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# Social Policies in Latin America: Causes, Characteristics, and Consequences

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This chapter classifies the main social policies enacted in Latin America from 1920 to 2010; explores the effects of those policies on the well-being of the poor; and outlines some of the forces and circumstances that led to the policies. The study's main findings are that social assistance and the public provision of many basic social services improved in Latin America after about 1990, even as the coverage of social insurance programs fell; that democracy and authoritarianism played an important and multifaceted role in shaping and constraining social policy-making in the region; and that a full explanation for why Latin American social policies evolved in the way that they did requires taking into account a wider range of factors than are usually invoked to explain the origins and evolution of welfare states in advanced industrial countries.

Latin American countries since about 1920 have produced three main types of social policies: *contributory social insurance* (against the "four basic risks" of old age, disability, illness, and unemployment); *social assistance* (general revenue-funded cash or other types of transfers to needy individuals, households, or communities); and the *public provision of general revenue-funded basic social services* (such as health care, nutrition, education, family planning, water, and sanitation).

Most political science research on Latin American social policies has focused on contributory social insurance. If the goal of such research is to find out "who gets what, when, and how," then social insurance is a suitable topic. In twelve of the sixteen Latin American countries for which data are available, social insurance around the year 2000 absorbed more than fifty percent of public social spending. In each of the four most populous countries (Brazil, Mexico, Colombia, and Argentina), it absorbed more than seventy percent (Table 1). Social insurance is a less appropriate focus, however, if the

outcome of interest is the well-being of the Latin American poor. In 2002-2003, discounting the contributions made by employers and workers, public spending on social insurance benefited the richest 20 percent of the population, as compared to the poorest 20 percent, in a ratio of 4:1 in Mexico, 7:1 in Brazil, and 12:1 in Argentina.[i] It thus imposed a huge burden on economic output (more than 10 percent of GDP in Argentina, Brazil, and Uruguay, as Table 1 shows) while having a highly regressive benefit incidence. In contrast to social insurance, most types of social assistance and public provision of basic social services had a more progressive benefit incidence, but were funded more frugally and suffered for many years from design and implementation problems. Family planning and primary health care began to improve in some countries in the 1960s and 1970s, but it was not until the 1990s that widespread gains were made in social assistance and in the public provisioning of a range of basic social services.

[Insert Table 1 About Here]

During the first era of Latin American social policy (1920 to 1980) governments extended social insurance to white-collar and blue-collar formal-sector workers, but not to poor people living in rural areas or urban slums, who relied on usually inadequate social assistance and public social services. During the second era (1980 to 1990) economic hard times led to reduced social insurance coverage and, eventually, to efforts by policy-makers to rethink the provision of social assistance and basic public services. These changes inaugurated the third era (1990 to 2010), in which contributory social insurance coverage fell but social assistance and the public provision of basic social services to the poor improved significantly in many countries. Democracy, it will be argued, had a significant, multifaceted, and largely beneficial impact on these changes.

It is useful for the purposes of analysis to distinguish (a) the impact of social policies on well-being from (b) the (causally prior) impact of various political forces and circumstances on social policies. It also bears mention that the ultimate concern of the analysis will be primarily, although not exclusively, with the well-being of the poor and very poor. The sequence of causality (causes, then characteristics, then consequences) differs from the sequence of exposition (characteristics and consequences, then causes) because it makes sense to characterize social policies, and to explore their consequences for the well-being of the poor, before trying to unravel their causes.

Accordingly, starting with characteristics and consequences, the first section of the chapter will inventory and classify the main social policies in Latin America during each of the three eras from 1920 to 2010, and will outline the impact of these policies on the well-being of the poor. Moving on to causes, the second section will identify some of the forces and circumstances that influenced contributory heath and retirement insurance (from the 1920s), primary health care (from the 1970s), and conditional cash transfers (from the 2000s). The third section will draw some conclusions about the impact of political forces and circumstances on social policies, and about the impact of social policies on well-being, in Latin America during the past century.

## 1. Characteristics and Consequences of Latin American Social Policies

Mesa-Lago distinguishes three sets of countries in terms of the dates when each first introduced contributory health and retirement insurance: pioneer (pre-1940; Argentina, Brazil, Chile, Costa Rica, Cuba, and Uruguay); intermediate (1940-1960, Mexico, Panama, and the five Andean nations); and latecomer (1960-1980; the rest of Central America, the Dominican Republic, Haiti, and Paraguay).[ii] Pension and health

insurance programs are funded partly by worker and employer contributions, but are "state" programs to the extent that they are legally mandated or regulated, and that the state itself contributes to the funds either directly (for public employees) or indirectly (by way of subsidies and bailouts to funds covering private-sector workers).

Haggard and Kaufman identify a Latin American regional welfare model, distinct from those of East Asia and Eastern Europe, involving defined benefit social insurance for formal-sector workers; top-heavy, inequitable, and low-quality educational systems; and unequal and incomplete coverage of basic health services.[iii] De Ferranti et al. call this model a "truncated" welfare state, which provides health and retirement insurance to many people who receive a paycheck (and sometimes to members of their families), but much less, even next-to-nothing, to the rural poor or to urban informal-sector workers.[iv]

During the truncated welfare state era (1920-1980) social assistance took various forms, including family allowances (payments to workers according to number of family dependents), non-contributory pensions for certain groups, university tuition subsidies, hospital fee waivers, emergency public employment, and nutrition programs including food subsidies, food vouchers, free food, milk handouts, and school meals. In 1906, the first public school in Argentina began to distribute milk to students. In 1936, doctors associated with Chile's Mandatory Insurance Fund (CSO), which administered health insurance for blue-collar workers, introduced a milk distribution program. In 1963, Brazil launched the non-contributory FUNRURAL rural health insurance program.[v] Except for generalized food subsidies and university tuition waivers, social assistance programs had a progressive benefit incidence in Latin America before 1990.[vi] Their main defects were poor design and implementation, capture by clientelistic elites, and unambitious scale. In

13 Latin American countries from 1972 to 1982 social assistance spending on average absorbed 17 percent of total public social spending, vs. 83 percent for social insurance.[vii]

From the 1920s to the 1980s most Latin American countries evolved education and health care sectors that primarily served the interests of the rich, the middle classes, and some sectors of organized labor, while doing much less for the rest of the population. Health and education systems were remarkably top-heavy in some countries. In the mid-1980s Argentina had 69,000 doctors but only 16,000 nurses, giving it the second-highest doctor-to-nurse ratio among 87 countries for which data are available. Not least because of the political clout of students, professors, and university employees, 36 percent of public education spending in Costa Rica in the late 1980s went to universities.[viii] By the early 1970s family planning programs had emerged in Chile, Costa Rica, Colombia, the Dominican Republic, El Salvador, and Panama. At the other end of the spectrum was Argentina, which was officially pro-natalist through the 1970s; as well as Bolivia, Brazil, and Nicaragua.[ix] Between 1960 and 1980 the share of the Latin American population with access to an improved water source rose from 33 to 70 percent, while the share with access to sewerage rose from 14 to 30 percent. In poorer countries the situation was grimmer. In 1980 the share of the population with access to an improved water source hovered around 20 percent in Haiti and Paraguay, 35-40 percent in Bolivia and Nicaragua, and 50 percent in Ecuador, El Salvador, Guatemala, and Peru.[x]

As time went on the number of contributors to social insurance programs fell, while the number of beneficiaries rose. This maturation process began to affect Uruguay, a very early adopter, in the 1950s, but by the late 1970s population aging, low-yield investments, overstaffing, and often poor administration had reduced the solvency of

social insurance funds in the other pioneer countries. The resulting tax-funded bailouts of insurance funds combined with the costs of the single-minded pursuit of premature heavy import substitution, loan pushing by petrodollar-laden international banks, a spike in US interest rates, and a plunge in commodity prices to produce the debt crisis of the early 1980s. To tame inflation and reduce budget and trade deficits most governments enacted economic austerity policies, often accompanied by free-market reforms. These policies led in many Latin American countries to civil service layoffs, privatizations of state corporations, liberalization of trade and capital flows, deregulation of domestic markets, reduced subsidies to industry and agriculture, and cuts in social spending.

