trend can be observed In Chile, where since the 1980s, the policy architecture has been pushing the middle-classes towards the private sector. Currently, in spite of improvements in the public sector and even, despite the mistrust and criticism of private actors involved in health care, the middle-classes continue to rely on the private sector. In a way, they have remained prisoners in their practices of the legacies of the reforms that commodified health care 40 years ago, for the reforms developed in the 2000s have not addressed this issue. Moreover, the multi-tier health care hinders the formation of cross-class alliances and limits the interest of those groups holding private insurance for supporting further investments in the public sector. In the same fashion, the Ecuadorian 2008 reform, despite proclaiming that the public system, managed by the MSP, would offer health care to everyone as a social right, it did not change in practice the policy architecture trying to reach a greater mix of social groups. Thus, the reform kept untouched the practices of the middle-classes that were built from the legacies of several decades of fragmentation and quality deficits, which reinforced segmented health care.

CHAPTER VIII CONCLUSIONS

8.1.- Introduction

This chapter brings together the main areas analysed by this study. In addition, it discusses the relevance and usefulness of the analytical framework and methodological strategy adopted. The first section after this introduction (Section 8.2) focuses on the findings and conclusions for each of the research questions, both from the point of view of each of the countries and from a comparative perspective, as appropriate.

Having presented the main conclusions, Section 8.3 reflects on the relevance and usefulness of the research approach adopted throughout the study. I argue that the critical realist approach was fruitful for building an analytical framework aimed at comprehending the studied phenomenon in terms of its complexity. Then, Section 8.4 explains the major theoretical, methodological and empirical contributions that this thesis brings to current knowledge. Finally, Section 8.5 discusses future avenues of research, suggesting some potentially interesting areas opened up by the analyses and questions that this study has raised.

8.2.- Main findings and conclusions

This research was aimed at addressing three main questions:

- ***How does the policy architecture of health care contribute to universal or segmented health care?***

- ***What kind of practices for health care of the middle-classes are conditioned by the policy architecture?***

- ***What are the generative mechanisms which connect policy architectures, middle-classes practices and outputs of health care policy in Chile, Ecuador, and Uruguay?***

Addressing these questions has involved studying four central variables and their relationships: welfare regimes, policy architectures and policy outputs of health care and middle-classes practices for health care. The first and second research questions were focused on some of the variables addressed. They were analysed extensively through the case studies presented in Chapters IV, V and VI, whilst also being taken up from a comparative perspective in Sections 7.3 and 7.4 of Chapter VII. Throughout these different parts of the study, it was evident that the four variables are entangled with each other. Hence, both the questions and their answers should be considered a dissection for analytical purposes, but they require an integrated understanding. As for the third research question, this contributes a more integrative perspective. Its answer was built up in Section 7.5 of Chapter VII based on the integrated vision of all the domains considered in the three case studies. It points to the deeper mechanisms -the generative mechanisms- that account for the subject matter studied, highlighting that it is a social process and, therefore, dynamic and complex, as the critical realist perspective

understands the social. The answers to this third question could not have been arrived at without first addressing the first two.

Regarding the **first question**, i.e. *How does the policy architecture of health care contribute to universal or segmented health care?*, the analyses presented in Chapters IV, V, VI and VII unveiled that the case studies have strongly confirmed the argument that links the fragmentation of the policy architecture with lower chances of universal policy outputs (Filgueira, F., 2014; Martínez Franzoni and Sánchez-Ancochea, 2016b), which was particularly evident in Chile and Ecuador. However, the Uruguayan case suggests the need to observe this relationship in a more nuanced fashion, for this country has been capable to notably advanced all five dimensions of universal health care hand in hand with unification in some policy instruments (i.e. financing, benefits and regulation of outside options), while others (i.e. eligibility criteria and service delivery) remain fragmented.

These findings involve at least two analytical implications. First, it is necessary to consider that, just as universalism is a complex variable that involves several dimensions and that does not occur in a pure way, but rather, within a continuum the opposite ends of which are complete universalism and segmentation (Pribble, 2013; Martínez Franzoni and Sánchez-Ancochea, 2016b), fragmentation is not a univocal condition, for as was evident in the three cases studied, different types of fragmentation are associated with different outputs of universalism/segmentation. The analyses presented distinguished commodification-led fragmentation from labour-market founded fragmentation, being possible to find one or both types in a country. Throughout these analyses, it also became evident that, when commodification-led fragmentation occurs, regardless of whether it is explicit (as in Chile) or implicit (as in Ecuador), it generates segmented outputs, especially concerning the equity of the generosity and financial protection. Differently, when fragmentation is labour-market-founded and health care is not commodified (as in Uruguay), it seems that specific movements in the architecture still allow advances in equity in addition to sufficiency in coverage, generosity and financial protection.

The second analytical implication, closely related to the previous one, is that the relationship between universal/segmented policy outputs and unified/fragmented policy architectures needs to be attended to from a perspective that allows for examining the contribution of the unification/fragmentation observed in different policy instruments to each dimension of policy outputs. For instance, the analysis presented has shown that it has been possible to make advances in the universalisation of population coverage in the three countries, despite the fragmentation in one or more policy instruments. Instead, as evidenced by the differences between Chile and Ecuador, advances in the sufficiency of generosity require public investment and the institutional capacity of the public sector (i.e. expressed through financing and delivery policy instruments). Meanwhile, the unification of financing, benefits and regulation of outside market-based options, as in Uruguay, seems to have been the fundamental basis for tackling inequities in generosity and limited financial protection.

