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The Politics of Universal Health Coverage: Mechanisms in the Process of Healthcare Reform in Bolivia

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1 Introduction

The quest for Universal Health Coverage (UHC) has been an enduring theme in discourses about global social development during the last decades (UN 2019; WHO 2010), and in recent years, many countries have adopted this goal as a national aspiration (Reich et al. 2016). Globally, important progress has been made in this respect, but healthcare reforms have on many occasions been inadequate, or sometimes even increased the fragmentation of health systems, with persistent inequities in health as a consequence (Vega 2013).

Bolivia is an example of a country that has long sought to recast a fragmented and exclusionary health system in order to universalise access and overcome stark inequities. The introduction of a universal public healthcare system, the *Sistema Único de Salud* (SUS), in 2017, thus represented

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a milestone in the struggle for UHC in Bolivia, and at least a partial departure from the historically prevailing institutional logic of Bismarckian social insurance. But the reform has been long in the making and the path towards its realisation has been winding and riddled with complications. The challenges partly echo those of other countries, rich and poor, that have adopted UHC as an aspiration for national policy (Roberts et al. 2003; Reich et al. 2016) or that have otherwise sought to overcome a "truncated" social insurance system (Holland 2018).

Drawing on the revived interest in causal mechanisms to which this book is a testament, this chapter employs a mechanism-based approach to explain the winding processes of healthcare reform in Bolivia. The purpose of the study is, beyond proposing building blocks for a modular explanation of this specific case, also to contribute to the identification of mechanisms of broader relevance for the comparative literature on welfare state politics in the Global South (Dorlach 2021; Lavers and Hickey 2016; Sirén 2021). The empirical analysis elaborates on and updates previous work (Sirén 2011), drawing on a combination of sources, including semi-structured interviews, newspaper articles, official documents and research reports. Theoretically, the chapter draws on comparative welfare state research (see, e.g. Gough 2008), while recognising the need for an approach to policy analysis that is "sensitive to the sometimes complex historical interplay of forces" (Hacker 1998, 58; cf. Falleti and Lynch 2009).

Six different mechanisms emerge from the exploration of health system reform in Bolivia. Firstly, policy emulation by *expert theorisation*, whereby transnational epistemic communities influence the social construction of which policies are considered appropriate, was decisive for the emergence of an orientation of health policy that focuses on health as a citizenship right and a duty of the state. Secondly, *class-based mobilisation*, coloured by the protagonism of the indigenous peoples' movements in the political coalition that came to dominate Bolivian politics from 2005 onwards, was decisive for turning these ideas into government policy. Thirdly, *social movement–state interaction*, involving relatively autonomous public officials engaging in dialogue with the social movements making up the support coalition of the leftist government, shaped the orientation of the reform initiatives and gave the process sustained force.

A fourth mechanism, the *alarmed middle classes*, makes reference to the role of formal sector workers covered by the existing social health insurance funds and organised through the main trade union confederation, as a pivotal interest group whose contingent consent proved to be crucial for the advancement of a more transformative reform. A similar logic, whereby previous policies generate groups with interests in the preservation of existing institutional arrangements, fostered resistance also among employees of the health insurance funds, through a fifth mechanism labelled *provider resistance*. Lastly, healthcare systems rely on a powerful profession keen to act in defence of its autonomy. Indeed, the medical profession reacted to proposals for increased government regulation of their profession as such measures were perceived as a threat to their privileges and autonomy, giving rise to a specific mechanism here referred to as *professional autonomy*.

The analytical approach of the study is further elaborated in the next section, introducing how theories from comparative-historical research on welfare state development have been used to identify potentially relevant modular causal mechanisms. The following sections then delineate the process of healthcare reform in Bolivia and highlight sequences of events of particular relevance for the progress towards UHC. The chapter concludes with a summary of mechanisms making up the building blocks of the provided explanation, along with a few preliminary notes on how to further improve our understanding of the workings of the identified mechanisms.

2 Explaining Healthcare Reform: Causes and Mechanisms

The right to health can be seen as one dimension of a broader concept of social citizenship (Marshall 1950), and healthcare systems are fruitfully understood as embedded within the larger organisation of the welfare state (Quadagno 2010). The idea of social citizenship implies universalistic claims and is realised through the extension of social rights to every member of society, whereby the state is committed to its responsibility

for the welfare of its citizens. Within social policy research, universalism is moreover often understood as a specific characteristic of welfare state institutions that cater to the needs of all citizens, including the poor and more affluent workers within the same programmes (cf. Leisering 2019). In the same vein, universalism is a key concept in the literature on healthcare reform, describing an aspiration of health policy as well as a characteristic of health systems (see, e.g. Quadagno 2010).

Comparative analyses of healthcare systems typically focus on how countries compare with regard to the provision, regulation and financing of health services. Reflecting systematic differences between countries on these dimensions, two basic models of national health programmes stand out (Wendt et al. 2009; Navarro 1989). Within a *National Health Service* (NHS) or Beveridge system, the state is the main provider of healthcare through tax-financed services, while in *insurance-based* systems, the role of the state is more limited and restricted to regulating the function of insurance agencies whose services are funded by fees. Universality and social solidarity are core principles within NHS systems, but also systems based on compulsory social insurance have fostered virtually universal coverage in advanced capitalist economies. These systems thus represent parallel historical routes towards the expansion of health coverage, but with different causes and distributional outcomes (Navarro 1989; Quadagno 2010).

