

CHAPTER 15: Mechanisms of social exclusion in social health protection schemes

Paul Peter Vermeiren & Werner Soors



Introduction

Social Health Protection (SHP) is considered to be a crucial factor in enhancing access to needed health services while providing financial protection, but it is clear that there is no general layout for a successful SHP policy. Consequently, we are faced with distinct SHP programmes and schemes in different countries, tailor-made to the felt needs of a specific context, but also building on earlier experience and now and again co-defined by donors' preferences. Apart from distinct characteristics due to context and path dependence, SHP programmes and schemes also differ in outcomes, in terms of both access and protection.

Today, the limited success of a number of SHP programmes and schemes in various countries is well documented. This limited success is usually described and analysed on the basis of outcome measures. However, presenting the success or failure of a scheme merely by means of outcomes doesn't say much about how and why the scheme produced that limited success. What happens between the setup of a scheme and its outcomes often remains clouded. The process that leads the scheme to perform poorly remains hidden: as long as that process is not well understood and explained, steering the scheme towards more successful results can only follow a path of calculated guesses, or at best trial and error.

A different way of analysing an SHP programme or scheme is by focusing on explanation, as a basic form of social theory formation. Having identified social exclusion as a core process restraining the success of SHP efforts in previous chapters, we attempt to delve deeper into the process of social exclusion by seeking out its mechanisms.

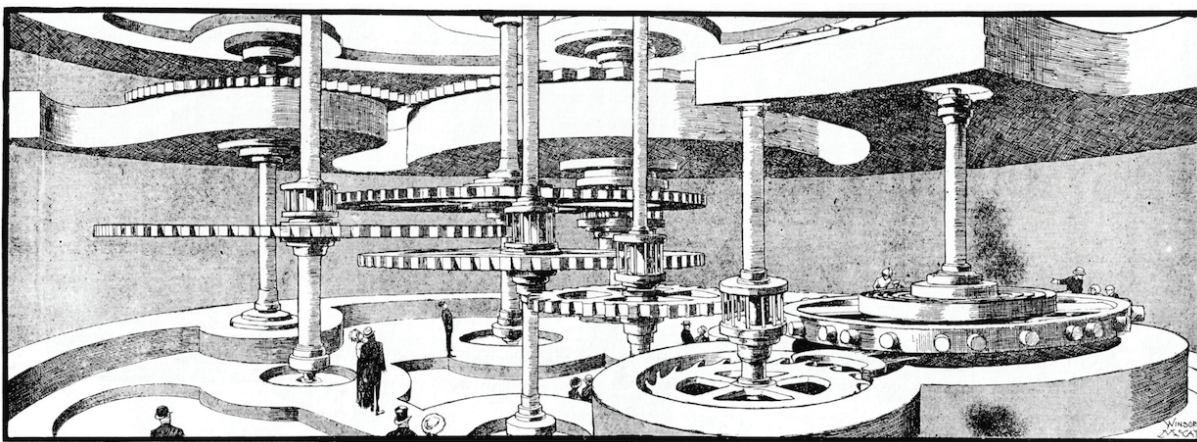
On process and its underlying mechanisms

A perennial flaw in evaluation of all kinds of social programmes—and in comparison within and between social programmes for that matter—has been lack of attention to what happens between inputs and outcomes. As Scott and Sechrest (1989) worded it: “We may know that an intervention is in place and that it has some effects, but as long as we lack further understanding of it, we will be helpless to improve on it in any way. In fact, without greater understanding of it, efforts to change and improve the intervention may actually have adverse consequences.” Or as Chen and Rossi (1989) viewed it: “Most so-called evaluations currently conducted are at best social accounting studies that enumerate clients, describe programmes, and sometimes count outcomes.” Such evaluations were critically termed ‘black-box evaluations’, consistent with experimental design and strong in internal validity, yet of little utility when one aims at improving a programme or policy.

