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The work of reform: a critical examination of health policy

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Abstract

Anthropologists have critically examined a range of reforms from education and land to finance and health. Yet the predominant way of looking at reforms has been through a lens focused on neoliberal governance. For example, prior studies of health reforms focus on insurance, financing, and access to care. Yet, seeing reform in this way fails to attend to other types of cultural work at play when calling a policy or law a reform. In this paper, we draw on ethnographic research on health policy reforms in Israel and Bolivia to examine the concept of reform and the work it does within national movements. We argue that while the language of reform often signals change or novelty, reforms also carry forward historical continuities and reifications of the past. By delving into the past and its relationship with ongoing health reforms, we attend to how reforms can reinforce and maintain health inequities in some cases, while creating a national language for new possibilities in others. Reform, as we will discuss in this paper, is not only about political ideology, neoliberal governance, or on-the-ground policy implementation, but centrally it is about representations of aspirations, and about crafting relationships between past, present, and future.

Keywords

reform; health policy; health inequities; Israel; Bolivia

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Ethics approval

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Disclosure statement

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Introduction

Reforms have served as central objects of anthropological inquiry in studies of land, healthcare, economics, and immigration (Waitzkin and Hellander 2016; Abadía-Barrero 2016; Tyak and Cuban 1997; Lashaw 2010; Moore 1998). But what does it mean to call something a reform? The language used to talk about reform is often represented as a turning point in the state's narrative as a signal of change or a new direction, and in many cases strives towards promoting equity. Yet, seeing reform in this way can fail to attend to the historical continuities and reifications of inequities that reforms carry forth. In this paper, we examine these aspects of reform by tracking studies of reform in the anthropological literature and in our own fieldwork on healthcare reform. Reform is not only about political ideology, neoliberal governance, or on-the-ground policy implementation, but centrally it is about representations of aspirations, and about crafting temporal relationships between past, present, and future.

In this paper, we focus on how various stakeholders, from policymakers who develop reforms to the individuals impacted by them, frame reform using notions of temporality to promote equitable changes within a nation. Our argument is twofold: (1) the concept of 'reform' relies on a work of time and temporality, where past, present, and future are put into dynamic relationship with each other; (2) these relationships between past, present, and future can have the effect of maintaining past unequal systems and infrastructures, even when new visions are projected onto the future. This exploration of the concept of reform has consequences for researchers of health reform and for policymakers crafting reform.

To do this work, we draw on our research on health reform in Israel and Bolivia and on theorists who have studied historical change. Scott (2004) writes about the relationships between pasts and presents in the telling of history. According to Scott, the present organizes how the past is retold. He asks: 'What present was this supposed to be that the past was being called upon to illuminate, and moreover, in relation to what prospect—what hope—what expectations?' (p. 3). Scott urges us to attend to how the present is represented, and how this representation shapes the way the past and future are understood and envisioned. Drawing on this insight, we suggest that reform can be understood as a site of contestation that enables and reifies certain ways of thinking about past, present, and future while erasing or silencing others. Examining reform through this lens opens the possibility of attending to the aspects of health or inequity that reforms may exclude, but that nonetheless shape healthcare and health systems.

Like other anthropologists who have done comparative work (Gupta and Ferguson 1992; Bartlett, Garriott, and Raikhel 2014), we have found it productive to bring together two distinct field sites (Israel and Bolivia) to develop our ideas about the concept of reform. We bring together these cases of reform, one that had taken place and one that was still under-way, to center our argument on the concept of reform itself and demonstrate the common themes that emerge when studying reform as an object, even in different contexts. While we pay careful attention to the historical contexts at each site, in both, healthcare reform was central to the state's narrative about its history and future direction, while also

relying on problematic, inequitable infrastructures and practices, thus undermining stated narratives of equity.