These changes shattered lives, but the previous economic model was no longer viable, so some dislocation was inevitable. Moreover, the negative side effects of some of the free-market reforms were not as bad as some critics of "neoliberalism" have claimed, not least because the previous model had done little to help the poor. Privatization was often poorly executed, but many of the privatized state firms had run huge deficits while providing substandard goods and services. Job security was protected inefficiently at the firm level by restricting hiring and firing, not at the market level through economic dynamism and an active labor market policy. Cutbacks in social spending during the 1980s mostly affected social insurance for the urban formal sector (that's where most of the money was), not the underfunded basic social services and social assistance programs that mainly benefited the poor. Lower inflation resulting both from economic austerity and free-market reforms helped the poor, who carried money around, more than the not-so-poor and the rich, who could often shield themselves from inflation using negotiated cost-of-living increases, foreign bank accounts, or other strategies or resources.

The debt crisis and the shift from nationalist and statist to free-market economic policies contributed to profound social policy changes in most Latin American countries. Many governments introduced market mechanisms into health and retirement insurance programs, which were facing demographic as well as economic challenges in the pioneer countries. In so doing they followed the military government in Chile, which as of 1980 had required new entrants to the labor force to enroll in defined contribution, fully-funded individual retirement accounts managed by private companies (AFPs), rather than in the old defined benefit, pay-as-you go public pension system. Current workers could choose whether to keep their own contributions (those of employers were abolished) in the public system or to move them to an AFP. From 1997 to 2001 Bolivia, the Dominican Republic, El Salvador, Mexico, and Nicaragua likewise phased out public defined benefit in favor of private defined contribution pensions. Colombia and Peru created parallel systems, where workers could choose either to stay with the public defined benefit system or to leave it for a private defined contribution account. Argentina, Costa Rica, and Uruguay introduced mixed systems, in which workers had the option of contributing to a private defined contribution plan in addition to the public defined benefit system. (In November 2008, however, the Argentine congress passed a law nationalizing the country's ten private pension fund companies, ending the private option.) Brazil, Cuba, Guatemala, Honduras, Panama, Paraguay, and Venezuela opted not to reform the existing public defined benefit pay-as-you-go systems. In every country except Bolivia, the military and police kept their generous public defined benefit pensions.[xi]

Chile pioneered health insurance reform as well as pension reform. A 1981 decree gave workers the option of making their health insurance contributions not to the public health insurance fund (FONASA), but to new private Instituciones de Salud Previsional

(ISAPREs), which worked like health maintenance organizations in the United States. From 1983 to 1997 ISAPRE enrollment rose from 2 to 27 percent of Chileans. The ISAPREs attracted the rich, young, and healthy; FONASA retained the poor, old, and ill. In addition, many ISAPRE members used the public system for expensive procedures.[xii] Over the years, however, the ISAPREs came to be criticized for fraud; lack of coverage for catastrophic illnesses; and enrollment and premium discrimination against women, the elderly, and people with pre-existing conditions. Between 1997 and 2006 the share of Chileans enrolled in an ISAPRE fell from 27 to 16 percent.[xiii]

In Argentina, health insurance contributions continued to go to hundreds of union- or government-controlled *obras sociales* that were notorious for corruption and mismanagement. Reforms were attempted, but few were sustained. In Peru, a 1997 law allowed health insurance contributions flowing into the state social security fund (ESSALUD) to be paid to private providers as well as to the fund's own health care personnel and facilities.[xiv] In both Argentina and Peru, however, a sharp distinction remained between the contributory and general revenue-funded public health care sectors. Mexico in 2003 launched a Popular Health Insurance scheme under which the 50 million or so Mexicans who lacked health insurance became eligible for state-subsidized coverage. Except for those in the poorest 20 percent of the population, Popular Health Insurance beneficiaries were expected to pay a premium. Only about 3 percent wound up doing so, however, so the program cannot really be called contributory.[xv]

In Brazil (1993), Colombia (1993), and Uruguay (2005) governments unified public and contributory health care financing. Henceforth a single stream of revenue, fed by both payroll deductions and general revenues, funded preventive and curative services

alike, ending the distinction between those eligible for higher-quality care funded by social insurance and those eligible only for lower-quality care financed by general revenues.[xvi] A different type of unification took place in Costa Rica, where the Costa Rican Social Security Fund (CCSS), which insured almost all Costa Ricans, replaced the health ministry as the direct provider of public primary health care.[xvii]

Employment was protected in Latin America mostly by laws that imposed severance payments on employers who laid off workers. As of 2010 only Brazil (1986), Argentina (1992), and Chile (2002) had adopted pay-as-you-go, state-administered unemployment insurance. In 1997 unemployment insurance covered about 12 percent of the Brazilian unemployed, and in 1999 it covered about 6 percent of the Argentine unemployed -- in each case, with meager and ephemeral benefits. Some countries had unemployment insurance security accounts, which operated like individual retirement accounts but were funded entirely by employers. The costs of employment termination were high in Latin America, making employers reluctant to hire new workers.[xviii]

Across the ten countries that introduced defined contribution, fully-funded, privately-administered individual retirement accounts, average pension coverage fell from 38 percent before the reform to 24 percent afterward. Compared to the preceding (or alternative) defined benefit, pay-as-you-go, publicly-administered pensions, privately-run retirement accounts tended to pay lower benefits for shorter time periods, with higher administrative costs and greater disadvantages for women. Meanwhile, health insurance coverage across all Latin American countries with data fell from an average of 52 percent in 1990 to 41 percent 2004.[xix]

Beginning with Bolivia in 1987 many countries introduced Social Emergency Funds and (later) Social Investment Funds, which gave cash transfers to community leaders who submitted successful proposals to build or improve public facilities like health clinics, water and sewer lines, roads, and recreation centers. Locals were usually required to contribute labor or other resources. The funds, it was hoped, would help the newly unemployed to stay in the labor force and prepare themselves to graduate to higher-skilled work, while building human capital (through education and training programs) and social capital (through participation in the proposals and projects). Chile's Fund for Solidarity and Social Investment (FOSIS) reduced poverty and improved welfare, but Mexico's National Solidarity Program (PRONASOL) seems to have been operated primarily to win votes. Social investment funds rarely reached the poorest of the poor, who tended to live in communities lacking the social capital needed to propose a project. Also, social investment funds were poorly integrated with other government policies, and few had much success in raising income or employment among the poor.[xx]