Building on these findings, it is feasible to argue that the advance of universalism broadly understood, namely with sufficiency and equity in coverage, generosity and financial protection,

demands that the public sector has enough institutional capacity and resources to deliver the same generous services to the entire population. This capacity and resource availability in turn depend on the financial arrangements and the strong regulation of market-based options to avoid that health care become commodified and, therefore, dependent on the households economic capacity. Thus, different to the argument that, if private options are within the architecture of the system, it is not feasible to break with segmentation and advance universalism (e.g. Sojo, 2017), private market-based options may be included in the system and still promote this outcome. However, it is necessary to ensure, through their regulation, that private market-based options provide all the necessary services without exposing people to financial risk, do not drain resources from the public sector (e.g. by capturing the highest payroll contributions and skimming the healthiest, as has happened in Chile), and do not hinder the solidarity of the overall system. Moreover, it seems fundamental taking into account the nuances of the involvement of private options in health care provision. This can range from a high level of institutionalisation, as is the case in Chile, where there is the option of opting-out of the public sector and choosing private insurance, to double public-private insurance or the search for complementary private services, as pursued by the middle-classes in Ecuador or it may be limited to supplementary services, as is the case with domiciliary services by the mobile emergency companies in Uruguay. Also, it can be intertwined with the public sphere, being supported by the public sector that transfers resources to the private sector rather than strengthening its own capacity to deliver quality services as described in Chile and Ecuador.

One last point relates to the significance of considering the characteristics of the welfare regime in which the policy architecture of health care is embedded. While each welfare regime is likely to give rise to social policies that adopt the same rationale, this cannot be taken for granted. In this regard, the analysis of the policy outputs has indicated that reforms with the intention of universalism face greater obstacles, if the proposed policy architecture is not consistent with, or is not supported by, the prevailing welfare regime, as was unveiled by the analysis of Ecuador. Moreover, as the literature states, the welfare regime also conditions the options for transforming the policy designs through the feedback between the balance of power associated with the production of social welfare and the institutional arrangements for its provision through social policies with a certain design (Korpi and Palme, 1998).

As for the **second research question**, namely *what kind of practices for health care of the middle-classes are conditioned by the policy architecture?*, the first point to highlight is that the three cases corroborated that middle-classes´ perceptions and practices regarding health care are coupled with the policy architectures and the outputs generated by such architectures. Thereby, in Chile, with a commodification-led fragmented architecture and policy outputs that have failed to offer equitable services and sufficient financial protection, the middle-classes perceive themselves as precariously protected and lacking public support, thus having to rely on their own resources. They perform individualised practices to cope with health risks and meeting their health care needs.

In Ecuador, where the system is fragmented based on the labour market, but also (implicitly) commodified, practices are also individualised and tend to rely on market-based options following non-institutional paths. This makes evident that the middle-classes´ practices not only reflect the explicit characteristics of the policy architecture, but also the implicit ones.

Otherwise, in Uruguay, with advances in unification, but still the leftovers of labour-market-based fragmentation, and a non-commodified architecture, the middle-classes practices mostly rely on the options offered by social security and market-based alternatives are mainly relegated to supplementary services.

The three case studies have made clear that rather than being the result of individual choices and preferences, the middle-classes´ practices for health care are conditioned by policy architectures and outputs. Hence, it is to be expected that if there are shifts in the policy architectures and outputs, perceptions and practices also gradually change to adapt to them. Even though it is central to bear in mind that regardless of being conditioned, these practices are also a fundamental piece in the path followed by the policy. These practices support day-to-day the policy architecture, such as it was evident in the participants´ narratives.

In addition, there is another aspect illuminated by the research that accounts for the complexity of the relationship between policy architectures, policy outputs and middle-classes practices. It is not only that they interact and have reciprocal influences, as indicated above, but also, that the temporal dimension matters since a change in one of these domains does not bring an immediate change in the others. Just as historical conditioning plays a role on the side of policies (i.e. through policy legacies), they also have an influence on the practices. This was clearly seen in the fact that the interviewees flatly ruled out resorting to the public options historically responsible for delivering services to the poor, despite recognising that their quality currently (i.e. after the 2000s reforms) does not differ from that of other providers in Uruguay, or may even be better than that offered by social security in Ecuador. Likewise, in Ecuador and Chile, the middle-classes assume it is natural for them to go to market-based providers due to the historical deficits in the public sector in the latter and the public and social security schemes in the former. In these two countries it seems that going private has become a constitutive feature of being middle-classes, this is the legacy.

To summarise, the reply to the second research question is that, in the three countries it was observed that the policy architectures condition middle-classes practices for health care that are ad hoc in their design. Although this answer is nothing new, it is significant since it implies recognising that whether the middle-classes deploy practices that reinforce segmentation, or whether, on the contrary, their practices contribute to universalism, this obeys the fact that there is a policy architecture that pushes them towards this, rather than any type of ´intrinsic` preference or option of the middle-classes.

Moreover, it is significant that in none of the three countries was it found that the recent health reforms had been focused on modifying the middle-classes´ repertories of practices for health care access. In Chile and Ecuador, the reforms have addressed primarily improving health care access for disadvantaged groups, allowing the middle-classes to continue with the same access mechanisms as before the reforms. This, in turn, was verified by the interviewees, who did not report any transformation in their health care practices. In Uruguay, although, unlike what happened in the other two countries, the health reform has sought to integrate the middle-classes with the rest of the population, its design has done so by aiming that the middle-classes

maintain the same practices that they had for decades and trying to bring the rest of the population closer to the traditional health care spaces of the middle-classes.
In this context, several questions remain open regarding both the possibility of changes in the middle-classes` health care practices and their possibility of triggering transformations on the policy architecture. The answers to them will require resorting to the temporal dimension. Regarding the former question, it would be expected that, as is currently the case, if new reforms to the policy architectures put the middle-classes in a different place, these will also condition ad hoc practices. However, it will be necessary to wait for this type of reform to see whether this is the case and, more specifically, to analyse, how deep and in what policy instruments the transformations must be developed to trigger changes at the level of practices.

