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The remarkable dynamism of government welfare provision in Africa and in Latin America and the Caribbean is embedded in a broader context. As a legacy of the colonial past, social protection for old age and health care was generally the privilege of the rather small group of formal sector workers. French colonialism emphasized an active role of the state in social protection and had a quite uniform focus on the nuclear family and especially family allowances. In British colonies, social protection programs were more heterogeneous. Former Spanish colonies used the colonial montepíos as the starting points for their pension systems. In addition to this, there are global influences. For social protection in old age, a growing focus on social pensions replaced recently the two longstanding competing global models of the ILO and the World Bank. In contrast, there is no clear model in the domain of health care. However, in recent years, a certain consensus emerged regarding the question of user fees.

Keywords: Latin America and the Caribbean, Africa, health care, old age pensions, cash transfers

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Health Care and Old Age Pensions in Latin America and Africa: Introduction to the Issue

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Abstract

The remarkable dynamism of government welfare provision in Africa and in Latin America and the Caribbean is embedded in a broader context. As a legacy of the colonial past, social protection for old age and health care was generally the privilege of the rather small group of formal sector workers. French colonialism emphasized an active role of the state in social protection and had a quite uniform focus on the nuclear family and especially family allowances. In British colonies, social protection programs were more heterogeneous. Former Spanish colonies used the colonial montepíos *as the starting points for their pension systems. In addition to this, there are global influences. For social protection in old age, a growing focus on social pensions replaced recently the two longstanding competing global models of the ILO and the World Bank. In contrast, there is no clear model in the domain of health care. However, in recent years, a certain consensus emerged regarding the question of user fees.*

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Introduction

Health care and social protection in old age are generally seen as key fields of social policy (Kaasch 2013: 47). These two fields of social policy are in the focus of this inaugural issue of socialpolicy.ch that has a special interest in two UN regions: Africa and Latin America and the Caribbean.[2] Both regions are presented as socio-political laggards compared to East Asia and the established welfare states in an early systematic assessment of welfare regimes in non-European countries (Wood and Gough 2006). The picture painted is especially dire for sub-Saharan Africa. Dismissed as having *insecurity regimes*, these countries are not only assumed

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[2] We refer to the latter for convenience as Latin America.

to neglect the provision of welfare to their citizens, but even to actively threaten it. As a consequence, individuals have to rely on unstable and basically kin-based informal networks. Although patterns of informal welfare are also observed in Latin America, there is in this region a more extensive provision of social welfare by the state.

The proportion of national budgets devoted to health care and social protection in old age are markedly different between Africa and Latin America, yet suggest considerable government activities in these fields of social policy. In Latin America, non-health public social protection expenditure for older persons absorbs 4.6% of the GDP, which is above the global average of 3.3% (ILO 2014: 77). In contrast, African countries spend only 1.3%. However, they also have a younger population than most other regions. The picture for government expenditure on health is similar. This snapshot does not capture the remarkable dynamism of government welfare provision in both regions in recent years.

The aim of this issue is to shed some light on these developments. These are however embedded in a broader context which is explored in this introduction. The legacy of the colonial past is more central than frequently assumed and outlined in the first part. As a legacy of the more centralized approach in French colonies, quite uniform social security programs emerged especially in Africa and persisted in the post-colonial period. Their focus was on family allowances and work injury, not on old age protection. In contrast, Spanish colonial legacy generally included the introduction of pension schemes. Far more decentralized in its approach, British colonialism resulted in a much more heterogeneous legacy of social protection that included a preference for provident funds. In addition to these influences of colonialism, Latin American and African countries are exposed to global influences that are presented in the subsequent two sections of this introduction. For social protection in old age, a growing focus on social pensions replaced recently the two longstanding competing global models of the ILO and the World Bank. In contrast, there is no clear model in the domain of health care. However, in recent years, a certain consensus emerged regarding the question of user fees. The last section of this introduction situates the three articles of this special issue in this context. All of them present in-depth analyses of recent dynamics and point to the importance of political processes for an understanding of social policy in Latin America and Africa.

Social protection and colonial heritage

The origins of social protection in non-OECD countries only recently started to attract more attention. While there were important pre- and para-colonial forms of social protection, the main focus of this paragraph is on the influence of European colonial administrations. Colonialism also strongly affected other social, political and economic aspects of the societies concerned. It is generally assumed that colonial administrations not only introduced certain concepts of social protection and accordingly adopted an institutional framework, but that this also shaped post-colonial developments (Schmitt 2015).