Anthropology of reform

The national health reforms we studied developed within particular governments and bureaucracies. Attention to the study of governance is therefore a key way to consider how reforms emerge, the type of work they do, and the assumptions upon which they are built. In prior work, anthropologists drew attention to the inner workings and cultural life of government and bureaucracy as critical arenas to understand state-citizen relationships (Holston 2008; Feldman 2008). Anthropologists argued that bureaucracies are far from static or uniform entities, but instead suffused with affect and aesthetics (Navaro-Yashin 2002; 2007), histories (Feldman 2008), and materiality (Hull 2008; 2012). Reforms, from health, welfare, land, and education carry these entanglements with bureaucracies and the complexities that they invite (Waitzkin and Hellander 2016; Abadía-Barrero 2016; Tyak and Cuban 1997; Lashaw 2010; Moore 1998). For example, Hull (2008), in his study of land reform and bureaucracy in Pakistan, examined how government officials struggled to implement land reforms because of overlapping, and at times negating notions of how to measure and classify land. Hull emphasizes the importance of attending to the 'graphic artifacts' of bureaucracies (such as maps, surveys, and statistics) that are used by government officials and citizens to make sense of bureaucratic processes (p. 503). These artifacts often take the form of documents, but can also manifest in infrastructures, and they become important sites of anthropological inquiry into bureaucracy (Hull 2008; Riles 2006). The material artifacts of reform, such as the ways infrastructures include or exclude certain citizens, are also important when considering the cultural meaning of reforms themselves, such as what they reflect about equity, deservingness, and national aspirations (Willen 2012).

Prior studies of reforms also show the ways they are embedded within broader neoliberal policies, ones whose focus advances privatization and economics (Lamphere 2005; Uzwiak and Curran 2016; Kline 2019; Foley 2009). For example, in her work on health reform in Senegal, Foley examines critiques of neoliberal reforms that had the stated aim of distrib uting health care equitably and reduce health disparities (Foley 2009). Foley suggests these equity-driven reforms that rely on utilitarian and liberal moral frameworks can mask how reforms may worsen injustices and social, political, and economic inequalities. This in turn may place the burden on individuals to take responsibility for their health while shifting the focus away from systemic health disparities that lead to illness (Abadía-Barrero 2016; Biehl 2013). These cases show the consequences of competing ideologies and the on-the-ground manifestations of these tensions. Our work similarly looks at the intersection of health reforms and existing social structures and systems. However, we look further upstream by paying specific attention to what it means for the state and policymakers to explicitly name a policy a reform and attend to the ways that temporality manifests in these dynamics through inception and implementation.

Along these lines, social scientists of education have long considered reform to be a central concept (Cuban 1990; Lipman 2002). Lashaw (2010), for example, asks us to

consider, ‘What is signaled by calling something a reform? What ideological work does this concept do?’ (p. 324). Health reform, like education reform, is often tied up with questions of progress, deservingness, novelty, and equity. Like education reforms, health reforms continue to be proposed even as they often fail. We therefore take seriously Lashaw’s insights when she asks: ‘[I]f reform movements rarely deliver on their promises, what else do they do? What are their most important effects?’ (p. 324). For Lashaw it is the way reformers remain passionate about changing schools, despite the continued failure of these attempts. We found a similar passion among some of the reformers in our work and found that calling something a reform in healthcare—especially from a governance perspective—signaled an attempt to draw a distinction between old/new and past/future. As anthropologists we study the important cultural work these distinctions create and the material and ideological continuities, such as inequitable infrastructures, healthcare conditions, that transverse this supposed temporal break, as well as unexpected possibilities.

Comparing sites: the entanglement of past and future in the search for health equity in Israel and Bolivia’s health reform legislation

We both conducted ethnographic fieldwork during the years 2010–2012. In Israel, the passing of national health reform happened fifteen years prior to NR’s fieldwork, while in Bolivia, policymakers were actively engaged in designing and producing reform during ABS’ fieldwork. These differences resulted in our encountering reform at different stages of development, providing complementary lenses to think about the process of reform.