As for the possibility of these practices to trigger transformations in the policy architecture, it will also be necessary to count with time to arrive to an answer. For example, in recent years the Chilean middle-classes have processed collectively the dissatisfaction through the ´Estallido social`, demanding the transformation of the social arrangements that govern access to health. Nonetheless, we will see whether these demands entail, or not, changes in their practices for health care and whether, through this, they end up pushing or not transformations in the policy architecture.

Finally, the answer to the **third question** builds upon all the previous analyses. In the comparative analysis presented in Chapter VII, I argued that the scope and mode of the market entrance to health care provision, the availability of quality, timely and comprehensive services delivered by non-commodified options (publicly or social security managed) as well as the effects of policy legacies on both the possibilities of policy reforms and the middle-classes practices for health care are the central pieces that shape the *generative mechanisms that connect the policy architectures, the middle-classes´ practices, and the policy outputs of health care* in the three studied countries.

In short, the first generative mechanism identified stated that although segmented health care can result from different configurations of policy architecture, the conspicuous entry of the market is a sufficient condition for segmentation to be spurred. Moreover, it indicated that segmentation can be promoted both directly by the policy architecture through the fragmentation of the system and by the conditioning of practices that maintain or intensify segmentation.

This aligns with previous research that has revealed the segmenting effect of the conspicuous and unregulated entry of the market into the health care realm due to the fragmentation it generates in the policy architecture (Martínez Franzoni and Sánchez-Ancochea, 2016b; Sojo, 2017). Based on my findings, I add that a negative effect on universalism can also take place without the policy architecture contemplating the entry of the market into the health care provision, which in the analyses presented elsewhere (see Bernales-Baksai and Velázquez Leyer, 2021) colleagues and I called implicit commodification of health care. Moreover, in Chapter VII I argued that, when commodification expresses the deficits of public and social security options to deliver quality health services, it further hampers universalism compared with explicitly commodified policy designs that have more robust public and/or social security options. In

addition, independently of whether the commodification is explicit or implicit, segmentation also is pushed indirectly through the practices it promotes in the middle-classes. That is, it promotes practices aimed at coping with health risks in an individualised manner, which separates them from the rest of the population and even from the other members of the middle-classes.

A second generative mechanism identified operating in a complementary way to the previous one, is that, to advance universalism, a non-commodified alternative capable of providing sufficiently generous health services for the middle-classes is required. The fulfilment of this condition would allow for breaking with the vicious circle that the literature has stressed regarding the withdrawal of the middle-classes from the public sector to the private options, with the consequent harmful effect on the quality of publicly provided services (Ferreira et al., 2013; Filgueira, F., 2013). This is because the public sector loses social legitimacy to increase fiscal investment and lacks demanding users who can require its improvement. In addition, I argued that this necessary condition can be facilitated or hindered by the type of welfare regime and public institutional capacity of the country. All these elements taken together push for practices that may feed back positively the universalist advancements of the policy architecture.

Finally, the third generative mechanism identified is that the effect of health care policy trajectories is not limited to subsequent policy designs, for it is also expressed in the practices for health care, which in turn reinforces the effect of policy legacies on the policy design. This generative mechanism is still tentative, as it is based on the observations got through a relatively small number of interviews. Moreover, as abovementioned, the temporal dimension is fundamental to deepening the understanding of how the middle-classes practices for health care evolve, how they respond to changes in the policy architectures and outputs, and how they may influence the evolution of the health care policy. The claim of this generative mechanism contributes to the broad discussion of scholarship regarding the importance of policy legacies in determining policy trajectories and reforms in the region and their possibilities of advancing towards universalism (Mahoney, 2000; Pierson, 2000; Filgueira, F., 2007; Pribble, 2008; Mahoney and Thelen, 2010; Pribble, 2011). But, by including the conditioning on the practices and the supportive effect of these practices on the design of the policy, it broadens the focus of observation towards the feedback dynamics between the social structures and institutions and the agency of the social groups. In the particular case of this research, Chapter VII discussed the conditionings that the historical fragmentation and stratification of the health systems in Chile, Ecuador and Uruguay continue to exert over the middle-classes practices in spite of the changes undertaken by recent reforms to raise the quality of public services. In fact, the health care practices of the middle-classes have contributed to reproducing the historical differences between the public, social security and private sectors. Although these practices could also contribute to transforming the policy architecture.

8.3.- Reflections on the research approach

The greatest challenge of this research has been aiming to consider the phenomenon under study taking into account its complexity, that is, not seeking to establish linear cause-effect relationships between isolated variables. To this end, I assumed the perspective of considering most of those variables that, based on the review of the literature, seemed to be significantly involved in the generation of health policy outputs. In my attempt to capture as much complexity of the phenomenon of interest as possible, the critical realist approach gave me conceptual support for developing an analytical framework, where the focus is not on isolated variables, but rather on the relationships between them, which in turn are not linear relationships, but rather iterative processes with multiple forms of feedback. My aim has been to generate explanations from a relational perspective and embedded in the context.

The challenge, however, has not been negligible. On many occasions I made an effort to look at my research from the traditional perspective. I often wondered whether what I was proposing was a tangle of variables and whether it was more sensible to follow the traditional model of identifying a dependent variable to be explained by one, two or three independent variables. Nevertheless, having concluded the process of investigation, I realise that an effort like that would have meant a limited contribution. It would probably have repeated or corroborated explanations already broadly discussed (e.g. that policies generate legacies, that fragmented systems tend to generate segmentation, etc.) and that, although they are insightful, are restricted to a part of the problem.

The research process and findings, on the contrary, have taught me that there is still much complexity to be incorporated and that far from turning my gaze to an approach of isolated variables, it is necessary to ask myself what I have failed to consider and how to give even more attention to the relationships between multiple variables to approach the social processes that I am studying. In this context, Archer's (1995, 2010) contribution with her temporal dissections seems very fruitful as an analytical device to deal with complexity. Moreover, her proposal is able to include the different strata (i.e. society and human beings) and the relationship between them within the same framework.