While there is empirical evidence for such path dependency (e.g., Kangas 2012; Schmitt 2015), a theoretical explanation is rarely attempted. Pierson (2000: 251) explains "path dependence as a social process grounded in a dynamic of 'increasing returns'". Sticking to the established framework becomes more and more probable because the costs of switching to

another framework increase over time. There is thus a self-reinforcing feedback process that makes it difficult to reverse a course of action initiated. It is thus important to explore the social protection heritage of colonialism. The colonial projects of Northern European powers such as Denmark-Norway, Sweden, Courland, Prussia or the German Empire were too limited in time and space to leave signifiant traces for contemporary social policy. Other colonial powers (e.g., Australia, Japan, Russia) left their legacy outside the region of interest. We limit the discussion of the colonial social policy legacy to Spanish, French and English colonialism, as, to our knowledge, this question did not receive systematic attention for Portuguese, Dutch and Italian colonialism (but see e.g., Midgley 1984 for some scattered information). Regarding Belgian colonialism, suffice it to say that the paternalistic colonial policy attempted to stabilize the labor force with the early introduction of accident compensation schemes and, in 1957, with remarkable old age benefits (Iliffe 1987: 208) and has frequent similarities to French colonies (Midgley 1984: 155).

Spanish colonial heritage

Spanish colonial expansion consolidated comparatively early in Latin America, mainly during the 16th century.[3] In Africa, Spanish colonialism was less important and the two African territories (Western Sahara, Equatorial Guinea) were colonized later. Spanish rule also ended later in Africa (in the 1960s and 1970s) than Latin America (mostly during the 19th century). In Latin America, the Spanish colonial system initially had two center areas: the *Audiencia* of Mexico and the *Audiencia* of Lima, the capital regions of the two Spanish vice-royalties (New Spain and Peru) (Mahoney 2003). These regions had raw materials and a high density of indigenous populations and here colonial administrative activities concentrated. Linked to these centers by powerful merchants and treasury bureaucrats were the secondary or semi-peripheral *Audencias* (Guatemala, Santa Fe de Bogotá, Quito, Charcas). Finally, there were marginal peripheral areas of the empire. However, after 1700 there was a reversal initiated by a series of reforms to improve trade, production and administrative control in the context of an expanding global capitalism (Mahoney 2003; Lange, Mahoney and von Hau 2006).[4] Parts of the former periphery such as Argentina, Costa Rica and Uruguay experienced in the following 200 years economic growth and became lasting economic powerhouses. Having a sparse indigenous population they lacked the stratification of the old centers and performed comparatively well in the areas of health, education and literacy. This ranking had a remarkable continuity since the end of the 19th century.

Predating Spanish colonialism, the Inca and Aztec civilizations used work on communal land to provide for those in need (Mesa-Lago 1978: 18). These quite inegalitarian social protection institutions called *ayllus* and *calpullis* were transformed under Spanish colonialism, but disappeared by the end of the seventeenth century. So did the mutual aid societies called *cofradias*. Inspired by Spanish philosopher Juan Luis Vives, public charity hospitals offering free health care started to emerge in Latin America in the early sixteenth century and, at the end of the next century, covered all important cities, subsequently adding orphanages and

[3] Spain designates here the political entity that emerged from the alliance of Castile and Aragon.

[4] These reforms can be broadly characterized as a switch from mercantilist to more liberal policies.

homes for elderly, all known under the umbrella term *beneficencias* (Mesa-Lago 1978: 18). Colonial Spain awarded gratuitous concessions or gifts to important loyal colonial servants (*gracias*), extended them towards the mid-sixteenth century to their needy widows and orphans and later turned them into cash payments (lump sums, pensions). Out of this emerged the *montepíos* as a pension system for retirement and for survivors. It was based on monthly contributions and additional funds by the state, now protecting a group and not individuals in a quite arbitrary way. Old age programs were consequently central to Spanish speaking Latin American countries and introduced very early (Schmitt 2015). Uruguay was a global pioneer in establishing a pension system already at the beginning of the 19th century. In other areas, the *montepíos* system was maintained and slightly modified after independence (Mesa-Lago 1978: 20). Old age provision was introduced in Equatorial Guinea later than in Latin America, but still comparatively early (Seekings 2002: 8f.).