In 1994, Israel instituted national healthcare reform with the passing of the National Health Insurance Law (henceforth, NHIL). The law’s authors explicitly state in the preamble that the NHIL was constructed with the core principles of promoting ‘justice, equality, and mutual support’ (Ministry of Health 1994). The law mandated equal access to medical services to all Israeli residents (Ministry of Health 1994; Borkan, Morad, and Shvarts 2000). Prior to the NHIL, there had been twelve unsuccessful attempts of national healthcare reform and six professional committees on the matter. The alignment of political and economic contexts in the early 1990s paved the way for the law’s approval (Shvarts and Davidovich 2005; Bin Nun and Rosen 2007). As Angel and colleagues note, while the law centered around themes of justice and equity, the NHIL emerged due to ‘repeated financial crises, poor quality of care, and low public satisfaction’ (Angel, Niv-Yagoda, and Gamzu 2021). The NHIL ensured financial sustainability to the health system through an obligatory health tax, and the law’s authors defined and guaranteed a basket of health services and decoupled health plan enrollment from political party or union affiliation (Shvarts and Davidovich 2005; Bin Nun and Rosen 2007).

Bolivia’s health reform began to formally take shape in 2006 following the election of a socialist candidate, Evo Morales Ayama, the nation’s first indigenous president. Morales’ presidency and the resulting health reform emerged from an indigenous social movement that grew out of an explicit reaction to aspects of the nation’s past that marginalized indigenous people: a history of colonialism, neoliberalism, and the privatization of natural resources (Anderson 1995, 644). The government, urged on by the social movements at the time, created a new constitution for the nation. This new constitution incorporated several

paper related to the right to health, including the mandate to create a unified healthcare system called *el Sistema Único de Salud.* This unified healthcare system aimed to make healthcare affordable and accessible to all Bolivian citizens in both rural and urban areas of the country, and shift healthcare away from being seen as a privatized commodity. As part of the health reform, a new vision of healthcare was developed and implemented via a new health policy, *Salud Familiar Comunitaria Intercultural*, or the Family Community Intercultural Health Policy (henceforth SAFCI), which was passed in 2006 and sought to strengthen the public healthcare system (Bernstein 2017; 2018).

In both of our studies, we examine what happens when something gets called a 'health reform,' and the ways this naming requires an attention to temporality. We look at how pasts and futures become entangled around the present in the ways reform is represented and enacted. Our conceptions of what health reform is and what it can do emerged from conversations we had about these two sites, leading us to develop this work about temporality, equity, and reform together. Below, we introduce our methods and examine how reform played out in each context. We highlight how reform orients future directionality and aspirations towards an equitable society while attempting to detach from a past whose continuity nonetheless is carried forward and challenges the ability to achieve the aspired reform.

Israel

Background: In southern Israel, where I based my research, Bedouin Israeli citizens, who are part of the Palestinian-Israeli community, make up about 20% of the regional population. When health reform went into effect in 1995, only half of Bedouin citizens had health insurance. Shortly after the NHIL implementation, over 90% of this group gained access to health coverage. Thus, for Bedouin Israelis specifically, healthcare reform dramatically improved medical coverage and access. However, health reform in this region intersected with deep divisions and inequities between Jewish and Palestinian citizens. Palestinian citizens persistently suffer worse health outcomes compared to Jewish Israeli citizens in key health indicators, including infant mortality, life expectancy, and cardiovascular disease (Chernichovsky et al. 2017; Ministry of Health 2019). In southern Israel, the gap between Jewish and Palestinians citizens' health is most severe. Bedouins' infant mortality rates are three-fold that of regional Jewish infants (Rubin and Yosef 2014). Jewish women in the region outlive their Bedouin neighbors by eight years (Rudnitzsky and Ras 2012). And nearly 80% of Bedouin children live below the poverty line in southern Israel, compared with 22.2% of Jewish children in the region (Andveld et al. 2019, 28). It is in this setting that I conducted research on how healthcare providers and patients navigated the health care system and made sense of a reform that promised equality while histories of exclusion and persistent inequities shaped the ongoing experience of Bedouin citizens in the region.