Previous research on the causes of institutional change in health policy reflects theoretical developments in the broader field of comparative welfare state research (this is clearly reflected in, e.g. Hacker 1998; Quadagno 2010; Béland 2010). A central perspective within this literature, power resource theory (Korpi 1983), has established the micro-foundations of a class-based mobilisation mechanism to explain welfare state development. This approach assumes purposive and reasoning actors, intentionally seeking to modify the market distribution of welfare. In particular for the working class, the efficacy of such action is supposedly enhanced by collective organisation, leading to mobilisation through trade unions and social democratic parties. Democracy and the extension of political citizenship moreover hold the promise of a more level playing field between social actors with asymmetric power in the marketplace, including on the labour market. This makes using the political arena to expand and enrich

social citizenship a central strategy of social democratic and other left-wing parties with their main constituencies in the working class. The extension of encompassing social policies is accordingly a core goal of working-class mobilisation, and the emergence of a comprehensive government health programme would accordingly be directly related to "the strength of the working class and its political and economic instruments" (Navarro 1989, 897). Beyond the strife to shift distributional struggles from the market towards the realm of democratic politics, trade unions and social democrats have also sought ways to resist or transform institutions fomenting the segmentation of social rights, including corporatist social insurance (Korpi 2001). Similar frameworks, emphasising the role of political parties on the Left, are now also being employed in explanations of the expansion of welfare policy in the Global South (Sirén 2021), not least with regard to Latin America (Huber and Stephens 2012).

Institutionally oriented scholars have in turn argued for an appreciation of the role of historical sequence, timing and contingency (Hacker 1998), emphasising the importance of policy feedback and institutional veto points (Thelen 1999; Pierson 1996). These insights are arguably important in order to understand the emergence of other organised interests or "power groups" (Navarro 1989) engaging in struggles over the organisation of health systems. Institutionalists have highlighted that welfare state expansion in itself produces new interest groups composed of beneficiaries and providers, who are swiftly mobilised in face of perceived threats to the policies from which they benefit (Pierson 1996). The character of existing social insurance institutions is thus likely to influence the mobilisation of current beneficiaries and providers of healthcare services.

The particular resilience of state corporatist social insurance institutions has moreover been attributed to the involvement of trade unions in the management of these programmes, making them resemble "well-organized regiments that can be mobilized with short notice" (Korpi and Palme 2003, 442). When such counter-mobilisation happens in reaction to government attempts to universalise access to contributory social insurance, we could speak of an alarmed middle classes mechanism, as it is generally not the most marginalised groups that benefit from social insurance systems in the Global South, but a less deprived and better

organised "middle class" of formal sector workers (cf. Rudra and Tobin 2017). When resistance comes from those providing the services, seeking to maintain their position, we can instead speak of a provider resistance mechanism.

The role of the middle classes can also be understood in light of scholarship focusing on social capital, and generalised trust in particular. Research has underlined the importance of trust for the possibility of acquiring contingent consent from the middle classes to universal social policy, while also stressing the institutional origins of such trust (Rothstein 1998; Levi 1993). In such a view, well-functioning and impartial government institutions increase generalised trust, making it more likely that ambivalent middle classes will consent to universal public policies. Social insurance systems of the Bismarckian kind, on the other hand, are prone to foster a "compartmentalised" form of trust reserved for one's own group, while preventing the development of generalised trust (Rothstein and Stolle 2003). Given the legacies of widespread corruption and ineffective institutions, in combination with the legacies of social insurance, it is accordingly likely that universalistic reforms are perceived as threats by groups that are privileged by the segmented social insurance system. The quality of government institutions thus emerges as a contextual factor with potential relevance for shaping the alarmed middle classes mechanism.

Theories about the impact of states on social policies have moreover highlighted that the relatively autonomous "collectivities of administrative officials can have pervasive effects on the content and development of major government policies" (Skocpol 1985, 12). This perspective encourages scholars to appreciate state bureaucracies as independent actors and to assess how state capacities to formulate and implement policies impact on processes of institutional change. However, state officials may not only have interests stemming from their position within the administration, but may additionally have ideological motivations. Tulia Falleti argued that subversive actors within the Brazilian healthcare system were able to push for more universal policies following the "infiltration of the state by reformist elements of society" (Falleti 2009, 40). Analogous arguments can be found in the literature on state feminism (Stetson and Mazur 1995), highlighting how political activists, through their

engagement with existing state institutions, create new opportunity structures through which they can pursue their aims (Chappell 2000). Along these lines we might thus additionally think of a mechanism of social movement–state interaction comprising, in a first step, activists with a reformist agenda occupying positions in the state bureaucracy, and subsequently relatively autonomous activism on the part of these public officials, interacting with social movements in shaping public policy rather than merely responding to societal pressures.

In addition to the abovementioned perspectives, there is an emerging literature emphasising the role of ideas, and particularly their transnational diffusion, for developments in social protection policy, not least with reference to the Global South (Béland 2010; Weyland 2006; Lavers and Hickey 2016). Research on social policies has commonly highlighted the role of International Organisations (IOs) for the spread of particular policies across countries (Leisering 2019), and recent scholarship has also emphasised the importance of South–South exchange in this regard (Stone et al. 2020). While different mechanisms have been implied by this literature, including coercion, competition and learning, sociological research has mostly been concerned with the mechanism of emulation, referring to the social construction of appropriate policies (cf. Leisering 2019). Weyland (2006), for example, found emulation to be of relevance for the establishment of the universal right to health for all as an overarching norm among policymakers across Latin America. Unlike the other commonly specified mechanisms of policy diffusion, emulation does not assume rational assessments of policy consequences, focusing instead on the adoption of appropriate policies conforming to prevailing norms (Gilardi and Wasserfallen 2019). A mechanism that can generate such diffusion processes is through expert theorisation within epistemic communities (Haas 1992), but emulation may also result from countries following the lead of a perceived role model or by policymakers imitating policies pursued in countries perceived as close or similar (Dobbin et al. 2007; Weyland 2006).