Throughout the 1980s, Chen and Rossi (and Sechrest, and others) insisted on programme evaluation “to move (...) from the black box evaluation, which is concerned primarily with the relationship between input and output of a program, to the theory oriented evaluation, which emphasizes an understanding of the transformational relations between treatment and outcomes, as well as contextual factors under which the transformation processes occur” (Chen & Rossi, 1989). By 1990, they had put theory-driven evaluation on the map once and for all. In the next decade, Weiss (1995) would make an even stronger case for a theory-based approach.

When researchers unseal the black box of a social programme – as we attempt in Health Inc – chances are that opening the box leaves the researchers agape. The image of cogs and wheels comes to mind, as beautifully depicted nearly a century ago by Winsor McCay who subtitled his cartoon “Do you know what this is?” (see Figure 1).

Figure 1. “Do you know what this is? (Wheels and cogs)” by Winsor McCay



Source: ‘Do you know what this is? (Wheels and cogs)’ by Winsor McCay, 1920 (Wikimedia Commons)

Tangled up in complexity, we don’t know the answer until we discover mechanisms across the paths and patterns, and thus develop theory: “a framework of interconnected concepts that gives meaning and explanation” (Lipsey, 1990). Theory then transcends the theoretical: it actually allows us to give sound advice to policymakers, specifically on the conditions required for interventions to work.

As the critical realist Sayer (1992) puts it, theory becomes part of the method to link explanans and explanandum. It encompasses the recognition of stratified social reality in which actors and structures interact, the identification of structures – defined as sets of internally related objects or practices, and retroduction – defined as the identification of causal mechanisms through iterative abstraction.

Bunge, scientific realist par excellence, provides yet another scholarly rationale for the need for a theory of explanation. Central to Bunge’s approach are systems, which are omnipresent: “everything in the universe is, was, or will be a system or a component of one”. He defines a system as “a complex object whose parts and components are held together by bonds of some kind” and a mechanism as “a process (or sequence of states, or pathway) in a concrete system, natural or social (...) that makes a system what it is” (Bunge, 2004) and that “makes a concrete system tick” (Bunge, 1997). Most importantly, Bunge reminds us that “highly complex systems (...) have several concurrent mechanisms. That is, that is they undergo several more or less intertwined processes at the same time and on different levels. (...) The coexistence of parallel systems is particularly noticeable in social systems” (Bunge, 2004).

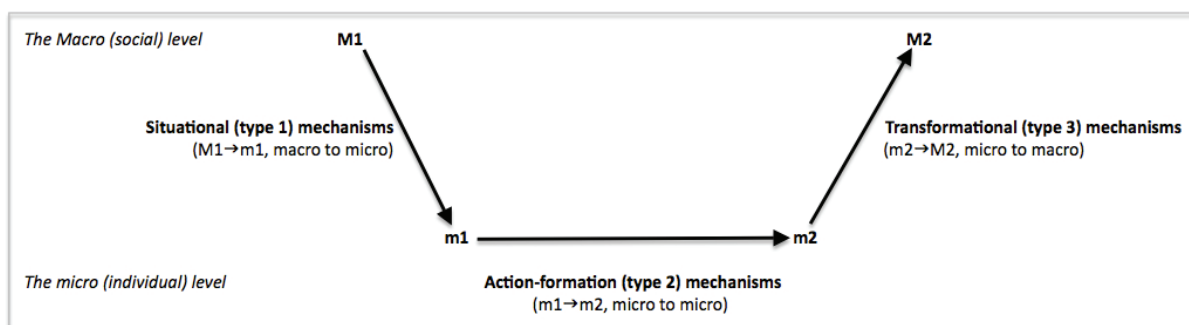
In our research context, health being a complex social system, we cannot but expect plural mechanisms.

Linking explanans and explanandum

Hedström and Swedberg (1998), based on Jon Elster’s work, state that “the search for mechanisms means that we are not satisfied with merely establishing systematic covariation between variables or events; a satisfactory explanation requires that we are also able to specify the social ‘cogs and wheels’ (...) that have brought the relationship into existence.” Schelling adds that mechanisms should be conceived as the systematic sets of statements that provide a plausible account of how inputs and outputs are linked (Hedström & Swedberg, 1998).