Methods: My research on health reform in Israel draws on fieldwork conducted over the past decade. I spent twenty-seven months conducting fieldwork, twelve of those spent continuously. I lived in a government planned Bedouin town to understand the complexity of daily life in the region. During that period, I conducted fieldwork in two departments at the regional hospital. My fieldwork consisted of joining the medical providers' daily activities: I

shadowed providers as they triaged, treated, and interacted with patients, their families, and one another. I attended staff meetings, journal clubs, and grand rounds. I also accompanied families as they navigated the medical system. While my time with providers (nurses, physicians, and social workers) required constant movement between patients, I spent many hours with families waiting—waiting to be seen by a provider, waiting for treatment, and sometimes simply waiting for symptoms to resolve. Many of my conversations with families took place in these extended periods of waiting. It is in these routine encounters that I witnessed how health reform materialized for individual families and providers. In addition to ethnographic work within the hospital, I visited community clinics throughout the region. I also formally interviewed thirty-two providers and twenty-two Bedouin families (n = 54). I conducted an additional round of fieldwork following up on earlier themes and additional interviews with health policy specialists. In what follows, I examine how health reform was experienced by the Bedouin community and providers who cared for them. Rather than accepting reform as leading to change and advancement, or solely limited to the implementation of a law, I turn to the manner by which health reform, even within its orientation towards change, failed to challenge the broader exclusion of Bedouins in the region.

Findings: One of the main challenges of Israel's healthcare reform was that it took place within a setting that did not address fundamental inequities, even as it elevated the language of equity. The Bedouin population consists of approximately 200,000 individuals. About half of these individuals live in towns that are not recognized by the state as legal, due to ongoing disputes about land ownership (Yiftachel, Sandy Kedar, and Amara 2012). Many of these towns lack running water, sanitation services, and most basic municipal services. The remaining half of the population resides in towns built by Israel's government. These towns, known as 'recognized towns', are consistently the poorest townships in Israel and experience ongoing neglect (Central Bureau of Statistics 2020). Implementing healthcare reform in such a setting meant that medical care, promoted as equal and advancing justice, encoun tered an inherently inequitable landscape.

One of the main tenets of healthcare reform mandated that each Israeli resident is guaranteed access to healthcare services 'at a reasonable level of quality, within a reasonable period of time, and within a reasonable distance from the patient's place of residence' (Ministry of Health 1994). As a result, the number of clinics in the Bedouin community increased with these reforms. One Jewish former government employee, Shimon, explained these changes to me:

> The availability of medical services [in the Bedouin community] expanded very significantly since the law… If before the farthest [a] Bedouin needed to travel something like, or walk about 10 kilometers… Today in the worse situation it is two or three kilometers. And there is transportation, there are cars and phones and cell phones and everything is much simpler. So from that perspective you can see there is significant development.

Shimon highlighted the increased presence of medical services such as primary care clinics among Bedouin towns as evidence of improvement due to the health reform. Although the

number of clinics increased, the health of the Bedouin community in the broader sense of the term remained inadequate. When I visited one of these new clinics established in an unrecognized town, Dr. M, the physician who worked there three days a week, explained to me how the decision to place a clinic in the village in fact reflected the broader exclusion of the community. The clinic was placed not in the center of the town, which would have better served the community, but rather at the edge of town which made it difficult for residents to access services. Israel has long used infrastructure as a way to seize or recognize territory (Weizman 2007). By not placing the clinic in the town's center, it maintained an ongoing exclusion and lack of recognition of the town. As Dr. M. explained to me, '[The government] did not want it [the town] to be a permanent community [*yeshuv keva*]… So the clinic is far from the community… If the clinic was there [near housing and school] it would serve 3,000 [individuals] but we just serve 800.' When I asked him where the rest of the community goes for healthcare, he explained that it was easier to get to other towns as people could get a ride. Dr. M, grew up in the region. And as a Bedouin physician he witnessed health reform not with the optimism of Shimon, but rather as a failure to actually challenge long standing inequities. By placing the clinic outside of the town, Dr. M. felt that the Ministry contributed to the ongoing marginalization of its citizens' needs. The law opened the possibility of caring for Bedouin residents, but decisions like where to locate a clinic perpetuated a reality of ongoing neglect.

One of the insights I gained while conducting fieldwork in Southern Israel was the limited scope that health reform carried despite its aspirational vision. Health reform in Israel focused on building clinical infrastructure without attending to the actual on-the-ground needs of the population that shaped health. Many Bedouins lacked electricity for refrigeration of medication, faced food insecurity because of poverty, and could not access clinics because of a lack of paved roads or vehicles. Thus, the investment in clinics, while welcomed by the community, was not viewed as truly reforming. Dr. A., another Bedouin physician, experienced the growth of clinics in the region not as promoting health equity but rather a reflection of a history of exclusion. He told me:

> The reason for the large investment in the Bedouin community is because we started from zero. The population was neglected, so it looks like there is a big investment to those who don't know the reality. There was a big investment because there was none for so many years. There is built-in discrimination against Arabs… There is discrimination in budget, manpower, integration. Compared to the Jewish citizen, the state is not equal to the Bedouin population. There is racism and the state does not fulfill [its obligation].