Microfinance -- the provision of small loans, usually to impoverished women, for the startup or expansion of tiny businesses -- was a second form of social assistance to expand after 1990. Microfinance in Latin America had varying combinations of state and non-state origins, administration, and financing. Loans were usually provided at above-market rates of interest (partly to cover the cost of handling thousands of tiny accounts), but did not require collateral. Instead, borrowers were often required to form groups that increase peer pressure (and support) for repayment. By 2008 there were at least 635 microfinance institutions in Latin America and the Caribbean; every Latin American country except Cuba had at least one. Microfinance programs in Latin America in 2008 provided loans averaging US $1,149 to a total of 9.5 million borrowers. Penetration

(borrowers as a share of business owners and self-employed) was highest in Nicaragua (59 percent), Ecuador (48 percent), and Bolivia (45 percent), and lowest in Argentina and Venezuela (just over 1 percent each). The total loan portfolio of microfinance institutions rose nearly five-fold from 2002 to 2007, before slowing in 2008 because of the financial crisis. Impact studies in Bolivia and Peru suggest that microfinance raised the incomes of borrowers but failed to reach the poorest of the poor, who often feared that they wouldn't be able to repay.[xxi] Such perceptions may have been well-founded. Recently, programs such as Mexico's Compartamos, the region's largest microfinance initiative, have been criticized for charging very high interest rates that have mired borrowers in a debt spiral.

Conditional cash transfers were a third set of social assistance policies to appear in the 1990s. Such programs involve the periodic transfer of cash from the public treasury to certifiably poor households provided that the households meet certain conditions, typically that children go to school and to health clinics and that expectant mothers get prenatal care. Early conditional cash transfer programs included Mexico's Niños en Solidaridad, which was introduced in 1989 in the context of PRONASOL, and Chile's Subsidio Único Familiar, which dates from 1990.[xxii] In 2008 the largest conditional cash transfer programs in Latin America were Bolsa Família in Brazil, which served about 52 million people (84 percent of the Brazilian poor), and Oportunidades (formerly Progresa) in Mexico, which served about 24 million (72 percent of the Mexican poor). By 2008 every Latin American country except for Cuba, Haiti, and Venezuela had a conditional cash transfer program covering from 12 percent (El Salvador's Red Solidaria) to 100 percent (Ecuador's Bono de Desarrollo Humano) of its poor population. Around 2000 the cash transferred to each household, usually monthly, amounted to between 8 and 30 percent of household consumption, depending on the program and the country. Around

2005 most such programs cost between 0.1 and 0.6 percent of GDP, depending on the share of the population participating and on the size of the cash transfer.[xxiii]

Impact evaluations of Mexico's Oportunidades and of Brazil's Bolsa Família generally find that they had beneficial effects on income poverty, school attendance and enrollment, nutrition, height for age, child labor, and the utilization of basic health services.[xxiv] In Brazil, the need to sign up for the Universal Registry in order to receive benefits from Bolsa Família also encouraged many poor people to acquire state-issued identity cards, without which it is hard to get benefits from state agencies or buy things on installment (a common practice in Brazil).[xxv] Partly because conditional cash transfer programs do not require beneficiaries to propose projects or borrow money, they reached the poor more successfully than social funds or microfinance initiatives.

Conditional cash transfer programs have been criticized on administrative grounds for excluding poor households while including non-poor ones; for poor monitoring and enforcement of the stipulated conditions; and for saddling beneficiaries with duties that are paternalistic, time-consuming, costly to enforce, and no more effective than unconditional transfers at promoting schooling and health visits. On economic grounds, the programs have been charged with giving recipients an incentive to stay out of the formal-sector labor force in order to qualify as "poor." Critics who focus on gender issues have pointed out that already overtaxed mothers are usually the ones taking children to schools and health clinics, and that the schemes reinforce gender stereotypes by engaging women mainly as mothers. On the political front, conditional cash transfer programs have been denounced for being susceptible to corruption, patronage, and political manipulation; for being politically unsustainable because their

beneficiaries are poor and powerless; and for sidelining broader redistributive policies such as a universalistic, unconditional minimum income funded by progressive taxation.

Some of these criticisms may be overstated. A worldwide comparison of 120 social assistance programs found that Bolsa Família and Oportunidades ranked in the top ten percent for targeting accuracy.[xxvi] Research has found that both of these programs reduced child labor but that neither deterred adults from seeking work.[xxvii] Some studies have found that cash transfer programs without conditions have improved health and education outcomes, but quasi-experiments suggest that conditions -- even awareness of conditions that are poorly monitored or enforced -- elicit behavioral changes that would probably not otherwise have occurred.[xxviii] Conditional cash transfer programs impose added burdens on mothers, but interviews with participants indicate that some mothers think that these burdens are worth bearing. Also, most cash payments go to women, raising their bargaining power within the household.[xxix]

As for criticisms on political grounds, it has been argued that Brazil's conditional cash transfer programs have "crowded out investments in the improvement of basic services such as sanitation and health."[xxx] In Bolsa Família's first six years of operation, however (2003-2009), per capita public health care spending rose 70 percent and primary health care spending more than doubled.[xxxi] In Brazil, Lula's government appears to have expanded eligibility for Bolsa Família, and claimed credit for expanding it, with the explicit aim of winning votes in the 2006 presidential election.[xxxii] That might qualify as a "political" use of a conditional cash transfer program, but it also amounts to electoral incentives having their hypothesized effect of promoting a policy beneficial to the poor. Like all means-tested social policies, conditional cash transfer programs serve people

with limited political power, jeopardizing their sustainability.[xxxiii] In the eyes of non-participants, however, the conditions that beneficiaries are statutorily required to meet may give conditional cash transfers more legitimacy than they would otherwise enjoy.[xxxiv]

In Bolsa Família municipal officials are responsible for certifying the incomes of beneficiaries and for aggregating information about compliance with conditionalities, so the program is potentially vulnerable to local clientelism. In practice, however, the federal government makes available so many spaces in the program that mayors find it hard to exclude any income-eligible household, reducing their leeway for discretion.[xxxv] Also, the penalty for not attending school or for failing to show up for health care visits is that the government sends a social worker to the household to see whether it might need additional support. These low stakes make shenanigans at the compliance monitoring stage less rewarding for patrons seeking to capture new clients or to retain existing ones. In 2009, interviews with focus groups in Northeastern cities and towns found little evidence that Bolsa Família was permeated by clientelistic practices of any kind.[xxxvi]

Unconditional cash transfer programs including subsidies to poor households, child and family allowances, and non-contributory pensions were a fourth class of social assistance interventions to gain prominence after 1990. At least eleven such programs operated in Latin America in 2010; most paid beneficiaries US $30-150 per month. Brazil's Previdência Rural (1991), which absorbed the FUNRURAL program (1963; revamped 1971), was the earliest and in 2008 the largest unconditional cash transfer program in Latin America, with about 7,500,000 recipients. Bolivia's Bono Dignidad, which was funded by privatization proceeds and by a tax on natural gas exports, was Latin America's only truly universal social pension. In 2008 it paid about US $30 per

month to each of the 676,000 Bolivians aged 60 or older, rich and poor alike.[xxxvii] A "social pension impact index," which takes into account the share of elderly covered and the size of the benefit relative to GDP per capita, ranked Bolivia highest in Latin America, with Brazil second and the other countries far behind. Bolivia's Bono Dignidad and Brazil's Prêvidencia Rural have been linked to rises in school enrollment, partly by increasing the number of children living with pensioner grandparents.[xxxviii] Taken together, social pensions in Brazil have been associated with declines in the severity and incidence of poverty; with greater household investment in human, physical, and social capital; and with other improvements in the well-being of members of vulnerable groups.[xxxix]