Following Elster’s and Hedström and Swedberg’s reasoning, explanation should be distinguished from labelling, relabeling and description. Looking for generative mechanisms allows us to make a distinction between genuine causality and coincidental association. To explain tangible social events we must rely on a number of elementary mechanisms, as one is not enough in real-life, complex processes. Often the mechanisms counteract one another; sometimes they work together. This multiplicity of mechanisms requires a typology to sort them out. We therefore make use of Hedström and Swedberg’s (1998) typology that is based on Coleman’s macro-micro-macro model (1986), commonly known in social science as ‘Coleman’s bathtub’ (see Figure 2).

Figure 2. Coleman’s bathtub

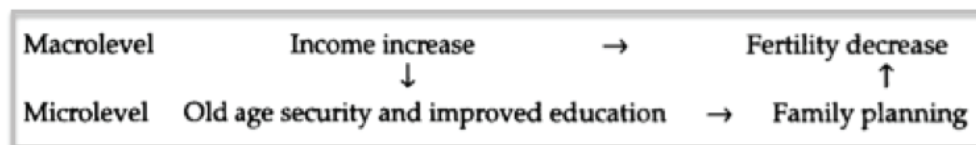


Adapted from Coleman (1986) and Hedström and Swedberg (1998)

This model provides an explanation of change at the macro level (M1gM2) by showing how macro states at a given moment in time influence the behaviour of individual actors and how these actions shape new macro states at a later time. In the type 1 (situational) mechanism, individual actors are exposed to a specific social situation at the macro level (M1), which affects them in a particular way. In the type 2 (action-formation) mechanism, a specific action is generated by a particular combination of individual desires, beliefs and action opportunities. Then, in the type 3 (transformational) mechanism, individuals interact with one another and the individual actions are transformed into an intended or unintended collective outcome (M2). What makes the model particularly attractive is its intertwining of structure and agency, thereby emphasizing the importance of both.

One early and clear example of an explanation following Coleman’s ‘bathtub’ is provided in Bunge’s ‘Mechanism and explanation’ (1997). He argues that it is hard to explain how rise in income (M1) leads to decline in fertility (M2) if one restricts the analysis to the societal level. Taking into account, however, what happens at the individual level, a plausible explanation becomes apparent (see Figure 3).

Figure 3. Bunge’s ‘Mechanism and explanation’



Source: Bunge (1997), p 453

Linking mechanisms and SHP

When looking for mechanisms that might lead to social exclusion in SHP schemes it is necessary to look for mechanisms in society as a whole that can lead to social exclusion. Social health protection doesn’t operate in a vacuum but is fully embedded in social reality. The mechanisms that function in the social realm apply to SHP just as well. Actors within a programme or scheme are actors in the whole social reality; their actions within the SHP cannot be isolated from that larger reality. It can also be argued that the mechanisms of the larger social reality are actually reproduced in the implementation of the SHP scheme.

Based on the work of Hedström and Swedberg, we identified a number of crucial, prototypical mechanisms that can be framed and categorised within Coleman’s ‘bathtub’ model:

1. Belief-formation mechanisms that can be categorised as type 1 situational mechanisms as described above

Self-fulfilling prophecy (Merton, 1948): an initially false definition of a situation evokes behaviour that eventually makes the false conception come true;

Network diffusion (various authors in Hedström & Swedberg, 1998): networks are important because information about innovations diffuse through them and an individual’s propensity to adopt to innovation is influenced by what others do, particularly when there is a great deal of uncertainty about the true value of the innovation;

Threshold theory of collective behaviour (Granovetter, 1978): an individual’s decision whether or not to participate in collective behaviour often depends (in part) on how many other actors already have decided to participate. Actors differ in terms of the number of other actors who already must participate before they decide to do the same. An actor’s threshold denotes the proportion of the group that must have joined before the actor in question is willing to do so. According to Granovetter, even slight differences in thresholds can produce vastly different collective outcomes.