While individuals may now have health insurance or could access a clinic, the socioeconomic landscape that cemented inequalities remained unchanged. Policy makers and health services researchers I interviewed were aware of the limited boundaries of healthcare reform. As one Jewish physician researching health policy suggested to me, the NHIL created a superficial equality. Sima, a Ministry of Health employee, similarly recognized the limits of the NHIL's reform:

> Maybe we should say [to government officials] 'Include budgets for trade or industry to decline unemployment,' or '[You] need to increased education, and

> [there is a need] for welfare'…. [But] we can't change the world. And there are big gaps and we can increase awareness and [highlight] that from here comes the problems… And we will try what the Ministry of Health can do, and what we can do is what is under its jurisdiction.

Sima underscores the hopes of the NHIL and the obstacles it meets. While the aspirational goal of the NHIL pivoted around equality and justice, it remained tied to a past that it did not adequately address: one of deep inequality and exclusion.

Through the limited purview of health reform that health providers and policy makers enacted, health reform narrowly focused on the biomedical conditions of the body—building required clinics and caring for physical bodies (Razon 2015; 2017). This meant that the broader cause of ill health—entrenched racism, socioeconomic inequities, lack of water and sanitation—continued. Reform carries the language of change and progress, and yet along with change, health reform in Israel maintained legacies upholding an inequitable status quo.

Bolivia

Background: In contrast to the long-standing reform that NR studied in Israel, I studied an emerging reform, as I started my fieldwork in Bolivia in 2010, just a year after the new constitution was enacted. The policymaking team in the Ministry of Health that was the focus of many of my interviews had been working formally on the ideas at the foundation of the health reform since 2006, but many had also been engaged with these philosophies for years through their training and in practice as activists, rural community doctors, and public health experts. I entered fieldwork to study health reform as it was currently developing, which enabled me to be uniquely situated within the dialogues, debates, and meetings involved in the development, implementation, and iteration of the ideas embedded within the reform. I was also able to access the very people who had helped design the ideas. This vantage point provided me with an experience of the everyday practices and discourses that produced a new health reform, as well as the challenges of addressing deeply ingrained inequitable histories.

One of the impetuses behind Bolivia's health reform movement, as well as other social movements at the time, was to create a vision of a future, one where all citizens are included in the health care system, contrasted against and as a remedy to the past. Health reform, mandated by the Constitution, grew out of the new government's platform for universal healthcare without social exclusion. Their policy focused on indigenous rights and providing access to healthcare for people living in rural areas in a country that is over 60% indigenous, with a third of the population living in rural areas. The maternal mortality rate around the time of this research was 234 out of every 10,000 live births, with major health disparities between urban and rural areas of the country (Moloney 2009). For example, at the time, 57% of women in the country sought out state medical services when giving birth, but in rural areas, only 30% sought out state services, disparities that had their roots in colonial and neoliberal approaches to health care provision (Johnson 2013). Bolivia's reform ideology formally rejected the past, which involved the privatization of healthcare that contributed to these disparities, with much of care centered in urban areas of the country, and little focus on indigenous and rural healthcare. The new reform included attention to issues around both

access to care as well as the lack of validation of indigenous conceptions of health and healing or attention to rural populations (Johnson 2010; 2013; Bernstein 2017; 2018).