The role of the medical profession has moreover been a salient theme in health systems research (Immergut 1992; Wendt et al. 2009). As noted by Jacob Hacker, in no Western country have physicians wholeheartedly welcomed the extension of government control over the healthcare sector

(Hacker 1998, 66). This reflects the fact that the introduction of national health insurance inescapably involves an inherent conflict of interest between governments and doctors as the buyers and sellers of medical services, respectively (Immergut 1992, 58). Still, the medical profession has not everywhere been equally resistant to government intervention, arguably reflecting the differential structure of healthcare markets and government institutions, with consequences for the preferences, orientations and relative strengths of professional organisations (Hacker 1998). One would accordingly expect a mechanism of professional autonomy, shaped by the historical legacies of the existing healthcare system, to unfold in the face of government attempts to increase the scope of its control and regulatory capacities.

In the next section, the development of the Bolivian healthcare system is explored in light of these theoretical insights. The narrative starts with an introduction of the historical context of healthcare reform, before reviewing the various attempts at realising the promise of healthcare for all in Bolivia, underscoring the identifiable causal mechanisms as they impinge on this process.

3 The Progress Towards Universal Health Coverage in Bolivia

3.1 The Emergence of Social Health Insurance

The origins of social health insurance in Bolivia can arguably be described as a confluence of the mechanisms of class-based mobilisation with a form of policy emulation driven by the adoption of policy scripts advocated by IOs (primarily the International Labour Organization, ILO) and the inclination of the Bolivian government to follow the examples of countries perceived as pioneers in social protection.

The national revolution in 1952 comprises a major branching point in the history of Bolivia, with fundamental impacts on state–society relations. The trade union movement, organised through the encompassing trade union confederation, the *Central Obrera Boliviana* (COB), and

centred around the mining workers' union, was instrumental for the revolution and gained considerable influence over the first post-revolutionary governments of the *Movimiento Nacionalista Revolucionario* (MNR). The other leg of the labour movement, the mainly indigenous peasants' movement, organised primarily through the *Federation Sindical Unica de Trabajadores Campesinos de Bolivia* (CSUTCB), also allied itself with the revolution and managed to push through extensions of suffrage and agrarian reform. In the post-revolutionary period, class was made the dominant form of expression of social identity in state–society relations, subsuming the indigenousness of the peasant movement to worker-based leftist ideologies (Postero 2010; Regalsky 2010).

It was in this context that social health insurance was introduced in Bolivia, with the adoption of the Social Security Law of 1956. The legislation built on the law on Obligatory Social Insurance from 1951, drafted with support from the Spanish government and influenced by the Iberian-American Social Security Organization (OISS). The 1956 legislation was in turn a result of a collaboration of representatives from the International Labour Organization (ILO), national specialists and a committee of deputies (Bocangel Peñaranda 2004). It included sickness, maternity, old-age, work injury and family benefits as well as social housing and was to be funded by tripartite contributions from employers, employees and the government. This system was based on a Bismarckian social insurance logic with the intention that, as industrialisation progressed and formal employment grew, universal coverage would eventually be achieved.

Social insurance did grow to become the most important subsystem in the Bolivian national health system, but the hopes for universal coverage failed to materialise as the Bolivian economy is still today characterised by very high levels of informality, even compared to other Latin American economies (Medina and Schneider 2018). Starting at a coverage rate of around thirteen percent of the population at the time of the introduction of social security in 1956, the rate gradually increased to a peak at around twenty-seven percent in the early 1980s. This rate then declined slightly during the 1980s, partly because of layoffs resulting from the structural adjustment policies implemented at the time. Coverage then started to grow slowly again over the course of the following decades, standing at

around thirty percent in the mid-2000s (see Fig. 12.1). Accordingly, despite the progress made during previous decades, a majority of Bolivians has lacked effective health coverage, with particularly high rates of exclusion among the poor, rural and indigenous population (Chacón and Valverde 2009).

Moreover, fragmentation in the Bolivian social health insurance system has increased over time, as the number of social health insurance funds (*Cajas de salud*) has grown over the years, from three originally to eight today. The system, indebted to the alliance between the first post-revolutionary government and the COB, moreover instituted the unions as important veto players by granting them influence over the management of the healthcare funds. However, in combination with political interference, this system has made the *cajas* major sites of patronage, nepotism and corruption (Bocangel Peñaranda 2004, 69), arguably setting the scene for the unfolding of the alarmed middle classes mechanism in response to the reforms that were eventually attempted.

3.2 Democratisation, Decentralisation and Neoliberalism

Democratisation after 1982 was accompanied by severe economic crises and hyperinflation. With support from the IMF, the government soon adopted a neoliberal structural adjustment programme, under the banner of the New Economic Policy in 1985. While seemingly curbing hyperinflation and stabilising the economy, reductions in public employment, flexibilisation of labour markets and austere budget policies also led to harsh social costs and came to weaken the class dimension in Bolivian politics, especially the influence of the COB.[1] Instead, the re-installation of democracy marked the beginning of the gradually increasing importance of other social movements, most prominently the peasant workers' unions, indigenous movements and women's organisations. The 1990s

[1] The privatisation of the mining industry, and the subsequent "relocation" of workers towards the peri-urban areas around El Alto in the highlands and the coca growing region of Chapare, proved to unintendedly foment the emergence of new social movements in the following decade (Postero 2010, 21–22).