2. Opportunity-generating mechanisms, also part of type 1 situational mechanisms

Vacancy chains (White in Chase, 1991): a social structure through which resources are distributed to consumers (or beneficiaries). In a vacancy chain, a new resource unit that arrives into a population is taken by the first individual in line, who then leaves his/her old unit behind, this old unit is taken by a second individual, leaving his/her old unit behind, and so on;

Reference groups (and role models) (Paynton, 1966): social groups to which individuals refer when making decisions and judgments. The individual’s choice is or can be determined by the reference group.

3. Preference-formation mechanisms, belonging to type 2 action-formation mechanisms

Adaptive preference formation (Elster, 1982): often referred to as the 'sour grapes' mechanism: someone realizes that what he or she wants is unattainable, and then reduces his/her dissonance by criticizing what he/she wants. This is very closely related with the concept of cognitive dissonance (Festinger, 1957) and cognitive consequences of forced compliance (Festinger & Carlsmith, 1959). The latter proved that if a person is induced to do or say something against his/her will, that person will have a tendency to change his/her opinion in correspondence with what he/she did or said;

Discounting (Ainslie, 2002): inter-temporal choices are no different from other choices, except that some consequences are delayed and hence must be anticipated and discounted (i.e. reweighted to take into account the delay). Given two similar rewards, humans show a preference for one that arrives sooner rather than later. Humans are said to 'discount' the value of the later reward, by a factor that increases with the length of the delay.

4. Type 3 transformational mechanisms

Tipping (point) model: coined by Grodzins (1957) when studying racial segregation in American neighbourhoods, further developed and expanded by Schelling (1978, pp. 147-155). It is similar to Granovetter's threshold model, but usually used to explain sudden and more dramatic changes in social behaviour. A tipping point is a moment in time when a group, or a large number of its members, radically and rapidly changes its behaviour by adopting a practice that the same group previously seldom used;

Tragedy of the commons: individuals that act independently and rationally according to their own self-interest tend to behave contrary to the best interests of the whole population group in the long run by depleting common resources;

Matthew effect: "initial advantage tends to beget further advantage, and disadvantage further disadvantage, among individuals and groups through time, creating widening gaps between those who have more and those who have less" (Rigney, 2010).

This non-exhaustive list of mechanisms gives us an indication of the cogs and wheels that could explain why an SHP scheme performs poorly or not. The Health Inc research put forward the hypothesis that social exclusion is a significant cause for the limits of the success of recent social health protection initiatives in low- and middle-income countries (LMICs). It could therefore be revealing to see if the identified mechanisms also function as mechanisms of social exclusion. But before we do that, let us take a closer look at social exclusion itself.

The process of social exclusion

As reported in Chapter 1 – and expanded upon in detail in the case of Africa elsewhere (Soors et al., 2013) – adopting a social exclusion perspective where poverty is prevalent is not necessarily obvious. All too often, social exclusion is simply not considered, or taken for poverty as a state of deprivation, or at best narrowed down to exclusion from social networks, leaving an important part of the political, economic and cultural dimensions of the SEKN definition we adopted for the Health Inc research out of scope.

A frequently used argument is that the concept of social exclusion would be too 'European', its validity limited to European welfare states and thus hardly applicable in LMICs. Yet even the purely European initiative Medium-term Community action programme to foster the economic and social integration of the least privileged groups (EC, 1989), also known as EC Poverty 3 programme, brought forward strong arguments for social exclusion being a truly universal phenomenon. The programme conceptualised social exclusion as more comprehensive than poverty, "much more than money" (Bruto da Costa in Berghman, 1997), in terms of one's sense of belonging to society. Belonging to society was described as dependent on four societal systems:

- The family and community system, promoting interpersonal integration;
- The legal and democratic system, promoting civic integration;
- The labour market, promoting economic integration;
- The welfare-state system, promoting social integration.