Methods: I conducted fifteen months of ethnographic fieldwork in Bolivia between 2010 and 2012. During my fieldwork, I did oral history interviews with eleven policymakers in the Ministry of Health, as well as 58 other stakeholders who were involved in policymaking, including government officials, community leaders, activists, NGO leaders, traditional healers and midwives, and biomedically oriented doctors. In these interviews, I asked about the process of designing the health reform and the SAFCI policy, the experiences- both personal and political- that those involved brought to the table, and how they understood the emergence of the different aspects of the reform movement and resulting policy (Bernstein 2017). I also interviewed nine leaders at two different *cajas*, a system of worker social security organizations that covered roughly 30% of health provision in the country outside of the public healthcare system, and 12 health care providers from the *caja* clinics. I conducted participant-observation at nine health policy events where the new health policy, and the reform were discussed, debated, and revised as well as in the offices and at health policy trainings and meetings of one of the *cajas*. Data included interview transcripts and in-depth fieldnotes from participant-observation and interviews.

Findings: In Bolivia, discussions about health reform—whether in my interviews or at events—typically involved a re-telling of Bolivia's racist, colonial, and neoliberal histories, where health reform was oriented as an intervention into healing that past by imagining a plurinational nation that placed indigeneity and a right to health at its center as a reparation. In many of these conversations, past reforms were discussed as 'unsuccessful' to illuminate a particular future that could emerge from the new government and policy. For example, those I interviewed contrasted past approaches to medical care focused solely on urban hospitals and meant to cure diseases with their new vision that focused on prevention, health promotion, and traditional medicine. This measuring against the past was an important way through which a concept of reform as novelty was produced (Postero 2007). Health reform was also discussed as something revolutionary and as part of the larger-scale national transformations emerging at the time. One Ministry of Health policymaker, when talking about health reform, noted that it was taking place in the context of broader reforms within the country that enabled health to be an object of transformation,

> When people began to march, marches asking for territory, marches for the right to a good life, and for the new Constitution, it stirred the imagination of the people around this theme and they began to get engaged. When they said, 'Look how I am living,' the only thing we could do was change the Constitution. We had to begin anew.

Another policymaker I spoke with echoed this sentiment of the need for novelty, using the language of revolution, while emphasizing that there had been prior inadequate attempts at incremental reform, 'In the health revolution in Bolivia, the real one, we may be able to make healthcare access a real right for the whole population. This is the real transformation in Bolivia.' These kinds of framings of the past made sweeping, overarching reform and a different approach to the future a necessary step for the nation.

Yet, discussions of the need for novelty and reparations existed alongside the nation's reliance on infrastructures from prior neoliberal governments, such as health NGOs, privatized health institutions, health insurance, and an emphasis on western medicine with little attention to rural areas of the country or indigenous principals of health and healing. As such, while the approach to reform involved a language of novelty that imagined a future vision of healthcare provision, policymakers also had to grapple with, on a practical level, the many continuities with the past due to existing health infrastructure in the country that enabled the health care system to function. Anthropologist Brian Johnson (2010) has called these continuities a 'paradox' of the Bolivian healthcare reform: the healthcare system itself was still anchored to existing structures on the ground that paradoxically served to detach the realities of implementing a transformational reform. These structures included both NGOs and social security and worker's health insurance organizations. The stated aim of eradicating unequal health infrastructures and the necessity to maintain these infrastructures is one of the central contradictions in the narratives of novelty relied on in this health reform, showing the ways these realities can co-exist as a reform moves forward.

One example amongst other steadfast infrastructures from the 'past' was the *cajas,* or social security and worker health insurance organizations. In my study of the *caja* system, I saw both reifications of past systems, as well as surprising adaptations and new relationships that were enabled that served to bridge the past and the future around the 'event' of reform. Aihwa Ong (2007) discusses this issue in her work on neoliberal reform, and the ways these reforms are often conceptualized as 'totalizing social change across a nation' when they actually involve a set of relationships rather than anything totalizing (p. 4). I interviewed representatives from two different *cajas* while in Bolivia: one *caja* was resistant to the idea of the health reform, while the other was actively reshaping their work to incorporate the premises of the reform. The contrast between these two perspectives highlights some of the challenges of the language of sweeping reform situated within an incremental on-the-ground reality.