After old age provision, (former) Spanish colonies started to introduce social protection against work injury (Schmitt 2015), having a predecessor in the barely enforced 1680 legal code *Recopilación de Leyes de los Reynos de las Indias*. This happened roughly at the same moment as in French and British colonies and with similar importance and is thus not related to the colonial past. Protection against the risk of sickness followed and was more important than in French and English colonies. Social protection against unemployment was also started earlier, yet remained rather unimportant. Finally, (former) Spanish colonies started to introduce family allowances around the same time as other colonies. They were not nearly as important as in the French colonies, but clearly more important than in English colonies, possibly because of the Catholic focus on families.

French colonial heritage

While temporarily dispersed, the French colonial project started later than the Spanish and had its climax in the late 19th century. Most French colonies in Africa and Latin America became independent after World War II and especially in the 1960s (Ziltener and Künzler 2013). French colonial administration was quite centralist and conceived colonies as extensions of France (Devereux and Lund 2010; Kangas 2012: 79f.). The French colonial state claimed an active role in developing social and economic planning (Cooper 1996; MacLean 2002). This role was fairly independent from the economic prosperity of the respective colonies and from their pre-colonial forms of social protection (Schmitt 2015: 339). The focus was on individuals and nuclear families and the centralized bureaucracy was supposed to replace informal social networks (MacLean 2002). Social services in the colonies were subsidized from 1928 on through the *Fonds d'Investissement pour le Developpement Economique et Sociale* (Luiz 2013: 111). The expansion of social protection in the colonies was strongly influenced by the debate in France and by an early and remarkable pluralism of trade unions in the colonies. The 1946 general strike in Senegal demanded identical benefits and work conditions in the colonies as existed in France.

French colonies first introduced social protection against work injury at the employer's expense. Yet, this happened at a similar time and to a similar extent as in the English and former Spanish colonies (Schmitt 2015). The French North African colonies Algeria, Morocco and Tunisia were among the forerunners (Gruat 1990: 405). Predominantly Catholic France

had a special emphasis on family allowances and, when reforming its family allowance system, also expanded it to North Africa in the 1940s and subsequently to other colonies (Mouton 1975; Midgley 1984: 121f; Gruat 1990: 405; Kangas 2012: 90). A milestone for the diffusion of family allowances was the introduction of the French *Code du Travail* in 1952. It also regulated protection against the risk of sickness, albeit more indirectly. Protection against the risk of sickness was consequently introduced in some of the more industrialized and rather populous colonies (Kangas 2012: 91). It subsequently diffused less quickly than the family allowance but became almost as generalized as in the Spanish areas and was clearly more frequent than in English colonies. Remarkably, the *Code du Travail* did not include pensions. A few rather industrialized colonies adopted old age benefits earlier, but most former French colonies established insurance-based pension schemes only after independence (Seekings 2002: 8f.; Kangas 2012: 91). Finally, social protection against unemployment was introduced in former French colonies late and sparsely after 1980. All the benefits mentioned were insurance-based and covered only a privileged group of mainly urban formal sector workers. Only a low percentage of the population was working in the formal sector which was mainly limited to the urban public sector.

British colonial heritage

The British colonial project was also temporarily dispersed and had a climax in the late 19th century (Ziltener and Künzler 2013). Most British colonies in Africa and Latin America became independent between 1960 and the early 1980s. In contrast to France, the British Empire had a decentralized imperial strategy and a more passive understanding of the colonial administration. It particularly focused on strengthening the informal social welfare system of the extended family and community. Colonies were required to finance their social policies from their own resources (MacLean 2002; Schmitt 2015: 332), leading to a more heterogeneous social protection than among the French colonies – both between and within British colonies.

As in the French colonies, the British colonies first introduced social protection against work injury at the expense of the employer (Schmitt 2015). British colonies, however, were rather slow to universalize them. The same holds true for old age pensions. In the context of the great depression (1930s), a few small Latin American colonies (Barbados, Trinidad and Togabo, Guyana) introduced noncontributory and thus redistributive old age pensions, followed by some African territories (Mauritius, South Africa) (Seekings 2008). However, many former British colonies introduced social protection for old age not until after achieving independence. A particularity of British colonies was the introduction of provident funds for formal sector workers, especially in Africa and Asia (Midgley 1984: 142f.; Gruat 1990: 416; Kaseke, Midgley and Piachaud 2011). Still anticipating a return to rural villages after retirement, these retirement schemes provided lumpsum payments and did not require large contributions by government (Seekings 2008; Schmitt 2015: 335). Other former British colonies choose flat-rate pensions or earning-related pension schemes. All these schemes are not redistributive. For civil servants, British colonies generally had noncontributory schemes (Midgley 1984: 110f.; Robinson 1990: 190), in contrast to the contributory Spanish *montépios*.