Integrated anti-poverty programs comprise a fifth category of recent social assistance initiatives. The Uruguayan PANES program, which originated in 2005 and merged in 2008 with an older family allowances program, included conditional cash transfers, a food debit card, workfare, and training.[xl] Chile Solidario, which rolled out in four waves between 2002 and 2005, involved teams of social workers helping members of poor households to improve their employment status, housing, health, education, legal documentation, and intra-household relations. It provided small unconditional cash transfers (US $5-20 per month) but phased them out over five years. Beneficiaries agreed to collaborate with social workers to lift themselves out of poverty, while the government agreed to tailor its programs more effectively to the needs of specific households. In 2009 Chile Solidario served Chile's 333,000 poorest households, about eight percent of all households. Research suggests that the program raised school enrollment, adult literacy, housing quality, and health service utilization. Beneficiaries also enrolled in more employment, social pension, family allowance, and water subsidy programs, were more aware of such programs, and were more optimistic about their economic future.[xli]

Several Latin American countries improved public primary health care services after 1990, notably Brazil with its 1994 Family Health Program and Costa Rica with its 1995 Comprehensive Basic Health Care Teams (EBAIS). Under each program, teams of health professionals were assigned to provide primary health care services to specific households, partly through home visits. The EBAIS included a doctor, a nursing aide, and a health worker. The Brazilian teams had more personnel and served more households. In each country the health teams came to serve as a gateway to the entire (unified) health system. Statistical analyses find that each program was associated with lower child mortality than would be expected from control variables.[xlii] El Salvador and Peru, which also implemented effective rural health care programs in the early and mid-1990s, achieved the steepest infant mortality declines in the region from 1990 to 2009.[xliii]

As with pensions and health insurance, Chile was the first Latin American country to apply market reforms to schooling. In 1980 the military government began to subsidize tuition-free private schools at the same rate as state-run municipal schools. Parents could choose to place their children in either type of school, and each school's subsidy depended on the number of students it enrolled. The subsidy thus worked like a voucher.[xliv] Beginning about 1990, other Latin American countries began to decentralize authority to municipalities and schools, to raise pre-school and secondary enrollment, to shift resources to underfunded schools, to introduce achievement tests, and to encourage parental involvement. Some of these changes were resisted, particularly by teachers unions. Efforts to impose fees on university students, who tended to come from wealthy families, met ferocious resistance and were dropped. Decentralization altered a core feature of the educational system, but progress was slow on test scores, dropout rates, and teacher training. In Latin American educational systems, improving quality turned out to

be harder than improving access.[xlv] A 2003 study of 15 year-old math, language, and science skills showed disappointing proficiency in Argentina, Brazil, Chile, Mexico, and Peru.[xlvi] Primary and secondary school students scored higher in Cuba, partly because of good teacher training and orderly classroom environments.[xlvii]

In 12 of the 18 Latin American countries for which data are available, expert ratings of family planning effort fell between 1989 and 2004, most steeply in Mexico, Central America, and the Andean countries. Only Argentina and Brazil raised their family planning effort scores by double digits (on a 120-point scale) between 1989 and 2004, and each started out from a low baseline.[xlviii] Fertility by 1989 had already fallen to near the replacement rate in many Latin American countries (including the most populous ones), so a generalized decline in family planning effort was not unexpected. In the area of reproductive rights, Chile in 1989, El Salvador in 1998, and Nicaragua in 2006 outlawed abortion even to save the life of the mother. On the other hand, the Colombian congress in 2006 relaxed some restrictions on abortion, and Mexico City in 2007 legalized it in the first trimester. The Uruguayan senate followed suit in 2008, but President Tabaré Vázquez vetoed the bill.[xlix] Cuba, which in 1996 had the world's second-highest abortion rate after Vietnam, kept its permissive regulations.[l]

In 1990 some 31 percent of Latin America's population lacked access to basic sanitation, and 15 percent lacked access to safe water. By 2008, to be on track to meet the Millennium Development Goal of halving these shares by 2015, the share without access to adequate sanitation should have fallen to 20 percent, and the share without access to safe water to 10 percent. The actual figures, at 20 percent and 7 percent respectively, matched or exceeded the required pace. Ecuador, in part through well-run municipal

provision, and Paraguay, where informal *aguateros* running small-scale water supply systems operated widely, were the most successful Latin American countries from 1990 to 2008 at raising access to safe water and basic sanitation.[li] In Argentina, the privatization of water and sewerage systems in several provinces expanded connections among the poor and contributed to a significant decline in under-5 mortality, almost all of it attributable to a reduction in deaths by water-borne diseases.[lii]

To summarize, market reforms to social insurance hurt the not-so-poor, many of whom lost coverage or benefits, without helping the very poor. Some of the new forms of social assistance, especially conditional cash transfers, noncontributory pensions, and integrated anti-poverty programs, helped the very poor; others, like social investment funds and microfinance, bypassed some of the most impoverished. Improvement in the public provision of basic health care, and in access to safe water and adequate sanitation, was beneficial both to the very poor and to the not-so-poor. Education reforms had more modest effects, increasing access to schooling but doing less to meet the more difficult challenge of improving the quality of education. Sexual health and reproductive rights policies advanced these goals in some countries but not in others. On the whole, the very poor in Latin America benefited more from social policies after 1990 than before 1980.

## 2. Determinants of Social Policies in Latin America

Research on the origins and evolution of welfare states in wealthy countries has highlighted patterns of economic development, legacies of previous institutions, and social class mobilization and class alliances.[liii] These factors mattered in Latin America as well, but full account of the origins and evolution of Latin American social policies needs to include at least three other factors: bureaucratic initiative, international factors, and

political regime form (democratic vs. authoritarian). Operationalizing social class mobilization and alliances as the activities of civil society groups and political parties, the determinants of social policies in Latin America may be classified into seven categories:

(1) Bureaucratic initiative, whereby officials in state agencies, acting with relative autonomy from forces and constraints in their environments, propose, design, approve, implement, sustain, expand, or repeal particular social policies.

(2) Economic forces such as international economic shocks; the dependence of social policies on the prevailing economic model; or the popularity of market-oriented policies.

(3) Inherited social policy arrangements, which impose legal, institutional, and political constraints on contemporary and future arrangements.

(4) International influences not fully captured under economic forces, such as war, ideological conflict, global norms, national prestige, bilateral foreign aid, international organizations, and foreign models.

(5) Political regime form. Democracy can influence social policy through electoral incentives, freedom of expression, freedom to associate, or (in the long run) by fostering a perception of entitlement to social services that encourages the utilization as well as the public provision and financing of such services.

(6) Civil society organizations (interest groups, social movements, or issue networks) can influence social policy. Some freedom to organize is a prerequisite for such activities, but civil society groups can influence social policies even under an authoritarian regime.

(7) Partisanship. In a democratic regime, certain groups of people, including -- but not limited to -- those in common economic circumstances, support certain political parties with particular stances on social policies.

