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Politics of Social Policy in Decentralized Countries

In 2009, the Argentine government launched a conditional cash transfer (CCT) program for impoverished families named *Asignación Universal por Hijo* (Universal Child Allowance). Seeing the program as an unwelcome federal imposition, the governor of San Luis obstructed its implementation, executing his own provincial program to compete with the federal one. In the words of the province's then governor, "In the past we suffered the Washington Consensus, now we suffer the Buenos Aires Consensus, and San Luis does not follow it ... We don't accept national policies because [the federal government uses] them politically" (Interview Alberto Rodríguez Saá).[1] Similarly, when the Brazilian government launched the CCT *Bolsa Família* (Family Allowance) in 2003, the state of Goiás hindered its implementation, promoting its own state cash transfer instead. Despite this obstructionism, San Luis and Goiás welcomed the federal government's health policies and even invested state resources in their success. Other states and provinces worked to support both federal CCTs *and* health policies, partly by developing complementary subnational policies.

Subnational governments react differently to national policies.[2] While some engage in activities to enhance the implementation of national policies, others actively hinder them. The same subnational government can react differently to different national policies. This poses the first puzzle of the book: Why do *some* subnational governments reject *some* (and not all) national policies that could benefit their inhabitants? In addition, the same policies encounter different contexts when implemented across the country. In particular, capabilities and

[1] Throughout the book, all direct quotations from personal interviews and secondary sources in Spanish and Portuguese have been translated by the author.

[2] "Subnational" refers to both intermediate and local territorial levels of government. I use the terms "provinces" to refer to intermediate levels of government and "municipalities" to refer to the local level, unless I am referring to the specific denomination in a country (for instance, "states" in Brazil or in the United States).

legacies vary within countries. What role do state capacity and previous policies play in understanding the uneven implementation of national policies? This book, *Uneven Social Policies: The Politics of Subnational Variation in Latin America*, seeks to uncover the conditions under which national policies are more successfully implemented across subnational units in decentralized countries.

In decentralized countries, individuals receive social protection from both national and subnational governments. Provinces in Australia, Austria, Belgium, Bolivia, Canada, Indonesia, Italy, Mexico, Spain, Switzerland, and the United States have the authority to affect the implementation of national policies.[3] The Federal District of Mexico City, for instance, has criticized the national CCT *Oportunidades* (Opportunities) program, advocating an alternative approach. To establish its own party's signature on social policy, Mexico City enacted the Law of Social Development in 2000 and dedicated nearly 20 percent of its municipal budget to the law's three main social programs. Partly as a result of these policies, coverage of the national CCT is low in Mexico City (Luccisano and Macdonald 2014). The Affordable Care Act in the United States is another clear example of the role of states in national policy implementation. On July 9, 2012, Texas Governor Rick Perry declared that his state would fight the federal health reform, commonly called Obamacare, by not expanding Medicaid or creating an insurance exchange. The governor called the health policy "brazen intrusions into the sovereignty of our state ... [that would] make Texas a mere appendage of the federal government when it comes to health care" (Fernandez, July 09, 2012). By 2016, twenty states had not expanded Medicaid and thirty-four had not developed health exchanges. In addition, nearly half of state legislatures had issued hundreds of bills and resolutions to hinder the health reform (Cauchi 2016).[4]

These examples show that multiple levels of authority mediate the process through which policies on paper become realities for citizens. This book examines the implementation of CCTs and health policies across Argentina and Brazil. I conducted 235 interviews with politicians and 148 with policy recipients in two provinces and four municipalities in each country. These initiatives are representative of recent social policy expansions in Latin America. Policies not associated with work contributions became more broadly targeted and their benefits more generous after a commodity boom in 2000 that allowed for a departure from retrenchment strategies. In addition, these policies follow strict rules for implementation as the receipt of the benefit is not contingent on political support. Those who receive the policy are not pressured to vote for the incumbent or participate in political rallies. These broadly targeted and patronage-free policies have the

[3] For a description of regional authority in these countries, see Hooghe et al. (2016).
[4] Medicaid.gov http://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html Accessed June 23, 2016.

potential to reduce poverty and inequality while improving human capital development. In order to promote the well-being of a given population, social policies need to reach it first. Yet in reality, national policies are only partially implemented in subnational units. As a result, their transformative potential has been limited.