A *caja* representative I spoke with from the organization that was resistant to the idea of the health reform explained that they feared that the government would attempt to unify all of the *cajas* under a singular system. While the messaging of the unified healthcare system was a human rights message signaling the equitable provision of healthcare coverage to all citizens, this posed a challenge to existing *caja* structures that functioned independently of a universal model of healthcare. Some *cajas* staged protests against the health reform proposal because they were concerned about this unification and what it would mean for their jobs, hours, and salaries. I witnessed these protests in downtown La Paz, where crowds of doctors and administrators staged demonstrations in front of government buildings, outside of the *caja* hospitals, clinics, and offices, and along the main thoroughfare, stopping traffic through the city with handmade signs declaring their resistance to the unification of the *caja* system by the government out of concerns that they would lose their independence as an organization or that the health care system would become nationalized. This viewpoint was reflected in a statement made in a national newspaper:

> 'We have decided to demand the resignation of [the] Minister of Health… Accordingly, next week the workers and leaders are going to intensify our protest

> measures here in La Paz and if necessary we will wall ourselves until the very end,' asserted Ariel Cáceres, secretary general of the Union of Workers of the National Health Fund (Los Tiempos 2011).

Through this statement, representatives from the *caja* expressed concerns of becoming subsumed by the government health reform efforts. Amidst a language of revolution and novelty coming from the government were voices of resistance on the ground that sought to maintain the often inequitable health infrastructures of the past.

In contrast, another major *caja* embraced the government's reform and began to align their own internal policies and language with the aspirational vision of the state while using their own existing resources and networks. These networks included offices throughout urban centers of the country and within the factories through which their employees received healthcare coverage. In an interview with a director at this *caja*, he discussed the tailoring of their approach to meet the vision of the reform within the context of their institution.

> It is very difficult to implement. The *caja* has its own policies, some of which overlap with the national policies. For the national policy they need baselines and strategies to implement it at the national level, and there are many difficulties in doing this, especially politically. We are pioneers for doing this in the *caja*. It is not complete yet, but we are starting with some approaches. The other *cajas* see what we are doing and ask, 'Why are you doing this, why are you implementing this policy? It is for the public system and you are a social security system.' But we do it because we have the opportunity to implement it, and other *cajas* will then try to copy our model. We can serve as a model for the rest.

'How and why did you decide to use the SAFCI model?' I then asked. He explained that his *caja's* original model was designed in 1956 and required a rethinking to fit the new vision of reform. He explained, using the language of 'old' and 'new':

> This model is very old, and very ambiguous. This is the 21st century, and there are other models, international models, that can help the patients more. I thought SAFCI was very interesting, and so I took aspects of SAFCI and combined it with the old model and created our strategic plan for the institution. There were problems and debates, and not everyone was in agreement about how it should be done, so we started by making a work schedule and made revisions of paper and created strategies that incorporated both SAFCI and our *caja* code.

I observed the implementation of this *caja's* approach to integrating past and future, such as the creation of SAFCI teams within *caja* offices to engage in health promotion activities with workers in their factories, educating them about the new health reform laws and policies, and providing new opportunities, such as intercultural care in their clinics, that fit with the government's reform vision. Yet, the *cajas* were based primarily in urban areas, and thus did not emphasize the radical shift towards rural, indigenous health practices that were central to the language of reform.

I thus suggest that when looking at how manifestations of reform were produced through tensions between 'old' and 'new,' new relationship and dynamics between the seemingly

cast-off past and future visions emerge. Although there appeared to be a contradiction given that the *cajas* represented a 'past' system meant to be unified for true revolution or change, there were also ways that some *caja* leadership and employees were able to create bridges and relationships with the new messaging of the health reform and the use of past approaches and infrastructure. There was thus a tension between eradicating unequal health infrastruc- ture and maintaining necessary health infrastructure that became a central dynamic in the health reform, and challenged the narratives of novelty that this health reform relied on. An examination of these tensions provides an on-the-ground account of the messiness of using temporal contrasts to make an ideological split when the foundations of a nation require a different type of approach.

When studying health reform and the attempts made in the name of reform to create a distinct break from the past, it is important to attend anthropologically to what gets carried forward, demonstrating ways in which the past is maintained or in fact takes different shape within the context of newly imagined futures.

Discussion: temporality, equity, and reform

> Far from flowing transparently out of the 'facts' of the past themselves… historical knowledge is constructed, which is to say made rather than simply given or found (Scott 2004, 40).