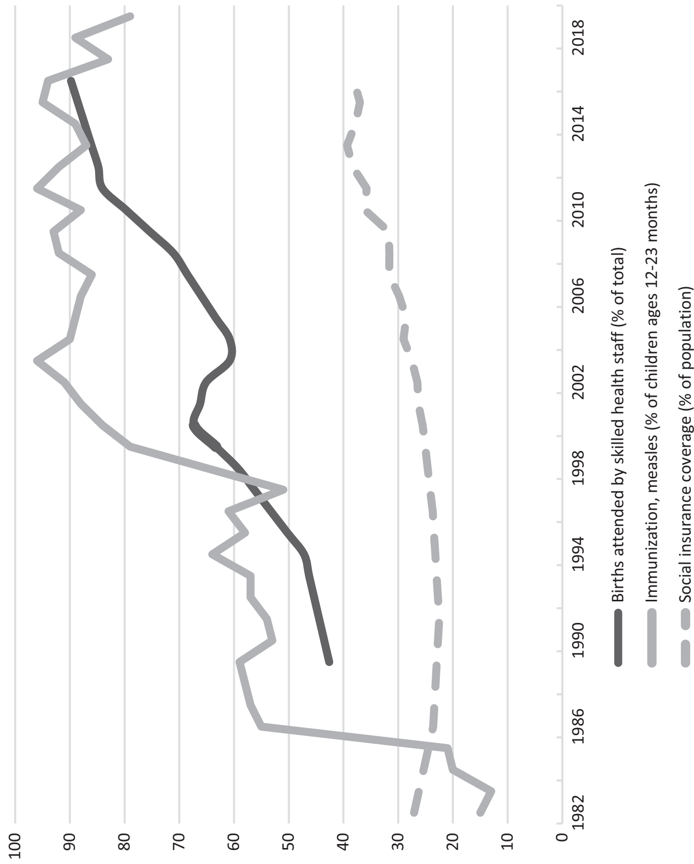


Fig. 12.1 Health indicators for Bolivia, 1982–2019. (Source: World Bank: World Development Indicators)

saw a growing salience of indigenous groups in the political landscape, primarily the *Confederation Indigena del Oriente Boliviano* (CIDOB) as well as the emergence of "identity politics" and multiculturalism as salient political themes (Postero 2010; Regalsky 2010).

While the social health insurance system was left largely untouched by the government during the decades following the return of democracy, a public system was gradually rolled out alongside. The first government after the return of democracy, headed by Hernán Siles Suazo of the MNR, came to introduce the concept of health as a human right and launched several public programmes, including health brigades in rural areas, popular health councils, vaccination campaigns and free medical care in relation to childbirth. The orientation of public health policy at this time was arguably shaped by the international influences regarding what was considered appropriate health policy, thus fostering policy emulation. In particular, crucial inspiration was provided by the International Conference on Primary Health Care held in Alma-Ata (WHO 1978). The effects of this stronger emphasis on public health can be seen in a stronger focus on issues related to maternal and infant health and communicable diseases, visible in the statistics on the share of births attended by skilled health staff and immunisation rates depicted in Fig. 12.1.

Although economic crisis, hyperinflation and the subsequent cuts to government expenditure hampered the expansion of a more comprehensive public healthcare system at the time, these initiatives marked the entry of the principles of primary care in Bolivian healthcare politics and would come to influence the future development of public programmes. Not least, by introducing and deepening public programmes in rural areas, a space was created where alliances between medical professionals and social and community organisations could be cultivated, an interaction which would prove to be crucial for later developments.

3.3 Transnational Influences and New Repertoires of the Social Movements

Reflecting a discursive change among international financial institutions towards a recognition of the instrumental value of social infrastructure

for the promotion of sustained economic growth and a fertile investment climate, the 1990s were characterised by structural adjustment policies simultaneously promoting ideas about indigenous citizenship, cultural recognition, decentralisation and popular participation, on the one hand, and privatisation and "capitalisation", on the other (Kohl 2002). The failure of these political reforms to actually revamp exclusionary social structures and ameliorate poverty frustrated many of the indigenous and less affluent segments in Bolivian society, thereby promoting the search for new strategies for political intervention among these groups (Postero 2010; Haarstad and Andersson 2009).

The policies of decentralisation and popular participation pursued during the 1990s had several unforeseen consequences. One such consequence was increasing opportunities for interaction between medical doctors and social movements in indigenous and rural communities, following the municipalisation of health policy. A strong current within the medical profession was already at that time heavily influenced by the Latin American social medicine tradition, which had emerged in the 1970s, promoting the importance of economic, political and social determinants for understanding the reproduction of health inequalities and advocating for healthcare as a social right and responsibility of the state (Tajer 2003). Organisationally, this current was articulated by the Latin American Association of Social Medicine (ALAMES). The intermingling of this epistemic community with the emerging social movements at the local level seems to have caused an amalgamation of the social medicine agenda with the demands for social justice coming out of the rural and indigenous communities (cf. Falleti 2009).

A two-stage process of policy diffusion is accordingly distinguishable. Firstly, there was an instance of diffusion through a regional network with the function of a transnational epistemic community. Secondly, in connection to their work in marginalised communities, these ideologically motivated health professionals came to associate themselves with the emerging social movements, thus transferring ideas and knowledge from the transnational context to the site of local struggles for redistribution and recognition. Through this process, these ideas were intertwined with the demands voiced by the emerging social movements, who accordingly came to adopt the understandings and policy prescriptions advocated by

the social medicine tradition as their own. Arguably, expert theorisation, with the support of regional epistemic communities related to health policy, was thus an important mechanism for shaping ideas about what constituted appropriate health policy among the agents that would later assume responsibility for the direction of state policy.

Another consequence of the particular blend of pro-market structural adjustments policy and a decentralisation process with multicultural underpinnings was a growing frustration with the effects of neoliberal economic policy, especially in indigenous communities. This frustration was increasingly channelled towards official institutions at the local level, in particular following the municipalisation of politics implied by the Law on Popular Participation from 1994. In this context, a coalition of peasants' unions, spearheaded by the CSUTCB, formed what they called a Political Instrument for the Sovereignty of the People in the mid-1990s. The "instrument" eventually took over the name and legal identity of a pre-existing political party, the *Movimiento al Socialismo* (MAS) (Postero 2010). The parallel processes of precarisation and democratisation thus seem to have set in motion a chain of events reflecting the mechanism of class-based mobilisation. This sequence displays clear analogies with the circumstances and strategies employed by labour movements in Western Europe around the turn of the last century, when social democratic parties were founded as the political instrument of labour unions as the political arena became the focal point of struggles for political recognition and social citizenship (cf. Korpi 1983).