Even the *Colonial Development Act of 1929* or the *Colonial Development and Welfare Act of 1940* did not induce colonies to uniformly adopt social protection programs. Consequently,

the introduction of family allowances and social protection against sickness and unemployment started in this context, but did not lead to a quick universal diffusion among British colonies. Protection against sickness started earlier than in the French colonies, but was more slowly to expand and clearly not as important. Unemployment benefits started only slightly later than in the Spanish areas, but only covered a few British colonies. Finally, family allowances were never as important as in French and Spanish areas.

Reinforced by the Labour Party election victory, the British took a more active role and designed a new development doctrine after 1940 (Seekings 2008; Harrison 2011; Lewis 2011; Midgley 2011). Again no systematic policy emerged across colonies, but in agrarian colonies a focus on peasant production, kinship-based protection against rural poverty and welfare through community development for *detribalised* urban Africans emerged (Seekings 2008; Luiz 2013: 112). Agrarian colonies implemented rather egalitarian policies with a more inclusive focus on health and education in comparison to colonies where migrant labor at plantations or mines was central. Here, patterns of inclusion and exclusion were more distinct, but more forms of social assistance inspired by the poor laws emerged.

To sum up, social protection programs depended more on the economic resources and were thus more heterogeneous across the British Colonies than among French colonies and Spanish areas. In addition to varying levels of social insurance, British colonies also introduced different forms of social assistance including noncontributory social pensions. However, the latter were rare. Across Latin America and Africa, social protection was generally the privilege of the rather small group of formal sector workers to the detriment of the poor. In this regard, there is not a huge difference between countries following the model of the British National Health Service (e.g., in the Caribbean) and those introducing health insurances. As for the main socio-political colonial legacy, it is important to bear in mind that

> *"(…) after their independence, former French colonies all kept the general structure of the Code du Travail of 1952 (…), Spanish former colonies used the colonial* montepíos *as the starting points for their pension systems and in many British colonies the provident funds pushed by the British government are still in place" (Schmitt 2015: 340).*

Global influences and old age: pensions, their privatization and the boom of social pensions

Social protection in Latin America and Africa is not only shaped by the colonial heritage, but also by regional processes of diffusion: "The probability of introducing a social security program increases if other countries in the same geographical region have already adopted that scheme" (Schmitt, Lierse, Obinger and Seelkopf 2015: 514). In a context where problems are frequently similar and countries are interconnected, policy diffusion is facilitated. The diffusion of Chile's pension privatization throughout Latin America or the spread of social pension programs from South Africa to the neighboring countries are frequently read as examples of policy diffusion (Weyland 2007, Niño-Zarazúa, Barrientos, Hickey and Hulme 2012: 169). However, in both examples the policies were shaped by the global context. Furthermore, the

policies diffused also to unlikely cases and, in the case of the pension privatization, also to other regions. It is thus crucial to discuss global influences on social protection.

Social protection through insurance: pensions and a wave of privatization

"For much of the twentieth century ideas about social security were largely, but not exclusively, defined and driven by the hegemonic influence of the International Labour Organization (ILO)" (Casey and McKinnon 2009: 85). Indeed, empirically, membership in the ILO is important for the proliferation of social protection (Schmitt et al. 2015: 503). Since the 1940s, the ILO supported the idea of a "unified, national pension insurance system under a central social security administration and a unified set of (old-age and disability) pension benefits which was rather influenced by the Bismarckian German idea of an old-age pension system (a pay-as-you-go [PAYG] system)" (Kaasch 2013: 49). The ILO favored a government-led pension system that is financed by contributions or taxation. The ILO's preference for a social insurance approach (as also in other domains of social protection) becomes evident in the ILO's flagship, the 1952 Social Security (Minimum Standards) Convention (102): it required member states to ratify minimum standards in at least three branches out of nine (medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit and survivor's benefit). These standards were conceived with a focus on formal sector employment which is more widespread in Latin America compared to sub-Saharan Africa. The ILO's standards largely promoted social insurance, although tax-financed social assistance was not excluded (Casey and McKinnon 2009: 85). The ILO had no power or means to force countries towards social insurance, however it clearly exercised soft power on (colonial) governments.