The reforms we studied were built on histories of past reforms and historical contexts of inequality. These contexts were continually part of the conversation that emerged about future possibility. Furthermore, both reforms reacted to the past even as entrenchments with the past that they inevitably carried forward made achieving their equitable vision difficult. Reforms, we have shown, address only certain histories and organize society (and in it, patients, teachers, physicians, government officials, and other stakeholders) towards particular futures. Said differently, reforms open horizons of possibility that align understandings of past and aspirational futures rather than necessarily providing a correct, or the only, solution to a problem. In considering our central questions of 'what is reform' and 'what is the work that reform does', Scott (2004) provides a helpful framework for considering how certain temporalities come to be aligned. Rather than accepting past-present-future as a linear and static trajectory, Scott argues that our understanding of the past and how we write histories remain contingent on the type of present we want to imagine for ourselves and the futures we aspire toward. Reforms, as Cuban (1990) suggests, are about values, but, we argue, they are also about arranging temporal relationships. These temporal linkages tell one narrative but may negate or silence others. They also may enable unexpected or new narratives to emerge.

In the national health reform movements we studied, reform became central to the State's narrative about its history and future direction. In both cases we have presented, the on-the-ground realities and infrastructures either failed to meet the visions that the reform put forth or met the visions in unexpected ways. In Israel, health reform emphasized equality and justice of all citizens, moving away from the persistence of racial and religious divisions and into a secular equality (Razon 2016). This secular equality was one that assumed

and prioritized Israel as a Jewish state, and thus de facto maintained ongoing exclusions of non-Jewish citizens. In Israel's health reform the language of access and equality failed to engage with the ingrained discrimination and ongoing inequalities Bedouin-Israeli citizens experience within the healthcare system and beyond. Thus the vision of health equality remained untenable because reform failed to address this haunting past that shapes healthcare in the present. In Bolivia, reform was used to tell a history of a racist, colonial past, and oriented health reform as an intervention into healing that past by imagining a plurinational nation that placed indigeneity and a right to health at its center. Yet, the realities of a resource-scarce environment and remnants of colonial and neoliberal pasts existed simultaneous to the move towards a pluralist view and a socialist government, thus requiring a reliance on NGOs and other health infrastructure of the so-called 'past' to continue to be integral to the healthcare system. Studying reform as a concept helps us make sense of why certain reforms are promoted and the ways reforms are framed in narratives about health and belonging in a country, sometimes subverting goals related to more equitable futures, while at other times giving rise to unexpected new approaches.

Studying reform through an analytic that examines both national narratives and on-the-ground actions and infrastructure helps make sense of why certain stories about reform are told. The NHIL has gone through numerous changes since its implementation in 1995. During my fieldwork, policymakers added capitation criteria to the NHIL funding. Capitation is the system by which each health fund is paid per enrolled member. Initially, each individual member received a sum of money from the National Insurance Institute based on age. This funding—couched in a language of equality among citizens and an aspiration of medicine's ability to transcend social ills—was changed to take into account the sex and geographical location (urban/rural) in 2010. Only in 2019, were poverty, disability, and older age added to the capitation formula. These changes provide insight into the dynamic borders of reform. The Bolivian reform involved claims to novelty and revolution, but also was distinct from something completely and radically new given the limitations of the structures and infrastructures within which it was implemented. For example, the *Sistema Unico de Salud* was never ultimately implemented as law, and so the government could not enforce or uniformly mandate the changes associated with the health reform, even within the context of a new constitutional mandate and the SAFCI policy. Furthermore, since I finished my fieldwork, there have been changes in the Bolivian government, the Ministry of Health, and the national policies regarding health reform. Different priorities have taken hold as new leaders emerged, demonstrating that along with the aspirational visions, health reform is also very much attached to people and bureaucracies, and to those who have the power to advocate for certain ideas and make them a reality.

At this moment, the concept of reform is being actively debated on many different social and political fronts. The insights we offer by thinking through reform are applicable beyond health and education, for example, to policing, land reform, and immigration reform, to name just a few. Reform, as we have discussed, carries continuities from the past, even as reformers aim to recognize and repair often horrific histories that become a central focus of many reform movements. Our work demonstrates that anthropological approaches can

be particularly valuable in contextualizing reform and illuminating the ways that the past persists amidst desires for change.

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