3.4 Mobilising for the Right to Health

As the neoliberal agenda of privatisation and capitalisation was continued over the course of the 1990s and early 2000s, reoccurring massive protests erupted, particularly against the government's plans to privatise water and natural gas. The "water war" in the year 2000 marked the beginning of a cycle of popular protests that resulted in the demise of two presidents and the virtual collapse of the traditional party system in Bolivia (Faguet 2019). During this time, MAS emerged as the main opposition party with a variety of associations, including the unions of teachers, street vendors and factory workers, as well as urban

neighbourhood associations and left-leaning intellectuals allying with the party, thus broadening the party's appeal also among the *mestizo* urban middle class (Madrid 2011). In the elections following the resignation of Carlos Mesa in 2005, MAS's candidate Evo Morales, the former leader of the coca growers' union, gained the presidency with fifty-four percent of the votes, and MAS managed to win a majority in the chamber of deputies, but fell short of a majority in the senate.

The electoral programme for the run-up to the 2005 elections is a testament to the influence of the social medicine tradition on the party's health policy, stating that the health system should be based on a social conception of health and characterised by "the identification and transformation of the determinants of health-illness and not only addressing its effects" (MAS-IPSP 2005, 113, author's translation). With MAS in government, positions within the Ministry of Health and Sports (MSD) were being occupied by officials with close ties to ALAMES, as well as with the social movements and various left-wing parties. Not least was the strong emphasis on social medicine represented by the first minister of health appointed by Morales, Nila Heredia.[2] This not only corresponds to the first stage in the social movement–state interaction mechanism defined earlier, but also builds on the diffusion of ideas associated with the Latin American social medicine tradition, thus pointing to the importance of recognising the political circumstances causing expert theorisation to foster actual policy change.

Following demands from the social movements, the formation of a constituent assembly was the most central promise of Morales' candidature in 2005 and became the main political project following his installation as president. The MSD was actively engaged in the discussion about the inclusion of the right to health within the working groups set up to draft the new constitutional text. The ministry organised discussions on healthcare policy through departmental assemblies as well as a national pre-constituent assembly on health, with representatives from civil society, the social movements and the medical profession. Central topics

[2] Heredia, Bolivian physician with a master's degree in public health and who participated in the leftist resistance movement under dictator Hugo Banzer in the 1970s, served as Minister of Health in 2006–07, and again in 2010–11, and as coordinator of ALAMES 2009–14.

arising from these deliberations were the recognition of health as a fundamental right, and the responsibility of the state to guarantee access to healthcare for all, but also the incorporation of communitarian and indigenous notions of healthcare (Johnson 2010). These themes eventually found their way into the constitutional text adopted in 2009, which includes formulations about the state's obligation to guarantee the universality of the right to healthcare, as well as the necessity of having a unitary health system to which access should be free of charge (Constitución Política del Estado 2009). This sequence of events thus represents a telling example of the social movement–state interaction mechanism, with public officials actively shaping the political agenda through iterative communication with social movements, rather than merely responding to calls from societal actors.

The initial institutional strategy suggested by MAS in order to reach the goal of universal health coverage was to extend access to the existing public insurance programmes, primarily the public scheme for mothers and infants as well as the old-age health insurance, to the entire population not insured by the social health insurance funds (MAS-IPSP 2005). The early orientation of health policy in the new administration is described in the National Development Plan from 2006, which specifically contemplates universal access to healthcare through the implementation of a new intercultural, community-based family health system. This was also reflected in the first legislative proposal of the Morales government in this respect, which envisioned the introduction of a new universal health insurance programme, *SuSalud*, that would incorporate all persons up to the age of twenty-one within a public insurance system. The government envisioned this as a first step towards reaching UHC through a gradual extension of these rights to the entire population, pending availability of sufficient resources to fund such an expansion (Bill 005/2007).

Funding was obviously a fundamental obstacle for a truly transformative reform. This issue was at the time intimately connected with the question of "nationalising" the country's hydrocarbons sector. Bolivia has one of the largest deposits of natural gas in the region, and stronger state control as well as redistribution of revenues from the sector had been central demands from the social movements in the run-up to the 2005

elections. The Morales government soon took action to strengthen the regulatory role of the state in this sector, to renegotiating concessions with the foreign companies, and introduced new fees and taxes on hydrocarbon extraction. A cornerstone of this policy was the introduction of the *Impuesto Directo a los Hidrocarburos* (IDH), which was channelled directly to the departments, municipalities, as well as universities and indigenous communities (Kaup 2010, 131). Eventually, the escalating regional and ethnic tensions during the negotiations over the new constitution resulted in a political deal being struck in which the government conceded far-reaching autonomy to the departments in managing their revenues from natural resources, in order to appease the oppositional forces based in the eastern lowlands (Postero 2010).

The newly introduced IDH was envisioned as the main source of funding for the *SuSalud* reform (Bill 005/2007). However, the centralisation of departmental resources implied by the proposal would mean significant redistribution from the wealthier lowlands to the more populous highlands. Consequently, four oppositional eastern departments opposed *SuSalud* (Santa Cruz 2010), arguing in favour of using the funds from the IDH for autonomous public health insurance programmes at the departmental level (see, e.g. Galindo Soza 2010). Accordingly, although the government proposition on *SuSalud* was in a first instance passed by the Chamber of Deputies, where MAS held the majority of seats, resistance from the opposition however resulted in it never being discussed in the Senate, which at the time was dominated by the opposition.