Which of these sources of influence had the biggest effect on social policies in Latin America? No general answer to this question can be given, because the importance of each source varied by country, time period, policy type, and policy process stage. The focus here will be on political regime (factor 5), which creates the context in which civil society groups and political parties (factors 6 and 7) operate.[liv] Bureaucratic initiative (factor 1) will be considered, but its impact resists generalization.[lv] Economic forces, inherited social policy arrangements, and international influences (factors 2, 3, and 4) will be treated analogously to control variables in a statistical analysis -- as factors whose omission could bias estimates of the direction or size of the impact of the variable of interest, political regime form. To keep the analysis manageable, the focus will be on three types of social policies: contributory pensions and health insurance (1920s-), primary health care initiatives (1970s-), and conditional cash transfer programs (2000s-).

2.1. Contributory social insurance. Insulated bureaucratic elites introduced contributory social insurance in Brazil in the 1920s, partly to deter potential labor unrest; and in Costa Rica in the 1940s, where reportedly "the decisive leadership in social security was undertaken as if in an authoritarian system, with little mass participation."[lvi] Explanations that stress bureaucratic initiative or political will beg the questions, however, of where the will originated and what determined whether and how it influenced policy.[lvii] Government policy makers always have some freedom of choice, but political will is shaped and constrained by the context in which it is exercised.

One feature of this context is the economy. In the larger Latin American countries tariffs and subsidies associated with import substitution allowed industrialists producing for the domestic market to pass along to consumers the costs of health and retirement insurance for their employees. The resulting high labor costs reduced work opportunities for the rural poor and for urban informal-sector workers.[lviii] As the beneficiary-to-contributor ratio rose, and as free-market reforms eliminated tariffs and subsidies, governments were forced to use general tax revenues to keep the funds solvent.

Previous welfare state institutions shaped the evolution of social insurance in Latin America, showing that "policies produce politics."[lix] Social insurance initially privileged the military, the police, public employees, private formal-sector workers, and businesses and health professionals dependent on insurance payments. Some of these groups became tenacious opponents of later equity-enhancing reform efforts. In Argentina, union leaders in the 1940s, 1970s, and 1980s blocked efforts by health ministers to use both payroll deductions and general tax revenues to fund a unified public health care system.[lx] In Brazil, associations of doctors, hospitals, drug manufacturers, and health insurers delayed until 1993 the debut of the Unified Health System.[lxi]

The international diffusion of policy models shaped the origins of social insurance in Latin America, as well as in Europe.[lxii] Chile's 1924 Workers' Insurance Fund law served as a model for Costa Rica's 1941 Social Insurance Law.[lxiii] In some developing countries governments established social insurance "to prove that they [could] give their populations the same protection other nations give to theirs," or "out of a wish to acquire for their nations all of the most visible signs of national modernity."[lxiv] In Costa Rica, worries about the spread of the Cuban Revolution led some legislators to vote in 1961 for

a constitutional amendment to extend health insurance to the whole population.[lxv] The International Labor Office helped to spread contributory social insurance across Europe and later to Latin America.[lxvi] After the debt crisis of the 1980s, the World Bank leaned on Latin American governments to privatize pensions and to introduce market mechanisms into health insurance and health care provision.[lxvii]

Competitive politics and freedom of association contributed during the first part of the twentieth century to the appearance of social insurance in many Latin American countries, not so much through electoral incentives as by allowing urban workers, professionals, and others to organize themselves to demand coverage.[lxviii] The greater a beneficiary group's political clout, the earlier and better its insurance. The military, police, and top civil servants got the first, widest-ranging, most highly subsidized, and best-quality benefits.[lxix] Social insurance was introduced, as in Europe, under leaders from the left (Calderón in Costa Rica), center (Perón in Argentina), and right (Ibáñez in Chile). Pressure groups, accordingly, did more than partisanship (the control of the executive and/or legislative branches by a political party with a specific ideological stance) to influence the timing and content of social insurance in twentieth-century Latin America.

2.2. Primary health care. Bureaucratic initiative contributed to primary health care programs as well as to social insurance. In Costa Rica, the Rural Health and Community Health plans of the 1970s were, one writer concluded, "a bureaucratic achievement. There was no popular crusade."[lxx] The EBAIS primary health care scheme was designed by a small team of experts commissioned by Guido Miranda, Costa Rica's health minister in 1984.[lxxi] In Chile in the 1970s Miguel Kast and his staff in the National Planning Office, to whom General Pinochet had given significant policy autonomy, expanded

maternal and infant health care and nutrition services in poor communities.[lxxii] Primary health care programs in Argentina and Peru in the 1990s were designed and advocated by small groups of technocrats in Argentina's finance ministry and Peru's health ministry.[lxxiii]

Primary health care tends to be cheap, making it compatible with difficult as well as benign economic circumstances. In 1977 Costa Rica's Rural Health and Community Health plans together cost about US $8 (in then-current dollars) per beneficiary per year. In June 2000 the annual cost per beneficiary of Brazil's Family Health Program was between US $34 and $53, depending on region and team composition. In Chile from 1974 to 1983 and in Argentina from 1977 to 1982, the improved public provision of basic nutrition and health care helped to reduce infant mortality sharply despite falling GDP per capita and skyrocketing income inequality and income poverty.[lxxiv]

Existing social policy arrangements influenced basic health service provision throughout Latin America. Contributory health insurance revenues financed health personnel and facilities that often (but not reliably) treated the uninsured. In countries such as Argentina and Brazil, however, such revenues also supported a powerful private health care industry, which tended to work against the improvement of public health services. "Once private sector entities have become important providers of health and education, they turn into interest groups that fight politically for their and their clients' interests and against financing for the public sector."[lxxv]

In decentralized countries, basic health service provision was also shaped by subnational initiatives. Brazil's Community Health Agents Program (1991), a precursor to the Family Health Program, was modeled on state programs in Ceará, Paraná, and Mato Grosso. Argentina's Plan Nacer (2004) was launched in nine impoverished provinces

before expanding to the whole country. Elsewhere, major primary health care initiatives have piggybacked on previous nationwide programs. Costa Rica's Rural Health Plan (1973) started out by using personnel from a successful malaria eradication campaign.[lxxvi]

International factors have shaped basic health service provision in Latin America since early in the twentieth century. In Costa Rica in the 1910s and 1920s, the Rockefeller Foundation financed hookworm control and health posts. In Brazil in 1942, US government officials helped to establish the Serviço Especial de Saúde Público in order to keep rubber and minerals flowing to the Allies. In Argentina in 2004, the World Bank provided technical advice and funding for the Plan Nacer.[lxxvii] The WHO/UNICEF conference in Alma Ata, USSR, in 1978 "boosted the legitimacy of 'health for all'....after this famous meeting, the universalization goal was on the minds of [Latin American] health officials, that is, cognitively available."[lxxviii] In the late 1970s military governments in Argentina and Chile expanded maternal and child health services partly in an effort to win support (or reduce hostility) abroad.[lxxix] Rural health posts in Costa Rica in the 1920s and 1930s were modeled on those the rural United States, and Brazil's Family Health Program was modeled on initiatives in Cuba, Britain, Quebec, and Switzerland.[lxxx]