In the middle of the 1990s, the hegemony of the ILO's social policy model became massively contested by the World Bank. Influential for this "war of positions" (Kaasch 2013: 45) was the radical pension privatization initiated at the beginning of the 1980s in Chile by a group of Chilean economists known as "the Chicago Boys" (Orenstein 2008). In its 1994 report, the World Bank standardized and theorized the Chilean pension reform into a pension model that was based on three pillars (World Bank 1994). The first pillar, and the only with a redistributive character, is a basic public pension on a low level. The second pillar is a compulsory privately pre-funded and managed pension. For this pillar, defined contributions were preferred to defined benefits. Finally, the third pillar is also privately funded and on a voluntary basis. This model was presented as the solution to avert an alleged old age crisis caused by aging societies and increasing problems to finance existing old age pensions. Based on a pro-market agenda and an interest in developing financial markets, the privatization entailed an individualization of risks.

Casey and McKinnon (2009: 85f.) remind that the last chapter of the World Bank report recognized that this model was not appropriate for most low-income countries where financial markets are not sufficiently developed. Nevertheless, the model was actively disseminated by the World Bank and a number of other institutions and discussed in the scholarly literature (Kaasch 2013). This made social security a global issue. A competing international epistemic community, including the ILO, promoted the older pension model and pointed to several weaknesses of the World Bank model. These included that defined contributions do not guar-

antee a certain level of benefits and thus do not offer social protection. Furthermore, the World Bank conceals the fact that their model is equally vulnerable to a rising old-age dependency ratio. Finally, it would also have been possible to adapt the ILO model to reduce the burden of the current generation. Nonetheless, the World Bank model influenced national pension reforms, especially in Latin America and in Central and Eastern Europe (Orenstein 2005). The model had a short boom and lost influence after 2005 (Béland and Orenstein 2013: 130).

> *"The timing of the decline in 2005 instead appears to be linked to three factors that helped alter ideas and perceptions about pension privatization worldwide: (1) the publication of major World Bank reports in 2005 and 2006 that produced a damning critique of pension privatization and World Bank advocacy of it; (2) the revision of Chile's landmark privatized pension system under President Michelle Bachelet; and (3) the failure of President George W Bush's efforts to enact pension privatization in the United States in 2005" (Béland and Orenstein 2013: 130).*

It is interesting to note that the World Bank model hardly diffused to sub-Saharan Africa. To be sure, even before the old age report had been published, the World Bank had advised since the 1980s a number of mainly English speaking countries whose pension systems already were in line with the model. However, Kpessa and Béland (2012) argue that the competing ILO had been more influential in this region. They show that three main factors were favorable for the ILO approach. Firstly, the age pyramid in sub-Saharan Africa differs from that in other regions of the world; the vision of an overaging society is not resonating. Secondly, the financial burden of the old age pension as a percentage of the GDP is lower in sub-Saharan Africa than in any other region of the world. Thirdly, a number of mainly English speaking countries had already experienced that the World Bank style pension model did have considerable weaknesses: The defined contributions paid were eroded by mismanagement and high inflation, and the lump sums consequently paid were much too low. A number of these countries adjusted their systems in the direction of the ILO model that was already quite widespread among French speaking countries. Supported by the ILO, Ghana was the first among these countries to do so in 1991, others followed.

As Kaasch (2013: 47) reminds us, the prescriptions and thus the models are neither natural nor static. In a context of a new president and internal reorganisation processes, the World Bank picked up both the criticism of and the experiences with the three pillar model and presented a five pillar model in 2005. In addition to the three earlier pillars, the World Bank proposed noncontributory social pensions as *zero pillar* and added informal monetary or non-monetary social protection as fourth pillar (Holzmann and Hinz 2005). In this model, pillar zero replaced the first pillar in order to guarantee minimal social protection and reduce old age poverty. In its more recent publications, the World Bank emphasized that there is no universal pension model that could serve as panacea (Wodsak 2011: 359). The World Bank's position on pensions, thus, has become less rigid than those of think tanks, for example (Béland and Orenstein 2013: 125).

The boom of social pensions

The implementation of a noncontributory social pension into the World Bank pension model is part of a broader development. Both the World Bank and the IMF had a focus on poverty reduction as an important objective of development in the 1960s and 1970s (Vetterlein 2013). During the 1980s, the focus narrowed to economic growth as it was assumed that this would trickle down and reduce poverty. Faced with increasing criticism, in the 1990s both organizations broadened their understanding of development that became known as the post-Washington Consensus (cf. e.g. World Bank 1990, UNDP 1990). The individual and its capabilities gradually became the target of development policies (von Gliszczynski 2015: 137). Poor people, initially still regarded as passive beneficiaries of development, were accorded a voice in the design of policies (e.g., Narayan 1999) and then conceived as central agents of development. This double discursive shift legitimized social policies in general and social cash transfers in particular as an instrument of development (von Gliszczynski 2015: 138f.). Since 2005, the terms *social transfers*, *cash transfers* and *social cash transfers* are synonymously used for noncontributory cash benefits to poor people. These were considered to have various benefits (von Gliszczynski 2015): they alleviate the most severe forms of poverty, reduce social inequalities through redistribution via tax-financed benefits, protect from different types of *risks*, *shocks* and *crisis*, they are allegedly beneficial for economic development and to strengthen social cohesion.