Accordingly, Berghman (1997) describes social exclusion as “a breakdown or malfunctioning of the(se) major societal systems that should guarantee full citizenship”. Clearly, this broad conceptualisation of social exclusion as withheld citizenship cannot be considered exclusively European.

The Poverty 3 programme also pointed out the rather important distinction between poverty as an outcome and social exclusion as a process. However, Berghman (1997) noted that on closer examination, both poverty and social exclusion can have a double connotation: a static one referring to outcome, which can be a lack of disposable income (poverty) or a multifaceted failure (social exclusion), and a dynamic one referring to process. Berghman therefore suggests “using poverty and deprivation to denote the outcome, the situation; and using impoverishment and social exclusion to refer to the process”. This results in the following scheme (Figure 4).

Figure 4. Berghman’s framework of poverty, impoverishment, deprivation and social exclusion

	Static Outcome	Dynamic Outcome
Income	Poverty	Impoverishment
Multidimensional	Deprivation	Social Exclusion

Source: Berghman (1997), p 7

From this scheme we can derive a concise, but more general definition of social exclusion: social exclusion is a dynamic, multidimensional process that leads to various forms of deprivation.

The definition of social exclusion as a process then provides us the link with the concept of mechanisms in the understanding of the same in social reality as a whole and in the SPH initiatives under scrutiny in particular.

But let us get one step closer to the social reality of social exclusion before having a look at the mechanisms that shape it as a process. We take this step by referring to the work of Jan Vranken, who studied poverty and social exclusion not so much at a theoretical level, but in its actual, daily life appearance for several decades. According to Vranken and De Boyser (2003), social exclusion occurs when ‘units’ (individuals, positions or groups) are hierarchically ordered and when on top of that clear fault lines appear. These fault lines are sudden ‘drops’ in the social continuum and take the (metaphorical) shape of chasms, walls or high thresholds. These fault lines indicate a qualitative difference between people, groups or areas, in terms of access to social benefits, political rights, formal and informal markets, and so on. Vranken also pointed out the important role of so-called ‘gatekeepers’. These actors are people, but often also institutions that are situated on the strategic junctions of a network and have control over the social goods. They can decide whether people have access or not to networks or social goods.

Based on the work of Vranken, De Boyser (2003) identified five central areas or fields that produce and/or reproduce social exclusion:

- The labour market through unequal access, negative consequences of unemployment, inequalities between formal and informal labour and the unequal access to social benefits derived from labour;
- The education system through unequal access due to the social, economic and cultural situation of the households, impact of physical factors of the environment (distance to the school, quality of school buildings, etc.), unequal access accentuates unequal outcomes;
- Housing through unequal access to (social) housing market, poor housing areas deprived of basic services;

- Health through poorer health quality due to social and economical situation and the resulting inequality in life expectations, unequal access to health;
- Social services through various thresholds.

One might argue that in the Health Inc research we should only look at the fourth area, health, but it is clear that when looking at social exclusion in SHP programmes and schemes, it is necessary to take into consideration the other four areas too, as they all have an impact on the success (or lack thereof) of the programmes and schemes.

The labour market: often SHP schemes are 'reserved' for people in the formal labour market, excluding informal labourers, although in many LMICs people who work in the informal sector are the vast majority of the work force;

Education: low educational outcomes deprive people from knowledge/information-gathering capacities that are needed in order to be able to benefit from the SHP schemes. This disadvantage is even more accentuated when gatekeepers accommodate the schemes' campaigns to the ability of more educated people;

Housing: many deprived people live in poor areas that are remote or otherwise isolated and where decent information channels and social services are sparse;

Social services: often have high thresholds.