Considering the aforementioned points, this research constitutes an initial effort to include these two strata, namely society and human beings, and their relationships in the field of health policies from a comparative perspective in Latin American countries. Focusing on the middle-classes has not only been fruitful because the literature has highlighted their importance for the development of universal welfare policies, but also, because from an analytical point of view, it is necessary to set boundaries around a social category. In fact, Bhaskar (2015) himself indicates that the point of contact between social structures and human agency has to be found in the position that people have within society.

Still, I am aware that this effort needs to be deepened, especially with regard to practices in terms of how these shape social agency and how they trigger changes (i.e. morphogenetic processes) or contribute to maintaining or even deepening the prevailing structures and

institutions (i.e. morphostatic processes). This study constitutes an incipient approach to consider the role of the middle-classes as social agents in a field such as health policies and universal outputs in Latin America, since the literature on the region has been prolific in analysing the role of organised interest groups and social movements (e.g. Niedzwiecki, 2014; Garay, 2016; Fairfield and Garay, 2017), but not so with regard to the involvement of non-organised agents, with respect to the evolution of policies.

8.4.- Contributions to knowledge

As discussed above, this study demonstrates the usefulness of addressing health care outputs considering the institutional conditions expressed in the policy architecture, the middle-classes as social agents and the context shaped by the welfare regime. The analytical framework proposed enables a comprehensive perspective of the social processes that sustain the dynamics of access to health care in different Latin American countries and the entry points that may allow for triggering transformations to such dynamics. Hence, this research has made a theoretical contribution by developing an analytical framework that integrates the conceptual background provided by the critical realist approach, building upon concepts such as generative mechanisms, morphogenetic/morphostatic processes and social agency with the contributions made by the social welfare literature, with particular emphasis on the concepts of decommodification, defamilisation, redistribution, universalism and segmentation along with the theorisation related to the policy architectures. This analytical framework has made a two-fold contribution by bringing together these two traditions. On the one hand, the critical realism lens has enabled the studying of universal health care and the role of the middle-classes from a relational and dynamic perspective. On the other, the critical realist approach itself has been rebuilt as a helpful framework to be used in social policy analysis.

A second theoretical contribution of this analytical framework has been the consideration of the context in which the policy of health care takes place, expressed in the welfare regime of each country. This has resulted in a better understanding of the implications of the policy architectures and the outputs that they produce. The methodological option of selecting contrasting cases in terms of their welfare regimes enabled the identification of the conditionings of different welfare regimes on the relationship between policy architectures of health care and the middle-classes. This was evident when considering, for example, that despite having similar policy designs throughout most of their trajectory, Ecuador and Uruguay have generated substantially different policy outputs, have recently achieved reforms with quite dissimilar architectures and given rise to different middle-classes´ practices for health care.

This research has also contributed theoretically by proposing a multidimensional definition for universalism in health care. This definition brings together the scholarship on social policy and health systems research to build up a conceptualisation that is pertinent and significant to addressing the field of health care, particularly in the context of Latin America. From the social

policy tradition, Martínez Franzoni and Sánchez-Ancochea made a noticeable contribution by differentiating three dimensions, namely coverage, generosity and equity for interrogating universalism beyond a formal definition (i.e. those that consider formal entitlement regardless of whether or not access occurs in practice and the quality of the services accessed) (2016b), whilst also pointing out that universalism and segmentation are the two opposite ends of the same continuous variable (2018). In turn, the scholarship on health systems has also considered universalism through a multidimensional lens, contending that UHC entails population coverage, service coverage and financial coverage (see WHO, 2010).

The conceptualisation of universal health care that I adopted for this thesis brings into dialogue these two traditions. Moreover, it takes into account the specificities of the region regarding the long history of social inequalities, markedly stratified social policies, significant quality deficits in the public sector and neoliberal reforms that strongly introduced the market into health care provision. I have argued that the understanding of universalism in health care cannot be restricted to formal population coverage (i.e. the proportion of individuals formally entitled), for the sufficiency and equity of generous services, as well as financial protection, also need to be considered.

Despite this thesis not intended to assess universalism in health care, it advanced the identification of suitable indicators for each dimension of universalism in health care, which is another analytical contribution. These indicators were presented in the methodology of this research (Section 3.5) and applied in each case study. A major challenge was to identify indicators that illuminate not only the sufficiency of the outputs but also their performance in terms of equity. Moreover, in some cases, the indicators are frequently used and, therefore, easily accessible (e.g. the percentage of population coverage overall and by the different schemes or insurance), but in others, the information is more challenging to obtain or even not available.

For example, to analyse the quality of the services accessed, there is much less consensus regarding the suitable indicators, and most of them are difficult to obtain, especially if the aim is to carry out analyses that compare differences between schemes, providers or groups of the population. Similarly, despite global OOP spending being easily accessible in most countries, which allows for the first overview of financial risk/protection, a more detailed analysis of it is much more difficult to obtain. The indicators used in this thesis can be a starting point to continue building comparable indicators and producing the necessary primary information to achieve more comprehensive assessments, capable of adequately capturing all the dimensions of universalism in health care.