While contributory pensions were also expanded in recent years, the number of cash transfer programs grew impressively across the world, especially since 1990 (Leisering 2009; Palacios and Know-Vydmanov 2014). Already in 2009, the World Bank counted 123 cash transfer programs in sub-Saharan Africa alone (Garcia and Moore 2012). This growth is, however, unequal across the four different variants of cash transfers distinguished by von Gliszczynski (2015: 36). General household assistance, the first variant, was instrumental for the global spread of cash transfers. A household assistance scheme – the Kalomo pilot scheme launched 2003 in Zambia – has frequently been used to argue in favor of cash transfers in general. However, this variant was outstripped by the other three variants, that offer more specific categorical benefits: noncontributory family allowances, social pensions and conditional cash transfers.

For old age, the social pensions variant is central.[5] Initially discussed as noncontributory pensions in the mid-1990s, the model became globally recognized around 2001 when it was re-labelled to social pensions, and was attributed indirect nutritional, educational and health effects on grand-children in addition to direct effects on the social and economic status of indigent old people (von Gliszczynski 2015: 48). This argumentation was supported by empirical evidence. A coordinated campaign was initiated in 2003 by Help Age International in cooperation with other international organisations ranging from the World Bank to the ILO. Treated as self-evidently useful by the main global policy actors, social pensions have been

[5] In the two regions discussed, countrywide noncontributory old-age pensions were introduced in countries such as Algeria, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Botswana, Brazil, Cape Verde, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Egypt, El Salvador, Guatemala, Guyana, Jamaica, Lesotho, Mauritius, Mexico, Namibia, Panama, Seychelles, South Africa, St. Kitts and Nevis, St. Vincent and Grenadines, Suriname, Swaziland, Trinidad and Tobago, Uruguay and Venezuela. In other countries there are pilot projects that are not (yet) countrywide.

integrated as zero pillar in the World Bank model and the Global Social Floor recommendations of the ILO (Casey and McKinnon 2009: 86). There is thus a certain accomodation between the World Bank and the ILO.[6] However, the recent scientific focus on the wide diffusion of social pensions tends to neglect the fact that countries such as Uruguay, South Africa, Barbados, Trinidad and Tobago, Guyana, Argentina or Mauritius introduced social pensions in 1950 and earlier. The idea is thus not as new as is sometimes suggested (e.g., Hanlon, Hulme and Barrientos 2010).[7]

Similar to other forms of social policy, social pensions may be universal for an entire category of old people or selective through targeting. In the 1960s and 1970s, "the leaning was toward universalistic [social] policies" (Mkandawire 2005: 1) to the benefit of the whole population or at least entire categories of the population. However, from the 1980s onwards and in the context of economic crisis, a number of international organizations such as the World Bank argued that universal benefits were too expensive and inefficient. Most global and national policy actors favored targeting the benefits and tended to assume that it helped to increase the impact of cash transfer programs.[8] How this was to be done was less clear. Targeting is difficult and potentially divisive in communities where poverty is widespread and people do not perceive economic differences amongst them (Adato 2007; Ellis 2012). A number of other organizations including the ILO, UNICEF or HelpAge International criticized targeting as being administratively expensive and prone to exclusion errors; they favored universalism for its solidarity and rights-based character.

Global influences and health: from (free) primary health care to user fees and back

In Latin America, health was seen quite early in an international context. Already in 1902, the Pan-American Health Organization was founded. It promotes universal health coverage and universal access to health. The nationalist aim of promoting people's wellbeing and a context of widespread modernization and socialist theories led many African countries to expand their health services after independence in the 1960s (Mkandawire 2005: 2; Midgley 2011: 50). Some offered health services entirely or at least partially free of cost, others raised contributions. Competing epistemic communities around international organizations have not (yet) converged to some clear cut models in the field of health. In both regions the Alma Ata Declaration of 1978 (WHO/Unicef 1978) influenced health policies. This declaration, the result of a joint World Health Organization and UNICEF conference, considered essential primary health care key to guarantee everybody a level of health allowing for a socially and economi-

[6] The latter regained importance in global social policy since 2001 with the *Global Campaign for the Expansion of Social Security*. Furthermore, the ILO together with the World Health Organization (WHO) was a key driver of the Social Protection Floor Initiative adopted by a number of UN organizations and other organizations in April 2009 in response to the global economic crisis. See O'Brien (2014) for the limits of this accomodation .