This sequence of events illustrates the mechanism of class-based mobilisation, with resistance to reform coming from traditional and economic elites. The constitution of MAS as a "political instrument" of the social movements representing the less affluent classes gave sustained presence to these demands in the political arena. The electoral success of MAS, as well as the sustained mobilisations of the social movements during the first years of Morales' presidency, arguably helped bringing the issue of universal health coverage to the fore. MAS's electoral success also brought ideologically driven actors into central positions in the Ministry of Health, setting in motion another mechanism, that of social movement–state interaction. The configuration of the political institutions, especially the devolution of decision-making power to the departments, constitutes

a pivotal contextual factor activating regional cleavages and providing oppositional forces allied with the country's traditional elites with veto points where the government's initiatives could be blocked.

3.5 Reactions from Labour and the Medical Profession

In 2010, after the approval of the new constitution, Morales was re-elected as president by a broad margin, and MAS won a majority in both chambers of parliament. Still, recognising the difficulties in moving forward with a reform that would require consent from the departments regarding the use of the funds raised through the IDH, the Ministry of Health assumed a new strategy, now proposing an entirely public system, the *Sistema Único de Salud* (SUS), based on the NHS model. Policymakers saw breaking with the Bismarckian social insurance logic of the existing system as a way to overcome fragmentation and segmentation, perceived as particularly problematic in the context of a highly informal Bolivian labour market.

A first step in this direction was taken in the budgetary law for 2011, which demanded that the health insurance funds' financial resources are deposited in accounts supervised by the Ministry of Finance, with the ambition to strengthen the government's ability to monitor the system (Law 062/2010). This move by the government caused immediate reactions, which can be explained by the alarmed middle classes mechanism. Beneficiaries and employees of the health insurance funds, together with the La Paz branch of the union of medical doctors employed in the social insurance system (*Sindicato Médico y Ramas Afines*, SIMRA), immediately signed a joint statement with the workers' confederation, the COB, denouncing this move by the government. While claiming to support the idea of universal access, the organisations clearly stated their disapproval of reduced independence of the *cajas*, fearing that the social contributions paid into the funds would be diverted in order to finance the expansion of the public system (Sirén 2011, 34).

The ministry later organised a series of departmental health congresses where the new proposals for healthcare reform were debated and where delegates were elected to a national health congress held in January 2011. Here, the proposals from the MSD were debated and agreed upon, in the presence of representatives from the health sector and social movements (MSD 2011), again highlighting the relatively autonomous role of state actors in structuring the debate over the reform along the lines of the social movement–state interaction mechanism. And, as a manifestation of their discontent with the government's ambition to intervene in the management and financing of the *cajas*, the COB refused to participate in the congress (e.g. Los Tiempos 2011), thus continuously acting in accordance with what the alarmed middle classes mechanism would suggest.

Interviews with representatives from the COB reveal a critical aspect of how the alarmed middle classes mechanism unfolds in this particular case. The unions' resistance towards authoritarian governments in the 1970s and early 1980s, as well as towards the neoliberal economic policies pursued during the decades following the return of democracy, seemingly constitute a historical legacy provoking an anti-statist posture of the labour confederation, and a reluctance to cede control over social health insurance, won through previous struggles and now perceived as "patrimony of the workers" (Sirén 2011, 34). Moreover, unions accused the government of not complying with its obligations as an employer in funding social health insurance, raising doubts about the commitment of the state to support the new system financially. These observations underscore the possibly pivotal role of trust for the proclivity of ambivalent middling segments of the population to consent to universal social policy solutions and thus for the alarmed middle classes mechanism.

The ambition to incorporate the health insurance funds into a fully public system continued to spur resistance, in a situation where the popularity of the government was already seriously compromised due to a recent decision to discontinue a number of fuel subsidies, causing a wave of protests referred to as the *gasolinazo* (Deheza 2012). In March 2011, the medical doctors' association (*Colegio Médico*) launched a strike opposing a new law regulating the medical profession, while also voicing their

disapproval of the incorporation of the social insurance funds into the public system. This can be explained by both the professional autonomy mechanism and the provider resistance mechanism, pointing to the broader interests of physicians as a profession, as well as the more specific views of those employed by the social insurance funds. The conflict over the future of the social insurance funds also coincided with a strike for higher salaries for healthcare employees, which further fuelled the ongoing mobilisations against government intervention along the same logic, an effect that can thus also be explained by the provider resistance mechanism. In response, the government aired the idea to use its position as employer to move all public employees currently insured with the *cajas* to the proposed public scheme, thereby debilitating the funds to the point where these would have to merge with the public system out of self-interest. Simultaneously, several indigenous organisations, allied with the government and supportive of the reform proposals, came out in defence of the plans to implement a unified NHS-type system (Sirén 2011).

The chain of events described above also illustrates how the institutional context contributes to structuring conflicts over health reform by the way in which defensive strategies are activated. In the conflicts over regulation and funding, COB and to some extent also the professional organisations in the health sector emerged as veto players, despite the government's power to take legislative action following MAS's landslide victory in the 2009 elections, which gave the party a majority in both chambers of parliament. This observation underscores how the alarmed middle classes mechanism is underpinned by the presence of corporatist social insurance in the existing health system, as it both structured the interests of these actors and provided them with opportunities to act as de facto veto players due to their position within the system.