This research has also made a methodological contribution to the development of studies based on a critical realist approach. As discussed when presenting the methodology, critical realism provides guidelines regarding the logic to follow for the development of empirical research, namely the application of abductive and retroductive thinking, as well as regarding the type of possible designs to use, depending on the objective of the research. Nonetheless, there is less clarity regarding the specific methodological strategy to follow. In this framework, based on the review of the methodologies applied by different studies that defined themselves as critical

realist (see Table 3.2), I proposed a series of methodological stages that led to the concrete application of abductive and retroductive logics throughout an empirical research process. These stages allowed for the development of a theoretically-led process of information gathering that was also open to the emergence of new analytical categories, especially concerning practices for health care. Likewise, this methodology made it possible to move from more descriptive analyses, which were presented at the beginning of each case study, to higher levels of integration between the variables, unveiling the relationships between them in each country and finally, to the identification of the generative mechanisms of the studied processes. Regarding the lattermost, the comparative cross-country analysis was fundamental, since this contributed to analytically separating the generative mechanisms from the contextual contingency.

Empirically, this research contributes to current literature on universalism in social policy and health care, in particular, showing that the middle-classes have a role to play in the processes of advancing universalism, as well as the context in which the policy reforms unfold. Firstly, this study has corroborated that lower levels of universalism, or more segmented access to health care, associate with policy architectures that are prone to separate the middle-classes from other population groups and that drive forward individualised practices for accessing health care. I have also shown how the policy architecture of health care intersects with the welfare regime in which is embedded, in shaping both the policy outputs and the practices for health care.

Thanks to the production of primary information, I have also illustrated how the public and the private intersect in more complex ways than might be initially anticipated. Thus, more than clearly separating public and private options, this research has shown that both tend to coexist in the practices of the middle-classes, as was evident in the double insurance that the middle-classes usually have in Ecuador or even in the contracting of private mobile emergencies or other supplementary services by the middle-classes in Uruguay. It has also been demonstrated that the private sector is not even, but rather, made up of multiple tiers that associate with different benefits, costs and security for the middle-classes.

Also, the research has revealed the conditionings that the policy architectures and the welfare context impose over the middle-classes´ practices, thus demonstrating that far from being explained as individual preferences, they need to be understood as responses to the social context. Hence, transformations of these practices require to go hand in hand with shifts in the context and vice-versa. In other words, policy institutions and practices are entangled with each other either for their reproduction or transformation. This empirical recognition of the reciprocal feedback between policies and social agency constitutes an input for future research aimed at explaining policy trajectories towards universalism.

A last empirical contribution, and one that also has practical implications for policy development, is that the findings help to identify the barriers and entry points for the design and implementation of health reforms that seek to achieve universalism. They have shown that reforms to policy architectures do not always fit the broader characteristics of the context or the experiences and practices of the middle-classes. Thus, I contend that this research provides

inputs for identifying contextually relevant entry points for the development of health care policy in the countries studied, which might be extendable to other countries in the region.

8.5.- Future avenues for research

The last point to discuss relates to the identification of areas in which further research is needed. Some of them are about addressing the limitations of this study and others to the new avenues opened up by the analytical framework and findings.

The analytical framework proposed for this research highlighted the iterative, dynamic and contextualised character of the relationship between the policy architecture of health care, the policy outputs and the middle-classes´ practices for health care. The analyses carried out with the case studies constituted a first step in observing these variables in their reciprocal interactions. Nonetheless, and this is the first research avenue, there is a need to shed light on the kind of policy reforms required to promote health care practices among the middle-classes that support universalist aims, as well as whether and to what degree their practices can drive transformations in architecture, thereby contributing to transforming policy outputs. These aspects, mainly pertaining to the right side of the diagram of my analytical framework (see Figure 3.2), demand an effort to study them from a diachronic research strategy.

In the documental review I made an effort to examine not only at the current architecture, but also, at the trajectory of the health care policy. Nonetheless, this study did not observe the transformations of the middle-classes´ practices for health care over time. These are only indirectly addressed through the interviewees´ narratives. A diachronic strategy would shed light on, for instance, how these practices change (if they change) when the policy architecture is reformed, whether practices change with contextual shifts different from transformations of the policy architecture, and whether this leads to changes to the policy architecture, as well as the influence of the intergenerational reproduction of practices among others. Moments of profound social change, such as what has been observed in Chile in recent years with the ´Estallido social`, are excellent scenarios to develop these research avenues and to elicit, for example, whether the middle-classes, or some segments of the middle-classes, become active agents with a clearer impact on change processes.

A second research avenue that it would be fruitful to explore is the cultural conditioning on the practices for health care. Despite this kind of examination being beyond the scope of this thesis, it does not mean to deny that cultural conditionings are not playing a role in the observed social processes. Archer (1995), for example, incorporates culture into the morphogenetic approach. She points out that agents are always located within systems of meaning; they inhabit particular socially and discursively defined positions within the complex systems of social relations. Thus, cultural conditions also influence the processes of social production, as ´the battle between legitimatory and oppositional ideas form part of most social struggles and transactions` (Archer, 1995, p.305). Thus, including culture as another variable to consider would enrich the study and contribute to a better understanding of the complexity of the links between social institutions and social agency.

A third area to explore through further research is the extent to which the findings presented can be generalised to other policy areas, contexts and countries. The three generative mechanisms identified for universal/segmented health care can be considered as hypotheses and the starting point for future research. Regarding policy areas, the segmentation of access to education in Latin America makes it particularly relevant to undertake this kind of research. Likewise, it would be fruitful to analyse, with the necessary adaptations to the analytical framework, the segmentation present in the policy of pensions (e.g. with uneven benefits across occupational categories) as well as the role played by the entrance of market-based alternatives (e.g. schemes for voluntary contribution). As for different contexts, to go beyond urban settings and including the rural world supposes significant challenges. For example, being able to distinguish which and how much of the middle-classes practices for health care in rural areas respond to the lack of availability of certain health services (e.g. private options), difficulties of access, or patterns of relationship with the health system that are different because these middle-classes are not assimilable to the urban ones. Regarding the possibility of extending this line of research to other countries, it seems sensible to apply it in others of Latin America, now comparing countries with similar welfare regimes and thus testing the identified generative mechanisms. Moreover, the analytical framework of this research may be useful for applying in other regions with similar problems or even to countries that have achieved higher levels of universalism in health care, but that are currently under the threat of segmentation.