[7] The term *cash transfer* was first used in the late 1980s in the context of German development cooperation. Especially projects in Mozambique were an early, but failed attempt to establish this kind of benefits for the poor. The notion *social transfers* was primarily used by the World Bank from the mid-1990s as umbrella term for monetary social security. Finally, the term *social cash transfer* was introduced in 2005 by the British Department of International Development (DfID). The terms were ambiguously used and initially also referred sometimes to contributory benefits (von Gliszczynski 2015: 28-30).

[8] For an overview over the strengths and weaknesses of different targeting methods see Pfleiderer (2013).

cally productive life. While this declaration inspired countries across the globe to expand their health services, the meaning of key concepts such as *primary health care* or a *comprehensive national health system* remained vague. Beyond availability, free health care services or services at very low cost were not explicitly mentioned, but considered an important way to make health services more affordable and accessible for people. This tendency towards universal health policies was dominant during the 1960s and 1970s.

However, the trend towards universal essential primary health care came increasingly under pressure. Falling export commodity prices and increasing oil prices contributed to economic problems and a debt crisis (Jarrett and Ofosu-Amaah 1992: 164). Governmental health expenditures in most Latin American and African countries declined both in absolute and relative terms and it became increasingly difficult to import medicine. In Africa, at a regional WHO meeting in 1987, influenced by UNICEF, the so-called *Bamako Initiative* was launched with the aim to strengthen primary health care, especially maternal and child health. Its resolution and guidelines were frequently implemented in a quite selective way. The term *community financing* generally meant higher direct health costs for individuals through payment for drugs or different kinds of user fees (Olivier de Sardan and Ridde 2012: 14; Robert and Ridde 2013: 10). It was assumed that people were generally prepared to pay for quality health care and medicine. While the availability of medicine did increase, health care and medicine became inaccessible for the poorer population, particularly for women and children (Oliver de Sardan and Ridde 2012). The fee exemptions were erratic and failed to ensure poor people's primary health care as had been the aim of the initiative. Furthermore, government financial support for primary health did not increase as was assumed. Structural adjustment programs designed by the World Bank and the IMF contributed to reduced governmental spending in the health sector (Robert and Ridde 2013: 10).[9] The World Bank, thus, became more influential in the health sector and encouraged fees for health services and private health care facilities in the 1980s and 1990s. There was considerably less social security in the field of health compared to that of old age: out of 44 African countries surveyed in 1987, only 11 covered medical care while 38 provided some protection for old age (Gruat 1990: 408).

However, the World Bank was quite ambiguous in its approach towards health care and did not advocate a clear model pushing for privatization. Moreover, there are no clearly dominant international organizations and significantly contested ideas in the field of global health policy (Kaasch 2013). Several organizations compete contest over positions, but at the same time, they cooperate in other areas. Arguments exist over the advantages and disadvantages of health care financing by means of social insurance and taxation, but there is no encompassing *one-size-fits-all* model (Kaasch 2013: 52f.). However, there is unanimous support for universal health care coverage (see also Olivier de Sardan and Ridde 2012: 13f.).

Besides poverty alleviation and education, health care has been central to the Millennium Development Goals (MDGs) adopted in 2000. These goals, in turn, have been significantly influenced by the OECD (Kaasch 2015: 78). Since the start of the new millennium another

[9] The focus on the World Bank in the international discussion neglects other lenders such as the African Development Bank (AfDB), the most important bankroller of structural adjustment loans in sub-Saharan Africa (Coburn, Restivo and Shandra 2015: 276). AfDB loans have quite contradictory effects: investment loans in the health sector improve health care, structural adjustment loans have an aggravating effect.

international consensus emerged in addition to universal coverage: None of the 56 global health actors that Robert and Ridde (2013) surveyed were clearly in favor of user fees. A small majority supported the abolition of user fees or free health care at the point of service, generally for specific categories of the population (children under five years, pregnant women) or health services (primary, essential).[10] A significant group of international organizations avoided taking a position on the issue of user fees. The World Bank again was ambiguous and supported both user fees and free health care at the point of delivery. Regarding social pensions, international organizations and NGOs used empirical evidence to strengthen their argument (Robert and Ridde 2013: 10).