Of all of the ways in which democracy can affect social policies, electoral incentives have drawn the most attention. In Chile in 1970, in Costa Rica in 1970 and 1974, in Argentina in 1973, and in Brazil in 2002 and 2006, candidates courted votes by expanding or promising to expand primary health care, water supply, or basic nutrition programs.[lxxxi] Sometimes, however, electoral incentives have worked against the improvement of basic health services for the poor. In Costa Rica in 1994 legislators advocated placing the EBAIS initially in densely populated areas, where most of the

votes were. Health sector technocrats resisted, insisting that the EBAIS commence in impoverished, sparsely populated rural areas. With the backing of president Figueres the technocrats won out, and the EBAIS appeared first in peripheral regions.[lxxxii]

The fewer the impediments to the free flow of information, the easier it is to publicize social problems. In Chile in the 1950s, the publication of studies revealing high infant mortality encouraged policy-makers to try to do something about the problem. In Brazil in the early 1990s, highly publicized cholera epidemics in the Amazon and the Northeast prompted health ministry officials to introduce a national Community Health Agents program. In Costa Rica in 1992, news coverage of a measles epidemic added urgency to the launch of the EBAIS program.[lxxxiii]

Democracy also opened the way for left-of-center political parties to capture the presidency and implement pro-poor primary health care policies, as with the Partido Liberación Nacional in Costa Rica in the 1970s and 1990s; Cardoso's Social Democratic Party (1995-2002) and Lula's Workers' Party (2002-2010) in Brazil; and Chile's Socialists in 1970-1973 and 2000-2010. The election of left-of-center presidents is, however, only a supportive condition for such policies. Authoritarian regimes from Castro's to Pinochet's have implemented pro-poor primary health care programs. Conversely, the programs of Hugo Chávez in Venezuela, an elected leftist, are widely touted as pro-poor, but their overall impact has been disappointing. In mid-2003 Chávez started the Misión Barrio Adentro program to expand basic health services in poor areas. By the end of 2004 an influx of Cuban doctors had raised the number of primary care physicians in Venezuela from 1,500 to 13,000 and increased the number of medical consultations from 3.5 to 17 million. From 2003 to 2010, however, Venezuela’s infant mortality rate fell only from

18.6 to 16.0 per 1000. This 2.1 percent average annual rate of infant mortality decline placed Venezuela 19th out of 20 Latin American countries, despite oil-fueled GDP per capita growth averaging 6.0 percent per year from 2003 to 2009 (more than double the 2.8 percent rate for Latin America and the Caribbean as a whole). Similarly, the "Misión Robinson" adult literacy program appears to have had little or no effect on literacy.[lxxxiv]

Freedom of association permits civil society groups to influence health policy. Some such groups, like Brazil's Pastorate of the Children, even deliver primary health care services on a large scale. In Costa Rica, community organizations pressured the Coalición Unidad government (1978-1982) to preserve primary health care policies begun by the PLN in the 1970s, and lobbied the Social Christian government of Miguel Rodríguez (1998-2002) to preserve the EBAIS program started by the preceding PLN administration.[lxxxv] Brazil's Sanitarian and Primary Care movements, which emerged in the 1970s and 1980s during the transition from authoritarian rule, helped to persuade the Collor and Franco governments (1990-1994) to scale up to the national level municipal and state experiments with Community Health Agents and Family Health teams.[lxxxvi] Not all demand-making by civil society groups is good for the poor, however. For doctors, shifting resources to primary health care often means "lower salaries, less sophisticated equipment, pressures to serve where living conditions and career prospects are unattractive, and the substitution of less highly trained health workers (nurses, public health workers, midwives) for doctors in performing certain services."[lxxxvii] Accordingly, physicians' associations have resisted the expansion of health services in several Latin American countries, including Argentina, Chile, and Costa Rica in the early 1970s.[lxxxviii]

Democracy is based on the principle that citizens have equal rights. Over time, this principle tends to produce a perception that the state is obliged to provide social services that enable every citizen to live with dignity.[lxxxix] The diffusion throughout society of an expectation that the state will attend to basic needs encourages the provision of basic health services to the poor. In Chile, democracy contributed to the emergence of expectations, expertise, and infrastructure that made the military government's maternal and infant health care and nutrition initiatives possible, and increased the propensity of impoverished households to utilize the services provided.[xc] Cross-national quantitative studies have found that a country's "stock" of long-term democratic experience, not just its current political regime form, is closely associated with the more widespread provision of basic health services and with the reduction of premature mortality.[xci]

2.3. Conditional cash transfer programs. This section will highlight some of the factors that shaped Mexico's Progresa, which was inaugurated in 1995 and evolved into Oportunidades in 2002, and Brazil's Bolsa Família (2003-), which grew out of Bolsa Escola (2001-2003) and its subnational precursors (1995-). Progresa was mainly a top-down initiative, whereas Bolsa Escola emerged from the activities of civil society groups. Determinants of some other conditional cash transfer programs will also be assessed, but the main focus will be on the Brazilian and Mexican programs, the region's largest.

Progresa was designed and advocated by Santiago Levy, an undersecretary in the Mexican finance ministry, and José Gómez de León, the director of Mexico's National Commission on Population. Levy cites as his main inspirations a 1994 economic crisis, whose severity persuaded him that existing social assistance schemes could not protect the poor, and research underscoring the interdependence of education, nutrition, and

health.[xcii] To ameliorate the impact of the crisis on the poor, Levy and Gómez de León devised a program to replace food subsidies and handouts with cash transfers conditional on regular medical checkups and implemented it in the southern state of Campeche. When an impact assessment revealed that his pilot project had improved nutritional status and increased the utilization of health services, Levy and Gómez de León proposed to scale it up to the whole country. This proposal was resisted by officials in other ministries and by members of congress, including from the governing PRI. Crucial to overcoming such opposition was the backing of president Zedillo, as well as the resources and prestige on which Levy could draw as a top official in the ministry of finance.[xciii]

Brazil's Bolsa Escola (2001) and Bolsa Família (2003) had two subnational precursors, the Bolsa Escola program in the Federal District of Brasília and the Programa de Garantia de Renda Familiar Mínima in the city of Campinas. Each of these programs was introduced in January 1995. The main policy entrepreneur for the Brasília program was Cristovam Buarque, who was the governor of the Federal District from 1995 to 1998 and at this time belonged to the Workers' Party (PT). His counterpart in Campinas was Eduardo Suplicy, a national senator from the state of São Paulo from Cardoso's Brazilian Social Democratic Party (PSDB). Brasília's Bolsa Escola program was conceptualized in 1986 in seminars involving Buarque and others at a research center at the University of Brasília. The ideas behind the minimum income program in Campinas date back to 1975, when a scholar at the Fundação Getúlio Vargas published an article in a prominent Brazilian economics journal proposing a negative income tax resulting in a guaranteed minimum income. After losing the 1989 presidential election Lula invited both Buarque and Suplicy to join a "shadow cabinet" to prepare for his next presidential run in 1994.[xciv]

Economic factors influenced conditional cash transfer programs in several ways. In a climate of economic austerity, such programs appeared to be cost-effective. In 2005 Mexico's Oportunidades had a budget of $5.06 billion, $210 annually for each of 24 million beneficiaries. In 2006 Brazil's Bolsa Família had a budget of $6.76 billion, $153 annually for each of 44 million beneficiaries.[xcv] In Brazil in 2003 conditional cash transfers took 2 percent of federal spending on social insurance and social assistance; pensions took 87 percent. In Mexico in 2002 the figures were 8 and 73 percent.[xcvi] The popularity of free-market reform enhanced the appeal of conditional cash transfers, which were said to be consistent with the "logic of the market" and likely to avoid "distortions of relative prices."[xcvii] Also, many Latin American policy makers saw cash handouts contingent on school attendance and medical checkups as a way to improve human capital, and thus international competitiveness.[xcviii]