In terms of the methodological field, I previously discussed that further research is needed to achieve a comprehensive assessment of universal outputs (i.e. considering the five dimensions of universal health care). This assessment needs to be based on comparable indicators between countries and, at the same time, capable of capturing sufficiency and equity in coverage, generosity and financial protection, that is, specific enough to capture access to health care beyond raw averages. The construction of such a detailed proposal to assess the policy outputs of health care goes beyond the scope of this thesis and constitutes an area of research in itself. Moreover, this will have to cope with the challenge imposed by the gaps in reliable information in the countries, especially regarding more complex aspects, such as quality, service utilisation and effective access. In the three countries that were part of this research, for instance, there was a significant lack of information, especially in Ecuador, for analysing the utilisation of services and satisfaction with the health system by the middle-classes.

Also, regarding methodological aspects, the small N strategy adopted for this study allowed me to prioritise the depth of information gathered. However, this has implied that the findings are not extendable beyond specific segments within the middle-classes. The sampling criteria privileged exhaustiveness and were demanding to define someone as belonging to the middle-class. Hence, it could be argued that the findings and conclusions apply to that group of the consolidated middle-class and do not represent the entire middle-classes, which is coherent with the discussion presented regarding the heterogeneity within the so-called middle-classes. Consequently, the last research avenue that I would like to propose is the extension of the enquiry to other sectors of the middle-classes, which I am confident would provide new insights and complement what I have unfolded here.

Finally, it is impossible to conclude this thesis without referring to the global health and social situation in recent years associated with the Covid-19 pandemic. At the beginning of this research and during the development of the fieldwork, no one could even think that as humans we would face such a situation. A few years later, however, we are in the middle of a reality that

seems to be taken from two centuries ago. This pandemic has exposed inequalities in access to health care and well-being in the most radical way we could have imagined. The poor and vulnerable groups have been, as usual, the most affected, but the middle-classes have also experienced major shocks. Many of the so-called middle sectors fell into poverty (WB, 2020; CEPAL, 2021) and many others came to realise how unprotected they were against health risks, job loss, failures in care systems, among many other aspects that have put our habitual lifestyles in crisis. In this context, I would like to wrap up by expressing my profound hope that, beyond the merits and shortcomings of this research from an academic point of view, it will be a grain of sand that contributes on the road to building equitable health systems, fairer societies and a good living for all.

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APPENDIX

Appendix 1: Indicators to update the analysis of welfare regime

List of indicators used by Martínez Franzoni (2007) in the typology of welfare regimes in Latin America

Dimension	Indicators	Year	Source
Commodification in the labour market	Labour market participation (gross national, years 15–64)	1999	IDB
	Unemployment (national rate)	1999	IDB
	Female economically active population	1999	IDB
	Children participating in the labour force (ages 10–14)	1999	IDB
	Occupied salaried EAP (%)	2002	ECLAC
	Unqualified independent workers (%)	1999	ECLAC
	GNP (per capita, US$ 1995)	2003	ECLAC
	Poverty (as % of population under poverty line)	1999	ECLAC
	Income inequality (as Gini coefficient)	1999	ECLAC
	Remittances (as % of the GNP)	2003	WB
	Rural population	2000	ECLAC
Decommodification of welfare	Private expenditures on health care (per capita US$)	2001	PAHO
	Enrolment in private education (%)	2001	UNESCO
	Private consumption (as % of total consumption)	2002	ECLAC
	Public servants (% urban occupied population)	2002	ECLAC
	Expenditures in health care (per capita US$ 1997)	1999-2001	ECLAC
	Expenditures in education (per capita US$ 1997)	1999-2001	ECLAC
	Overall social expenditure (per capita US$ 1997)	1999-2001	ECLAC
	Overall social expenditures (as % of GNP)	1999-2001	ECLAC
	Salaried workers with social insurance (%)	1990S	UNDP
Defamilisation of welfare	Extended and compose families (%, urban)	1999	Arriagada
	Economically active women in reproductive years (15–34)	2003	ILO
	Female heads of households	2002	ECLAC
	Nuclear families, spouses with unpaid work (%)	2002	Arriagada
	Domestic servants (as % of urban employment)	2002	ECLAC
	Population under 12 years old (%)	2000	CELADE
	Population over 65 years old (%)	2000	CELADE
	Dependent population 12–64 years old (%)	2000	CELADE
Performance	Infant mortality (under 5 years old)	2003	UNICEF
	Homicides (per 100,000 people)	2001	UNDP
	Gender Human Development Index	2002	UNDP
	School life expectancy	2001	UNESCO

Source: Martínez Franzoni (2008)

List of indicators used in this research to update the welfare regime of Chile, Ecuador and Uruguay