Without doubt, there is a certain focus on more inclusive health systems in recent years. In Latin America, this coincides since the late 1990s with the election of leftist governments in several countries (Venezuela, Brazil, Chile, Argentina, Bolivia, Uruguay, Ecuador, Nicaragua and El Salvador). Generally aiming at universal health care, these governments raised their government's share of total health expenditure (Hein 2013). Furthermore, they introduced both constitutional reforms and health care reforms such as the tax financed *Sistema Único de Saúde* in Brazil, the *Acceso Universal con Garantías Explícitas* (AUGE) in Chile, the *Seguro Popular* in Mexico or the abolition of certain health fees in Peru. Despite these more egalitarian intiatives, health care in Latin America is still characterized by huge inequalities that might even increase with the current conservative backlash.

Exploring old age pensions and health care in Latin America and sub-Saharan Africa

Beyond the colonial legacy and global influences, domestic political processes are key to explain health care and old age pension policies and their changes. The contribution of Künzler (2016) to this issue discusses five concepts used to explain social policy change: the influence of donors, the veto of powerful policy actors, electoral competition, cross national policy learning and windows of opportunities. However, these concepts are rarely used when analyzing health care reforms in sub-Saharan Africa. Using them for a case study on health care reforms in Kenya clearly shows that there is no single theoretical explanation of social policy reforms or their failure. Not only are different combinations of factors at work in Kenya, but they also result in ambivalent policies. There is a remarkable persistence of hospital insurance for the privileged formal sector workers, whereas the provision of health care for the rest of the population is more influenced by consecutive global models.

The importance of domestic political processes also stands out in Budowski and Vera's (2016) contribution. The *bottom-up* solidary and inclusive health model implemented and expanded in Costa Rica was mostly able to resist international and national pressures. Health care was excluded from market-oriented reforms during the 1990s and again recently during the negotiations for the *Central American Free Trade Agreement*. It has expanded universal health coverage, despite various demographic challenges. The political challenges have led to

[10] Robert and Ridde (2013) distinguish between economic (catastrophic health expenditures, cost-effectiveness of health services), pragmatic (financial access barrier, MDGs) and moral and ethical (equity, gender inequalities, human rights) arguments against health fees.

the inclusion of a few market-oriented reforms. Chile contrasts starkly: It was one of the Latin American pioneers implementing a Bismarckian health care model in the 1950s deducting funds directly from salaries and implementing a National Health System that was publicly funded and provided public health services. It was also a pioneer when introducing market-oriented policies to the health system during the 1980s under Pinochets' dictatorship. Chile's return to democracy did not lead to a substantial model change. To amend various accumulating problems in the health domain, demographic changes and public pressure, Chile, again, pioneered a rights-based scheme to enable access to quality treatment in due time without risk of impoverishment for a previously defined list of illnesses. Comparing Chile and Costa Rica's health models reveals considerable differences regarding structure, access, financing, health costs and public investment. Similar coverage rates and similar aggregate health outcome indicators, however, should not obscure that the populations experience the models very differently in terms of satisfaction and stress as various population surveys and a deeper insight into the everyday life of households with health problems clearly highlight.

In the field of social pensions, a closer look reveals that only few countries introduced universal social pensions without means or pension test (Bolivia, Botswana, Guyana, Mauritius, Namibia, Seychelles, Suriname and semi-autonomous Zanzibar). Müller (2016) presents a fascinating paradox behind the introduction of a social pension in Bolivia: The precursor of the current *Renta Dignidad*, the *Bonosol*, was introduced in 1997 by a decidedly neoliberal government in the run-up to elections to overcome resistance against the privatization of public enterprises and pensions, against resistance of the World Bank and the Inter-American Development Bank. The *Bonosol* was financed by dividends of former public enterprises. When the leftist Morales government came into power in 2005, the oil and gas industry was renationalized and the *Bonosol* lost its funding. Abolished at the end of 2007, it was replaced by the tax-financed *Renta Dignidad*. The universal social pension was subsequently in 2009 enshrined in the new constitution.

Social policies for old age and for health, i.e. for human conditions of dependency and incalculable individual risk, are devised within a field of tension between domestic and global actors, between economic, political, individual, and other interests. It is important to reveal the underlying logics of their creation, their aims and implementation. The assembled texts show that social policies have a variety of functions. Also, the varied ways of organizing, financing and structuring of social policies might have similar outcomes; yet they should lastly not only be evaluated by benchmarking indicators, but also regarding the way they provide people with alternatives and options to manage their everyday life risks, or, in other words, by looking at how people experience them in everyday life.

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