Existing social policy arrangements shaped the design of both Progresa and Bolsa Família. Each program was initiated in part to compensate for the shrinking coverage of social insurance. Progresa was administered by Mexico's Social Development Ministry, the agency that had run the PRONASOL social investment fund (1989-1994). Progresa built on PRONASOL's Niños en Solidaridad, which in 1994 had given about 650,000 families cash transfers conditional on class attendance by elementary school-aged children.[xcix] Brazil's Bolsa Família in late 2003 combined four previous cash transfer programs, two of which, Bolsa Escola and Bolsa Alimentacão, were conditional on school attendance. Bolsa Escola, which dated back to the last year of the Cardoso administration (2001), was inspired by Brasília's Bolsa Escola (1995-), by Campinas's Guaranteed Minimum Income program (1995-), and by the national Program to Eradicate Child Labor (1996-), which made cash transfers to households contingent on school

attendance for children (this component was folded into Bolsa Família in 2005).[c] The 1988 Brazilian Constitution and the 1999 Statute of the Child and Adolescent provided a legal basis for public policies to promote school attendance. Also crucial to the operation of the demand-side Bolsa Família program was the supply-side FUNDEF initiative, which guaranteed that the equivalent of US $300 would be made available annually for the education of each public school student up to the eighth grade.[ci]

International organizations have contributed to Latin America's conditional cash transfer programs. The Inter-American Development Bank (IDB) in 2001 approved a $500 million loan for Bolsa Escola and a $1 billion loan for Progresa, which at the time was the largest loan that the IDB had ever made. It also made loans to support conditional cash transfer programs in Argentina, Colombia, the Dominican Republic, Honduras, and Nicaragua.[cii] The World Bank in 2004 lent US $572 million to support Bolsa Família.[ciii] Multilateral financing has been particularly important in poorer countries like Honduras, Nicaragua, and Paraguay.[civ] UNICEF in 1996 gave Brasília's Bolsa Escola its "Children and Peace" award, and several international agencies helped to evaluate the performance of the national Bolsa Escola program.[cv]

Brazil's Bolsa Escola influenced Mexico's Progresa, and Progresa's successor, Oportunidades, influenced Bolsa Escola's successor, Bolsa Família. The Mexican government in 1996 sent a delegation to Brazil to visit some of the municipal Bolsa Escola programs.[cvi] Several years later Mexico's Santiago Levy encouraged the Brazilian government to combine Bolsa Escola with the three other programs into Bolsa Família. The Chile Solidario program inspired Brazilian officials to change case management practices in Bolsa Família.[cvii] Conditional cash transfer programs in Brazil, Colombia,

Honduras, and Mexico influenced Nicaragua's Red de Protección Social, which in turn influenced such programs in the Dominican Republic, El Salvador, and Paraguay.[cviii]

Electoral incentives shaped various aspects of Brazil's Bolsa Escola and Bolsa Família. In his 1994 campaign for governor of Brasília, Cristovam Buarque touted his Bolsa Escola proposal. When Bolsa Escola was scaled up in 2001, observers opined that the government had shrunk the stipend in order to maximize the number of beneficiaries capable of casting a vote. The rapid growth of the national Bolsa Escola from May to December 2001 (when nearly 5 million families enrolled) has been linked to the presidential hopes of Paulo Renato Souza, the education minister at the time.[cix] A 20 percent rise in the income cap for eligibility led to a spike in Bolsa Família coverage in June 2006, when one million Brazilians enrolled before a three-month electoral quarantine closed the program to new entrants. In one town, "the mayor sent a letter to all *Bolsa Família* recipients explaining that [raising the income cap] was a personal initiative of the president himself."[cx] In the 2006 race for governor of Piauí, the candidate of the conservative Liberal Front Party made a notarized pledge to maintain the Bolsa Família program that his opponent had introduced.[cxi] From 1999 to 2003 Bolsa Escola reduced dropout rates 36 percent more in municipalities where the mayor was legally eligible to be re-elected than in municipalities where term limits precluded another run.[cxii]

Publicity in the mass media, which presupposes some freedom of expression, was another democracy-related factor that affected Bolsa Escola. Reports of the death of a child from malnutrition in Campinas, one of the country's wealthiest large cities, helped to galvanize public opinion in support of the city's 1995 minimum income program. Gilberto Dimenstein, a journalist for *Folha de São Paulo*, called attention to Brasília's

local Bolsa Escola program in ways that helped it get on to the national agenda. The Cardoso government midway through its second term (1998-2002) was taking criticism in the mass media for neglecting social policy; such criticism is said to have contributed to the rapid rollout of the national Bolsa Escola scheme in 2001.[cxiii]

In Chile and Uruguay Socialist governments introduced conditional cash transfer schemes, non-contributory social assistance, and integrated anti-poverty programs.[cxiv] The impact of partisanship on Latin America's conditional cash transfer programs should not be overstated, however. In Brazil, Cardoso's center-left PSDB government modeled Bolsa Escola on local PT programs, while Lula's PT government expanded it as Bolsa Família. In Mexico the centrist PRI government of Ernesto Zedillo (1994-2000) initiated Progresa, and the conservative PAN government of Vicente Fox (2000-2006) enlarged it as Oportunidades. Interest groups, whose activities are facilitated by democracy, were not heavily involved in Brazil either in promoting or resisting conditional cash transfer programs. Bolsa Escola raised school enrollment and attendance, creating extra work for teachers, but teachers' unions did not oppose the program. Business organizations were also absent from the conditional cash transfer policy-making process. Issue networks advocating a guaranteed a minimum income, however, along with others lobbying for greater access to schooling, were heavily involved in the local conditional cash transfer programs in Brasília and Campinas respectively. Cristovam Buarque, after losing the gubernatorial election in Brasília in 1998, founded an organization called Missão Criança (Child Mission) to promote conditional cash transfer programs both within Brazil and abroad. Missão Criança reportedly helped to initiate such programs in Recife, Mato Grosso do Sul, Acre, and Goiás, as well as in Argentina and Bolivia.[cxv]

## 3. Conclusion

Bureaucratic initiative influenced social insurance, primary health care, and conditional cash transfers alike. That was to be expected, however, because policies always originate, in an immediate sense, from some sort of bureaucratic initiative. Economic factors were closely intertwined with social policies. During the import-substitution era tariff protection and industrial subsidies gave employers the resources they needed to provide social insurance for their employees. After the debt crisis of the 1980s this model was exhausted, or at least discredited. The expansion and improvement of social assistance programs and of publicly-provided health care, nutrition, water, and sanitation services in the 1990s and 2000s was facilitated by the relatively low cost of these initiatives at a time when economic difficulties and the prevailing free-market ideology made funds scarce. Previous social policy arrangements created new interests and political actors that shaped and constrained social policies in later years. International factors, notably foreign models and the activities of international organizations, shaped and constrained all three major categories of social policies in Latin America.