Dimension	Indicator	Years	Source
Commodification in the labour market	Economic participation rate (% of the working-age population)	2000 and 2019	ECLAC
	Employees (% of the total employed population)	2000 and 2019	ILO
	Unemployment (Average annual rate)	2000 and 2019	ECLAC
	Women economic participation rate (% of the working-age women population)	2000/03 and 2015/19	ECLAC
	Children in employment, total (% of children ages 7-14)	2003/4 and 2012/15	WB
	Share of workers in informal employment (% of non-agricultural employment)	2000 and 2019	ILO
	GNI per capita, PPP (constant 2017 international $)	2000 and 2018/19	WB
	Poverty headcount ratio at $5.50 a day (2011 PPP) (% of population)	2000 and 2017/18	WB
	Gini coefficient	2000 and 2017	ECLAC
	Personal remittances, received (% of GDP)	2000 and 2019	WB
	Rural population (% of total population)	2000 and 2020	ECLAC
Decommodification of social welfare	Private health expenditure (% of Total Health Expenditure)	2000 and 2018	WHO
	Out of pocket health expenditure (% of Current Health Expenditure)	2000 and 2018/20	WHO
	School private enrolment, primary (% of total primary)	2002 and 2014/15/16	UNESCO
	Households and NPISHs final consumption expenditure (% of GDP)	2000 and 2019	WB
	General government final consumption expenditure (% of GDP)	2000 and 2019	WB
	Public expenditure on health care (% of GDP)	2000 and 2018	ECLAC
	Public expenditure on education (% of GDP)	2000 and 2018	ECLAC
	Public expenditure on social protection (% of GDP)	2000 and 2018	ECLAC
	Overall social expenditures (as % of GDP)	2000 and 2018	ECLAC
	Old-age contribution ratio (% labour force)	2000 and 2008/09/11	ILO
	Old-age pensioners recipient ratio above retirement age	2011/12	ILO
Defamilisation of social welfare	Extended and composite households (% of the total number of households)	2000/07 and 2017/19	ECLAC
	Domestic servants (as % of total employment)	2000/07 and 2017/19	ECLAC
	Women full-time to household chores (% of the population of women aged 15 and over)	2000/01/07 and 2017/18	ECLAC
	Female share of part-time employment (% of total employment)	2000/01 and 2012/14	ILO

	Female heads of households (% of the total number of households)	2000/07 and 2017/18/19	ECLAC
	Demographic dependency ratio (children and older persons)	2000 and 2020	ECLAC
Outcomes	Under-five mortality rate (Deaths per 1,000 live births)	2000 and 2019	WB
	Expected years of schooling	2000 and 2019	UNDP
	Gender Development Index (GDI)	2000/10 and 2019	UNDP
	Homicide rate (per 100,000 people)	2000/05 and 2018	UNDP
	Individuals using the Internet (% of population)	2000 and 2019	WB

Source: Own elaboration

Appendix 2: List of Interviews

Policy makers and scholars

Area	Position that motivates de interview	Country
Policy maker	Director of FONASA-Chile and former Vice-minister of Public Health during Michelle Bachelet´s first government	Chile
Policy maker	Director Super Intendencia de Seguridad Social (SUSESO)	Chile
Policy maker	General Secretary of JUNASA (2008-2009), Representant of the Ministry of Public Health at JUNASA (2010-2015), Director of the SNIS (2010 - 2015)	Uruguay
Policy maker	Former Vice-minister of Public Health during the Tabaré Vázquez first government	Uruguay
Policy maker	Former Vice-minister of Health Service Provision during Rafael Correa´s Government	Ecuador and Chile
Policy maker	Former Vice-minister of Governance and Public Health Surveillance during Rafael Correa´s Government	Ecuador
Scholar	Senior Social Affairs Officer, Social Development Division, ECLAC	Chile
Scholar	Member Presidential Commission of Health 2014	Chile
Scholar	Lecturer at Universidad Alberto Hurtado. Expert on social stratification	Chile
Scholar	Scholar at the Universidad de la República. Expert on Uruguayan health system	Uruguay
Scholar	Lecturer at Universidad de la República. Expert on political economy	Uruguay
Scholar	Lecturer at Universidad Católica de Uruguay. Expert on social protection	Uruguay
Scholar	Lecturer at Universidad de la República. Expert on Uruguayan health reform	Uruguay
Scholar	Lecturer at Universidad de la República. Expert on social security	Uruguay
Scholar	Lecturer at FLACSO Ecuador. Expert on social stratification	Ecuador

Members of middle-classes

Country	Fictitious name	Sex	Age	Position in household	N° members of household	N° children	Occupation	Employment status	Public/Private sector	Participation in social movements	Health Insurance/scheme	Date of interview
Chile	Cesar	M	36	Head-of-household	1	0	Engineer	Salaried	Private	Yes	ISAPRE	13.10.17
Chile	Catalina	F	37	Co-Head-of-household	3	1	Consultant in social research	Self-employed	Private	No	ISAPRE	13.10.17
Chile	Damian	M	44	Head-of-household	4	1	Businessman	Self-employed	Private	No	ISAPRE	18.10.17
Chile	Domingo	M	58	Co-Head-of-household	4	5	Medical doctor	Salaried	Public	No	ISAPRE	19.10.17
Chile	Emilio	M	41	Husband	4	2	Researcher	Self-employed	Int. Organisation	No	FONASA-CHILE	20.10.17
Chile	Elise	F	47	Co-Head-of-household	3	1	Manager	Salaried	Int. Organisation	No	ISAPRE	25.10.17
Chile	Esther	F	53	Co-Head-of-household	5	3	Geologist	Salaried	Private	Yes	ISAPRE	27.10.17
Chile	Flavia	F	41	Co-Head-of-household	3	0	Lecturer	Salaried	Private	No	FONASA-CHILE	30.10.17
Chile	Gonzalo	M	43	Co-Head-of-household	4	2	Lecturer	Salaried	Public	No	ISAPRE	02.11.17
Chile	Javiera	F	44	Head-of-household	1	0	Seller	Self-employed	Private	No	ISAPRE	25.11.17