Berghman (1997), based on Bouget and Gachet (1996), points out the importance of the spatial dimension of social exclusion, as manifest in the isolation of 'island' communities, not necessarily based on distance. This refers to poor spaces in themselves rather than to spaces where there are poor persons. Such a space may be a poor region, village or neighbourhood surrounded by more 'developed' ones. As such it emphasises that the attempts to counteract social exclusion need to be universalistic and should not only focus on persons and/or groups. "The notion of target groups, though not necessarily inappropriate, becomes incomplete, since ultimately the target group is the community of the space as a whole" (Berghman, 1997). Clearly, the unbalanced reliance on targeting can be seen as an inherent inadequacy of many a social protection initiative, as was also elaborately argued by Mkandawire (2005) when comparing targeting and universalism in poverty reduction strategies.

Health Inc: bringing together mechanisms and the process of social exclusion in SHP

If we apply the model of Hedström and Swedberg to a Social Health Protection scheme that is intended to have a transformative outcome, putting in place the SHP scheme at the macro level should activate situational mechanisms to which people react through micro-level action-formation mechanisms. If these lead to a large enough number of people taking part in the scheme, transformational mechanisms can enter into motion that lead to the desired output at the macro level: an effective SHP scheme that redresses the health inequities and even leads to a more equitable society in general.

The previous description is of course an idealised scenario. In the real world quite a few elements can prevent the cogs in the mechanisms from turning in the right direction, or even put in motion other, counterproductive mechanisms that lead to the opposite of the effect the SHP scheme intended to achieve. The Health Inc research identified a number of such elements in the different steps of this model.

Gatekeeping

In the first step of Coleman's model, our research identified gatekeeping as the strongest mechanism to produce counterproductive effects, operating at various levels and in different forms or variations. In all four case studies, our research showed that from the highest ranking cabinet collaborator who is part of the 'design team' of an SHP scheme down to the local civil servant who has to enrol the members of the scheme's target group, these gatekeepers all can and do exert in one way or another a certain amount of power that decides who's in and who's out of the scheme. At the level of conception of the scheme, the 'designers' decide who the target group will be

and what are the rules that make one eligible for membership. This is heavily influenced by the political currents and policy priorities that are dominant at the moment of conception and can result in the political interest for or neglect of a certain population group (e.g.: a scheme might be aimed at elderly people while the handicapped and migrants are neglected by the authorities). But even when the scheme is being implemented, members of the targeted group might be denied access by various 'implementers': e.g., by planning an information campaign that, even involuntarily, is set up in a way that it cannot reach the target group. This can be because of a wrong choice of communication channel: choosing television when the target group owns few or no television sets, opting for textual advertisement when targeting a mostly illiterate population, etc. Another reason for denying access might be an almost unconscious 'ostracism' that is present in the cultural and social mind-set of the gatekeepers towards certain population groups. The Indian case studies provide us with very clear examples of this 'ostracism', especially towards the Scheduled Tribes (chapter 14). Given their position, the gatekeepers can, deliberately or not, manipulate the wants of other people by triggering the cognitive dissonance/adaptive preference formation mechanism (see below). As Elster (1982) put it: "if one only wants what little one can get, one's preferences are perhaps induced by other people in whose interests it is to keep one content with little."

The role the gatekeepers played in each of the four locations where the Health Inc research was conducted also shows the importance of what Lipsky (1969) called the 'street-level bureaucrats'. They can be identified as persons who are (directly or indirectly) working for the government, interacting with citizens in the course of their jobs in which they have significant independence in decision-making and an extensive impact on the lives of their clients. At the same time, these street-level bureaucrats often find themselves confronted with unavailability of resources and ambiguous, contradictory and sometimes even unattainable role expectations. Regarding the latter, we found that quite a few people working in health centres in Senegal or Ghana found themselves in that position, giving care, but not informing the patients/clients correctly or extensively about the SHP schemes, often because they themselves had not been informed well by their superiors. This results in two types of gatekeepers at 'street level': active ones who clearly decide who is in or who is out, based on a 'du ut des' principle (greed, corruption...) or the relationship of the receiver of the benefit with the gatekeeper; and passive ones who exclude on a more involuntary basis because these gatekeepers were not or were poorly informed themselves about the functioning of the scheme. A clear example of the latter were the poorly informed administrators in Karnataka and Maharashtra who had to organise enrolment camps, but were not able to inform the people about the advantages of the scheme; in Senegal a number of street-level bureaucrats were not sure about the advantages of the scheme because of a lack of information, and doubted the efficiency of the scheme. Because of this, they took the decision not to inform the potential beneficiaries. In India we also find a "stepped" structure from top to bottom, where in every step/delegation of the implementation task, an important amount of information about the scheme and its inclusive character was lost while at each step more existing social, political, economic and cultural mechanisms of exclusion came in motion.