3.6 Reassembling a Reform Coalition

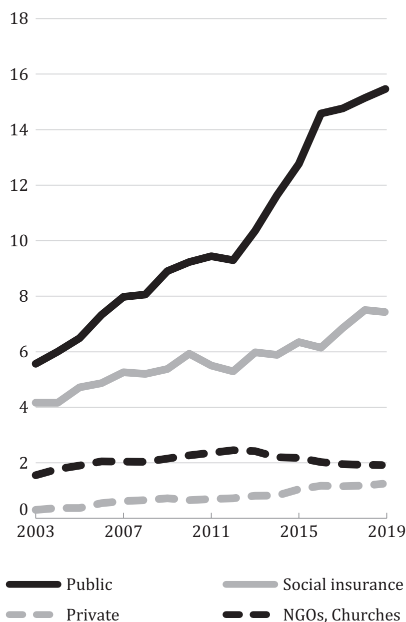
While the plans to unify the healthcare system were not realised at the time, the government eventually managed to get less contentious legislation passed that integrated the two existing public insurance schemes, the infant and maternal health programme and the old-age health insurance

scheme, into one integrated programme with stable sources of state funding, while also extending the range of services covered (Law 475/2013). With this legislation in place, growth in public provision and financing of health services accelerated, reflected for example in the number of health consultations conducted by the public sector as well as in the government's share of total health expenditure, and mirrored in a falling rate of out-of-pocket expenditures (see Fig. 12.2).

Against this backdrop of a more extensive public subsystem, 2018 marked the beginning of a new cycle of discussions about rolling out a universal healthcare system. In September, Evo Morales announced that the government would set aside USD 200 million during the next year in order to implement Free Universal Health Insurance. The president also emphasised that only resources from the National Treasury would be used and that the social insurance funds would be left untouched (MSD 2018a). This announcement was followed by an initiative from the MSD to organise a new series of meetings at different sites around Bolivia to discuss the new plans to once again implement the *Sistema Único de Salud*, SUS (MSD 2018b).

These meetings were swiftly followed up with the passing of a new law that replaced the legislation from 2013 and extended access to a defined package of free healthcare services to the entire population not covered by social insurance. The law moreover envisions a gradual extension of the number of services to be included. Funding was to come from the budget of the central government, as well as from the municipalities' own resources in the case of primary and secondary care for the benefit of their own residents (Law 1152/2019).

The government's new orientation seemed to have appeased resistance from the COB, which now came out as willing supporters of the new policies, with the alarmed middle classes mechanism thus apparently no longer playing a key role. This was not least made clear by the leader of the COB, Juan Carlos Huarachi, as he spoke at the ceremonial signing of the new law, stating that "The COB will defend [universal healthcare] because it is for my brother, my brother-in-law, my nephew, even my friend, we should all fight to defend its implementation, no longer will health be commercialised or private" (Opinión 2019, author's translation). The new system was officially inaugurated on 1 March 2019,



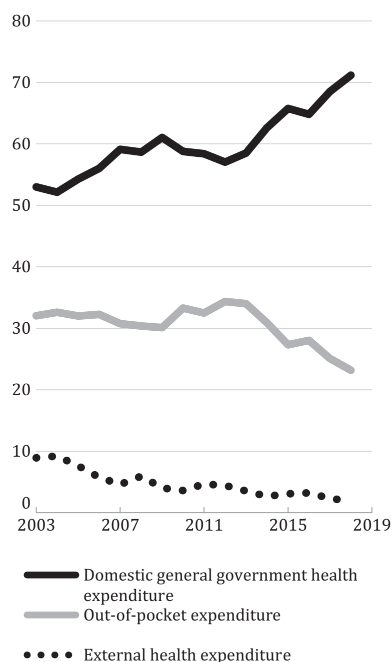


Fig. 12.2 Healthcare system indicators, 2003–2019. (**a**) External consultations (millions), by subsector. (**b**) Health expenditure (% of current health expenditure), by source. (Sources: (**a**) UDAPE 2020. (**b**) World Bank: World Development Indicators)

giving all Bolivians the right to free medical care, in the form of a package comprising 300 defined treatments. The legislation was followed up with an agreement between the COB and the government about a legislative initiative supporting the development of the main social insurance fund, the *Caja Nacional de Salud* (CNS), through the construction of a large number of health centres and hospitals, using funds accumulated in the CNS.

Still, medical doctors employed in the CNS continued to protest also against these policies, referring to their exclusion from the negotiations,

illustrating the continued relevance of a provider resistance mechanism. In this vein, representatives of SIMRA pointed to the risk that the new health infrastructure would primarily serve non-insured patients and that the plans therefore constituted a threat to the financial stability of the CNS (La Razón 2019). Meanwhile, the main coalition of indigenous organisations, *Pacto de Unidad*, came out in defence of the initiatives of the government and the COB, jointly proclaiming themselves "vanguard in the defence of the [SUS]", fiercely denouncing the strike called by the medical doctors (Pacto de Unidad 2019, author's translation), accordingly demonstrating class-based mobilisation as a mechanism continuously supporting universalisation.

3.7 Mechanisms in Bolivian Healthcare Reform

Drawing on insights from comparative social policy research, this exploration of healthcare reform in Bolivia identifies a set of complex causal mechanisms with modular qualities. Firstly, the immersion of healthcare officials within regional networks oriented towards social medicine is a salient feature, reflecting a mechanism of emulation through expert theorisation. The influences from IOs, through coercion as well as emulation, are apparent in earlier decades, but the formulation of proposals for a universal health system was influenced by the social construction of appropriate health policy. Here IOs were relevant for putting the issue of the universal right to health on the policy agenda. But the idea of the state as a guarantor of this right, and the particular orientation of health policy under the presidency of Evo Morales, seems more indebted to horizontal transmission of ideas through the Latin American Association of Social Medicine (ALAMES), clearly representing an example of an epistemic community with a shared belief in the universal right to health, an understanding of ill-health as reflecting broader social inequalities, a shared focus on improving public health and combating exclusions in healthcare, as well as a common policy goal of promoting UHC through state policy (cf. Haas 1992). The case study shows how the ideas of this community were in a first stage intertwined with the broader agenda of the social movements and how they later guided official policy when

affiliates to ALAMES and members of the social movements took up central positions within the Ministry of Health.