Chile	Juan	M	41	Head-of-household	5	3	Engineer (Sales manager)	Salaried	Private	No	ISAPRE	04.12.17
Chile	Jaime	M	57	Co-Head-of-household	2	1	Civil servant (professional)	Salaried	Public	Yes	FONASA-CHILE	06.12.17
Chile	Dalia	F	60	Head-of-household	1	3	Lecturer	Salaried	Public	Yes	FONASA-CHILE	06.12.17
Chile	Ambar	F	45	Head-of-household	1	3	Lawyer	Salaried	Private	Yes	FONASA-CHILE	08.12.17
Chile	Luis	M	39	Son	3	0	Psychologist	Self-employed	Public	Yes	FONASA-CHILE	12.12.17
Chile	Luna	F	37	Head-of-household	3	2	Account executive	Salaried	Private	No	ISAPRE	23.12.17
Chile	Manuela	F	36	Co-Head-of-household	3	1	Educational psychologist	Salaried	Private	No	ISAPRE	05.06.18
Chile	Oscar	M	45	Co-Head-of-household	6	4	Agronomist	Salaried	Private	Yes	ISAPRE	07.06.18
Ecuador	Alex	M	38	Co-Head-of-household	4	2	Sociologist	Self-employed	Private	Yes	MSP	26.01.18
Ecuador	Andres	M	36	Co-Head-of-household	2	0	Civil servant (Directive)	Salaried	Public	No	IESS	30.01.18
Ecuador	Alicia	F	50	Co-Head-of-household	3	1	Lecturer	Salaried	Private	Yes	IESS + Private	02.02.18
Ecuador	Barbara	F	31	Co-Head-of-household	2	0	Civil servant (Directive)	Salaried	Public	Yes	IESS	02.02.18
Ecuador	Camila	F	57	Head-of-household	1	0	Administrative	Salaried	Private	No	IESS + Private	03.02.18

Ecuador	Cecilia	F	32	Daughter	5	0	Civil servant	Salaried	Public	No	IESS + Private	05.02.18
Ecuador	Dante	M	30	Co-Head-of-household	2	0	Owner and instructor of a yoga centre	Self-employed	Private	No	IESS + Private	08.02.18
Ecuador	Gabriela	F	31	Co-Head-of-household	3	1	Architect	Salaried	Private	No	IESS	12.02.18
Ecuador	Eduardo	M	54	Head-of-household	1	1	Civil servant	Salaried	Public	No	IESS + Private	13.02.18
Ecuador	Federico	M	63	Co-Head-of-household	2	2	Consultant	Salaried	Public	Yes	IESS	13.02.18
Ecuador	Isabel	F	37	Co-Head-of-household	4	2	Teacher	Salaried	Private	No	IESS + Private	14.02.18
Ecuador	Carmen	F	58	Head-of-household	1	2	Dentist	Salaried	Private	No	IESS + Private	14.02.18
Ecuador	Felipe	M	36	Co-Head-of-household	2	0	Manager and Touristic Guide	Self-employed	Private	Yes	IESS + Private	19.02.18
Ecuador	Laura	F	34	Head-of-household	2	1	Lawyer	Self-employed	Private	Yes	IESS	20.02.18
Ecuador	Gaston	M	37	Head-of-household	1	0	Journalist	Self-employed	Private	No	IESS	21.02.18

Ecuador	Marcela	F	46	Co-Head-of-household	5	3	Engineer	Salaried	Private	Yes	IESS + Private	21.02.18
Ecuador	Manuel	M	47	Head-of-household	4	2	Civil Servant	Salaried	Public	No	IESS	22.02.18
Ecuador	German	M	52	Co-Head-of-household	3	1	Civil Servant	Salaried	Public	Yes	IESS + Private	23.02.18
Uruguay	Alvaro	M	29	Head-of-household	1	0	Sociologist	Salaried	Public	Yes	IAMC (COSEN)	12.04.18
Uruguay	Antonia	F	38	Head-of-household	2	1	Teacher	Self-employed	Private	Yes	IAMC (COSEN)	13.04.18
Uruguay	Celeste	F	41	Co-Head-of-household	4	2	Editor	Self-employed	Private	No	Private	14.04.18
Uruguay	Claudia	F	41	Co-Head-of-household	4	1	Lecturer	Salaried	Public	Yes	IAMC (SMI)	16.04.18
Uruguay	Diana	F	41	Co-Head-of-household	4	2	Publicist	Self-employed	Private	No	Private	17.04.18
Uruguay	Eliana	F	29	Co-Head-of-household	2	0	Architect	Self-employed	Private	No	IAMC (SMI)	19.04.18
Uruguay	Daniel	M	52	Head-of-household	3	2	Teacher	Salaried	Private and Public	Yes	IAMC (La Española)	21.04.18
Uruguay	Francisca	F	47	Head-of-household	1	0	Communication officer	Salaried	Public	Yes	IAMC (SMI)	22.04.18
Uruguay	Enrique	M	32	Head-of-household	1	0	Designer	Salaried and Self-employed	Private	No	IAMC (La Española)	25.04.18

Uruguay	Felipe	M	40	Head-of-household	4	3	Business Manager	Self-employed	Private	No	IAMC (Evangélico)	25.04.18
Uruguay	Fabian	M	44	Co-Head-of-household	3	1	Chemical engineer	Self-employed	Private	No	IAMC (COSEN)	26.04.18
Uruguay	Ida	F	43	Head-of-household	3	2	Administrative	Salaried	Private	No	IAMC (SMI)	12.05.18
Uruguay	Isidro	M	57	Head-of-household	1	3	Consultant	Salaried	Public	Yes	IAMC (COSEN)	14.05.18
Uruguay	Gaspar	M	31	Co-Head-of-household	5	3	Lecturer	Salaried	Private	Yes	IAMC (COSEN)	14.05.18
Uruguay	Joanna	F	44	Co-Head-of-household	4	2	Civil servant	Salaried	Public	Yes	IAMC (COSEN)	15.05.18
Uruguay	Cristian	M	47	Head-of-household	3	1	Civil servant	Salaried	Public	Yes	IAMC (SMI)	15.05.18
Uruguay	Ramon	M	52	Head-of-household	6	4	Lawyer	Salaried	Private	No	IAMC (La Española)	17.05.18
Uruguay	Elizabeth	F	41	Head-of-household	1	0	Engineer	Self-employed	Private	No	IAMC (COSEN)	18.05.18