Our analysis further revealed that the negative attitude of and the choices made by the gatekeepers were a main threshold that impeded collective behaviour of the targeted population, and created a strong atmosphere of distrust towards the state and government-related issues in general. This lack of trust is shared by a vast amount of the population that is targeted by the scheme and strengthens their doubts about whether or not to join the scheme, regardless of how much the improvements of taking part in it might be clear. The height of the thresholds shows the importance of social networks and the influence they have on the targeted, vulnerable population groups.

Network diffusion mechanisms

Gatekeeping as a mechanism is closely linked with network diffusion mechanisms that were clearly at work in all cases. People within the health services often did not inform the potential members of a scheme because they received negative or confusing information on the functioning of the scheme from within their professional network. At the same time, the social networks of the targeted population groups raised the thresholds for collective behaviour even further: "other people are not joining, so we don't either". Their compact networks are characterised by strong, but not very far-reaching ties that often don't provide the necessary, well-informed connections to convince them of the benefits of the SHP scheme. The qualitative data for West Africa show that people are strongly influenced in their decision to whether or not to enrol by the opinion of persons close to them in their social environment. The deteriorating social network of ageing people in Senegal contributes to their hesitations to join the scheme. A lack of trust in the institutional is often shared among the members of the community and even reinforced by the implementation of the SHP scheme.

Spatial isolation

The excluding power of the spatial isolation or seclusion mechanism is strongly present in all four studied locations. It is even strengthened when interacting with gatekeeping and adverse preference formation: isolated or poor spaces in rural and in urban areas are neglected by the political and administrative forces in power and this lack of political and institutional networks at the grassroots level enhances the feeling of the people living in the isolated areas that the SHP scheme "is not meant for people like them": there is no need to look for social benefits because these are seen as intended for 'other people'.

Adaptive preference formation

It is clear that the number of failures in the situational mechanisms is a serious impediment for entering in motion the following phase, the action-formation mechanisms at the individual, micro level. The Health Inc research, in particular the qualitative part of it, clearly demonstrated the importance of cognitive dissonance / adaptive preference formation as a mechanism. It was striking how in a number of interviews, the people who were targeted by the SHP scheme talked about it as 'something that is not meant for people like us' or 'When one is poor, one stays in the spot of the poor' (interview Senegal). It is important to point out, as Elster (1982) did, that this mechanism is an effect and not a cause. All too often this mechanism is interpreted as a deliberate act of the concerned actor, while in reality it is a way of coping with a situation of often prolonged deprivation over which the actor has very limited or no control or power at all. The analysis of the Senegalese qualitative data shows clearly how the older people, targeted by the SHP scheme, perceive themselves as such.

Discounting

A second important action-formation mechanism that is at work here in a negative sense for the scheme is the mechanism of discounting. Investing in the scheme is investing in something that might be advantageous in the near or far future. However, most people's daily needs are such that future benefits are strongly discounted in favour of more pressing, daily needs. When previous negative experiences with malfunctioning health (and other) services are added to the choice of using scarce resources for a possible advantage later in time compared to an immediate advantage of fulfilling a serious need now, the balance quickly tips towards the fulfilment of present-day needs. This is an active, deliberate decision not to participate in the scheme. It could be explained as self-exclusion from the scheme, but we can just as well conclude that these people actively take the decision to exclude the scheme from their lives.