Secondly, the progress towards UHC seems closely linked to a mechanism of class-based mobilisation. In particular, the mobilisation and organisation of the indigenous majority, through peasants' unions and neighbourhood organisations engaging in demonstrations, strikes and popular assemblies, emerges as a central driver of the reform process. The movement-based organisation of the *Movimiento al Socialismo*, upheld by the incorporation of workers', women's and indigenous peoples' organisations in its social base, is arguably key to explaining the orientation of the party's health policy. This mechanism, which enacts a chain of events resembling the experience of early welfare state development in Western Europe, seems to be indebted to the parallel processes of democratisation and precarisation of labour unfolding over the course of the 1980s and 1990s.

Thirdly, pervasive effects of a social movement–state interaction mechanism on the content and development of healthcare reform, following a pattern resembling the "infiltration of the state" observed by Falleti (2009) with regard to the developments in Brazil, are salient. In the Bolivian case, this mechanism moreover corresponds to a broader shift in the relationship between state and society tied to the overarching quest to "re-found" the nation (Artaraz 2012). In this process, public officials arguably acted in a relatively autonomous fashion, not merely responding to the pressures from organised interests but actively engaging in formulating policies, arguing for their appropriateness and bargaining for their enactment.

Fourthly, medical doctors were resistant to the stricter regulation that the government sought to impose on the profession in order to strengthen the state's ability to monitor and coordinate the provision of healthcare services. We might think of this as a mechanism of professional autonomy, as it activated defensive strategies broadly within the profession. As a fifth mechanism, physicians employed by the social health insurance funds were particularly resistant to the proposed changes, fearing that universalisation would bring with it a deterioration of their working

conditions and threaten their privileged position within the system. This illustrates the tendency for welfare state expansion to generate constituencies with strong interests in the preservation of current institutions. Service providers constitute such a category, and we might accordingly conceive of this mechanism as provider resistance.

Lastly, unions representing formal sector workers, who were already covered by social health insurance, emerge as instigators of resistance to the proposals for universalisation, in line with the alarmed middle classes mechanism. While part of the coalition that brought Morales and MAS to power, the central trade union confederation, in which the miners play a particularly central role, feared that the incorporation of these funds into a universal system would result a dilution of the funds' resources, and accordingly acted to halt the government's reform initiatives on several occasions. Conversely, the support of the same organisation at a subsequent stage was arguably pivotal for the introduction of legislation that formally universalised healthcare coverage. On this later occasion, the ability of the government to negotiate consent from the labour movement seems to have been a crucial factor for neutralising the alarmed middle classes mechanism, making possible the passing of the final legislation introducing the Unified Health System.

These six mechanisms can jointly serve as building blocks in a modular explanation of the winding path towards a universalisation of health coverage in Bolivia, and more particularly of the winding progress towards a unified government-funded system. In order to explain the challenges to the reform process and its intermittent advancement, the last three of these mechanisms are of particular relevance, sharing their origin in the feedback effects of institutions on actors' perceived interests and identities and the activation of particular social cleavages.

4 Final Remarks

This study has been motivated by the ambition to unveil the mechanisms underpinning the politics of universal health coverage in Bolivia. The analysis presented above has highlighted expert theorisation, class-based mobilisation, social movement–state interaction, alarmed middle classes,

provider resistance and professional autonomy as mechanisms that can be used as building blocks in a modular explanation of the present case, but which arguably also have the potential to travel to other instances of social insurance reform in the Global South.

While this chapter has identified these mechanisms as relevant for the political processes surrounding institutional changes in health policy, understanding the triggers of these mechanisms, as well as the contextual factors shaping their outcomes, should be the subject of further inquiry. The theoretical framework presented at the outset of this chapter gives us some clues regarding some of the potentially relevant factors in this respect. The precarisation of labour is arguably a central trigger of the class-based mobilisation mechanism, causing the less privileged to join forces and act to fight against perceived injustices. However, for these actions to be directed towards public policy reform, there needs to be at least a hope on the part of these groups that they will be able to exercise sufficient control over the state. Democratisation, or at least the prospect thereof, would thus arguably comprise a necessary contextual condition.

Any mechanism underpinned by a reaction to a perceived threat to current privileges, like the alarmed middle classes mechanism, is moreover more likely to unfold in a context of low trust, both towards one's fellow citizens and towards public institutions. Indeed, the low level of trust in the benevolence and impartiality of the Bolivian government voiced by trade unions is surely a common issue across many attempts at universalising access to social protection throughout the Global South and should motivate further attention to the interplay between social policy, trust and opinions. Moreover, the Bolivian experience illustrates how political institutions, and decentralisation in particular, contributed to inspire collective action aimed at changing public policy, but also had a conservative effect by giving oppositional forces associated with traditional elites the possibility to veto subsequent reform initiatives. Meanwhile, the social insurance system provided actors with opportunities to veto proposals when conflicts emerged over regulation and funding of the system.

Lastly, the concession made towards the trade unions to not interfere with social insurance was arguably made possible partly as a result of the gradual strengthening of the public subsystem that had taken place since

the first proposal to introduce a unified health system. This strengthening of state capacity unfolded without the clashes and grand gestures of the first years of the Morales administration. In a sense, the gradual implementation here seems to have been a prerequisite for legislation, rather than the opposite. This insight seemingly points to the potential of exploring the interplay between high-level policymaking and less conspicuous institutional evolution, in the spirit of institutional theory highlighting the potential of gradual changes to have transformative outcomes (Mahoney and Thelen 2009). At the end of the day, gradualism with regard to the means might prove to be the key to reaching more transformative ends.

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