Democracy exercised influence on social policies in the context of these other factors. Electoral competition and electoral incentives do not seem to have played a major role in generating social insurance in the "pioneer" countries in the first part of the 20th century, but they were important in producing primary health care programs in the 1970s and conditional cash transfer schemes in the 2000s. Freedom of expression helped to put social problems on the political agenda; facilitated debate and the spread of information that influenced the design, approval, and effectiveness of social policies; and encouraged the uptake of public transfers and services. Freedom to organize (which was granted

under certain authoritarian regimes as well as under democratic ones) allowed labor unions in many countries to extract subsidized contributory insurance from employers and the state; or to benefit from such insurance after governments introduced it to deter labor militancy. It also gave rise to medical business and doctors' associations, which in some countries resisted the extension of primary health care to the poor. In Brazil issue networks, as opposed to pressure groups, gave critical support to primary health care programs and conditional cash transfers. Partisanship, however, which requires a democratic regime in order to operate, does not seem to have played a major role in policy-making. Social insurance, primary health care programs, and conditional cash transfer schemes were each designed, approved, implemented, and expanded under governments at varying points on the ideological spectrum. Democracy's impact on social policies was neither unique, unidirectional, automatic, nor massive in every case, but no full account of the origins of such policies can ignore it.

Turning from the effects of politics on social policies to the effects of social policies on well-being among the poor, social assistance programs and improvements in the public provision of health, nutrition, water, and sanitation services led after 1990, despite a drop in social insurance coverage, to more rapid gains in the welfare of the poor than had been made during the truncated welfare state era. The improvements in public provision merit special attention. Prior to 1980 the literature on Latin American social policies focused on social insurance; since 1990 it has focused on social assistance. Social insurance and social assistance raise the amount of income that recipients command, but income is only a means to well-being. The public provision of basic health, nutrition, education, family planning, water, and sanitation services often contributes more directly to improving capabilities among the poor.

**Table 1: Public Spending on Social Insurance, Social Assistance, and Education/Health, circa 2000, Sixteen Latin American Countries**

| | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 |
|---|---|---|---|---|---|
| Country | Public spending on social insurance as a share of GDP, various years 1998-2005 | Public spending on social assistance as a share of GDP, various years 1998-2005 | Public spending on education and health care as a share of GDP, 2000 | "Total" social spending as a share of GDP (sum of Cols. 1, 2, and 3) | Social insurance spending as share of "total" social spending, circa 2000 |
| Costa Rica | 8.8 | 1.5 | 0.5 | 10.8 | 81% |
| Argentina | 10.7 | 1.5 | 2.0 | 14.2 | 75% |
| Colombia | 8.3 | 0.6 | 2.2 | 11.1 | 75% |
| Brazil | 11.7 | 1.4 | 2.9 | 16.0 | 73% |
| Bolivia | 8.6 | 2.0 | 1.4 | 12.0 | 72% |
| Mexico | 4.2 | 1.0 | 0.8 | 6.0 | 70% |
| Uruguay | 11.3 | 0.5 | 4.4 | 16.2 | 70% |
| Peru | 4.5 | 0.7 | 1.4 | 6.6 | 68% |
| Chile | 7.4 | 0.7 | 2.9 | 11.0 | 67% |
| Nicaragua | 5.4 | 1.1 | 2.6 | 9.1 | 59% |
| El Salvador | 4.2 | 1.0 | 2.0 | 7.2 | 58% |
| Panama | 5.0 | 1.7 | 2.7 | 9.4 | 53% |
| Venezuela | 1.9 | 0.6 | 1.5 | 4.1 | 46% |
| Paraguay | 1.8 | 0.4 | 1.7 | 3.9 | 46% |
| Dominican Republic | 1.1 | 1.7 | 1.8 | 4.6 | 24% |
| Guatemala | 0.7 | 1.1 | 4.2 | 6.0 | 12% |

Cols. 1 and 2: Margaret Grosh et al., "Spending on Social Safety Nets: Comparative Data Compiled From World Bank Analytic Work" (Washington, DC: World Bank, 2008), database accessed February 21, 2011, at http://www.worldbank.org. The "descriptive" tab of this database reveals that only in El Salvador, Guatemala, Nicaragua, Panama, and Paraguay does "social insurance" include public spending on health insurance (net of employer and employee contributions). Accordingly, except in these five countries, the

figure in Col. 1 has been raised, and the figure in Col. 3 reduced, by the amount of public spending specifically on health *insurance* as a share of GDP, which is calculated as the product of (a) "Social security expenditure on health as percentage of general government expenditure on health, 2000" times (b) "General government expenditure on health as a share of GDP, 2000" (data from World Health Organization, *World Health Statistics 2010*. Geneva: WHO, 2010, pp. 130-137). Colombia and Mexico require special attention. In Colombia, Grosh et al. (2008) include under social insurance the cost of the Subsidized Health Insurance Regime (0.9 percent of GDP), but not the cost of any other public spending on health insurance. To avoid double-counting, accordingly, 0.9 percent has been subtracted from the resulting Colombia figure in Col. 1 (cost estimate is from Tarsicio Castañeda, "Targeting Social Spending to the Poor With Proxy Means-Testing: Colombia's SISBEN System," World Bank Social Protection Discussion Paper 0529. Washington, DC: World Bank, 2005, p. 23). In Mexico, Grosh et al. (2008) include under social insurance the cost of health insurance for state workers in the ISSSTE scheme. No estimate of that cost was available, however, so the Mexico entry in Col. 1 unavoidably double-counts public expenditure on health insurance for workers in the ISSSTE plan.

Col. 3: Education spending ("Public expenditure on education, 2000") is from UNESCO Institute for Statistics Data Centre, accessed March 3, 2011, at http://stats.uis.unesco.org (the Venezuela figure is from 2006 rather than 2000). Health care spending ("General government expenditure on health as a share of GDP, 2000") is from World Health Organization, *World Health Statistics 2010*, pp. 130-137. Before being added to public spending on education, public spending on health care was reduced by the cost of public spending on health insurance, which was calculated as described in the note to Col. 1.

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[iv] David de Ferranti et al., *Inequality in Latin America: Breaking with History?* (Washington, DC: World Bank, 2004), p. 14.

[v] James W. McGuire, *Wealth, Health, and Democracy in East Asia and Latin America* (New York: Cambridge University Press, 2010), pp. 105, 129, 159-160.

[vi] Margaret E. Grosh, *Administering Targeted Social Programs in Latin America* (Washington, DC: World Bank, 2004), pp. 3-5, 39, 153.

[vii] Evelyne Huber, Thomas Mustillo, and John D. Stephens. "Politics and Social Spending in Latin America," *Journal of Politics*, Vol. 70, No. 2 (April 2008), p. 431.

[viii] McGuire, *Wealth, Health, and Democracy*, pp. 70, 135.

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[xiii] 1997: Armando Barrientos, "Health Policy in Chile: The Return of the Public Sector?," *Bulletin of Latin American Research,* Vol. 21, No. 3 (July 2002), p. 447; 2006: Carmelo Mesa-Lago, "Social Protection in Chile: Reforms to Improve Equity," *International Labour Review*, Vol. 147, No. 4 (2008), p. 379.

[xiv] Christina Ewig, "Piecemeal But Innovative: Health Sector Reform in Peru," pp. 238-241; Peter Lloyd-Sherlock, "Ambitious Plans, Modest Outcomes: The Politics of Health Care Reform in Argentina," pp. 102-108, both in Robert R. Kaufman and Joan M. Nelson, eds., *Crucial Needs, Weak Incentives* (Baltimore: Johns Hopkins University Press, 2004).

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