Education

At this level, the effect of gatekeeping reinforces or is reinforced by another mechanism: education, or rather, the lack thereof. When information is given in an unintelligible way, people will not be able to grasp it and act accordingly. It is important to see the correct direction of the causality. In this case it is not the targeted group that doesn't look for the right information, but the fact that the information is out of their reach that explains the low awareness about the SHP scheme. The mechanism that is at work here, education, is not part of the implementation process, but was already in motion quite some time before the scheme was put in place. This shows, once again, that when looking at a particular fact, like putting in place an SHP scheme, and explaining it, it is paramount to look at the broader social context in which it is taking place.

Failure to transform

The failure of the situational mechanisms to put in motion the right action-formation mechanisms in the end leads to the transformational mechanisms not entering into action, or at least not in the direction intended. There is no tipping point reached that would result in the transformative effects desired as an outcome of putting in place the SHP scheme. As a matter of fact, our research discovered that often the opposite was achieved, namely that the implementation of the scheme created a Matthew effect: it advantaged those members of the population who already had certain advantages. In that sense the mechanisms turned in the opposite direction.

Labour Market

The labour market often accounts for people being excluded a priori from schemes that are directed at those who work in the formal sector, leaving out a majority of the labour force in LMICs. The combination of the labour market mechanism with the previously mentioned mechanisms strengthened the Matthew effect. This is shown by the Health Inc results. In Senegal the SHP scheme was put in place to benefit a specific target group of elderly people, regardless of their position in the labour market or geographical location. However, in the end it gave an advantage to people who already had another SHP scheme at their disposal because of their previous jobs in the formal sector and those who lived in urban areas and already had easier access to health services. Often they were also better educated with a larger network, so the educational and network diffusion mechanism turned in the positive sense for them and strengthened their access to the new SHP scheme. As such, the profile of an elderly person who received care through Plan Sesame was that of an educated man retired from the formal sector and residing in an urban area. In India the political and institutional gatekeeping mechanism also favoured those who already held an advantaged position.

Policy recommendations emerging from these findings are discussed in the following chapter.

Conclusion

Applied to Coleman's model, our research found that the initial lack of attention for the institutional and societal environment in which the SHP schemes are implemented gives them such a handicap from the start that any further development of the schemes towards a positive outcome is truncated. The SHP schemes that were under study in the Health Inc research are meant to promote inclusiveness, but are implemented using existing structures in which strong mechanisms of social exclusion are embedded, resulting in an ill-fated start for the schemes, no matter what their intended outcomes were. Contextual mechanisms external to the scheme were copied and or reproduced in the functioning of the scheme. It is striking that quite a few of the conditions for inclusion in the SHP scheme, like age, gender, Below Poverty Line-status or informal employment, are at the same time the determinants/drivers of exclusion from the scheme. This supports the point made by Berghman (1997) that a target group should include

the whole community: in this case also the institutional networks have to be targeted in the information and implementation phase of the SHP scheme. The institutional network should be made aware of the mechanisms of exclusion (in order to be able to create awareness with the targeted people about the schemes) and address them before starting the implementation of the scheme.

The initial wrong-footed start creates a situation that is not favourable for setting in motion the necessary mechanisms that make the cogs and wheels in Coleman's model turn in the right direction towards a positive and transformative outcome. Our research discovered that more often than not the mechanisms that are put in motion tend to exclude the targeted population. As a matter of fact this failure to 'tick the right boxes' is such that quite a few of these targeted people actively and deliberately exclude themselves from the scheme, making the intended, transformative outcome impossible to achieve or even exacerbating the already existing inequities.

The lack of trust the targeted groups express towards the SHP programmes, and the hesitation or even refusal to join the programme because of it, is a clear indication that the targeted groups don't consider themselves involved and have no intention of getting more involved. To them, the programme or scheme is just another one of those government initiatives that 'come from above' and, in their opinion, will not deliver what it promises. As Zakes Mda (2000) phrased it in his wonderful novel "The Heart of Redness": '... that is the danger of doing things for the people instead of doing things with the people.'

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