While a considerable literature has focused on the development of welfare states and the challenges of decentralization, far fewer scholars have studied variation in the actual implementation of policies. This is paramount because it connects the design of policies to their socioeconomic outcomes. Existing approaches shed light on the reasons behind policy choices but are less equipped to explain why some policies are implemented better than others, why this variation is particularly relevant *within* countries, and why some policies deliver votes to incumbent governments while others do not. On the latter, while there are a number of studies on the role of clientelistic distribution of policies, it is crucial to analyze a less studied topic – the political determinants of nondiscretionary policy implementation.

The main contribution of *Uneven Social Policies* is to account for variation in social policy implementation through a combination of political motivations and capacities across multiple territorial levels within countries. It argues that successful policy implementation depends on having positive policy legacies and a competent state capable of delivering goods and services. At the same time, policy implementation also hinges on a political calculation about whether implementation serves politicians' electoral interests. For the latter, it makes an original connection between policies with clear national attribution of responsibility and the incentives facing opposition subnational governments to hinder such policies. The main implication is that to be successfully implemented, social policies should avoid clear attribution of responsibility. While claiming credit may increase the popularity of a leader and her party, it decreases the chances that the policy will succeed in opposition subnational units.

CCTs, HEALTH POLICIES, AND WHY THEY MATTER

This book identifies the principal factors that shape the successful implementation of national social policies by studying the main CCTs and primary health care policies in Argentina and Brazil. These policies are representative of the expansion of welfare states in much of Latin America. During the first decade of the twenty-first century, candidates from left parties were elected to the presidency throughout the region. Aided by the 2003–2007 commodity export boom, these governments were able to move away from retrenchment policies and govern on a redistributive platform (Levitsky and Roberts 2011, 2). This development has been particularly salient in the most advanced welfare states of Argentina, Brazil, Chile,

Costa Rica, and Uruguay, all of which introduced more broadly targeted social policies (Huber and Stephens 2012; Pribble 2013; Martínez-Franzoni and Sánchez-Ancochea 2016).

Perhaps the most visible, and internationally acclaimed, social policy innovation is the implementation of broadly targeted CCTs.[5] For the first time, CCTs in the region target a high percentage of the population living in poverty and, importantly, are implemented in a nondiscretionary manner. In other words, most of these programs have been free from political intermediaries and clientelistic machines, and therefore those who most need the transfers are those receiving it, independently of their political connections. A broker in a municipality in Argentina put it in the following terms: "With Plan Trabajar [discretionary national cash transfer in the 1990s] people were required to engage in politics ... But not now; now beneficiaries are required to go to school and have health check-ups" (Interview Argentina #51). This difference is key. There can be gaps in policy implementation due to the action of clientelistic machines. In these cases, policies are allocated discretionally, benefitting those affiliated with the party of the local broker, and recipients are asked to participate in political rallies in order to maintain their benefit. Additionally, subnational governments controlled by opposition parties receive fewer benefits from federal policies due to their party affiliation. These topics have been broadly studied (e.g., Shady 2000; Giraudy 2007; Kitschelt and Wilkinson 2007; Magaloni, Diaz-Cayeros, and Estévez 2007; Stokes et al. 2013; Calvo and Murillo 2014; Weitz-Shapiro 2014; and Szwarcberg 2015). However, nondiscretionary social policies can also be unevenly implemented as a result of politics in the territory. This topic has received much less attention. Given their potential for social transformation, the uneven implementation of nondiscretionary social policies deserves to be further studied.

Oportunidades in Mexico emerged as the pioneer patronage-free CCT in the early 1990s. Since then, these policies have spread to virtually every country in Latin America. In general, these cash transfers are conditioned upon the recipient's use of particular services aimed at reaching educational and/or health objectives. Bolsa Família in Brazil and Asignación Universal por Hijo in Argentina share similar characteristics to other CCTs. They are targeted at individuals or families living in poverty. Recipients withdraw funds monthly through an ATM card and after meeting a number of conditions aimed at human capital development. The conditions in health care include periodic check-ups and vaccinations for children and pregnant women. Education requirements generally include school enrollment and regular attendance. For these characteristics, CCTs improve the well-being and opportunities of those in need.

[5] I refer to CCTs as "broadly targeted" and not "universal" policies because they are means-tested and therefore not universal like their Scandinavian counterparts.

The most immediate effect of CCTs is the reduction in the levels of poverty and extreme poverty (Handa and Davis 2006, 518). In addition, the CCTs in Brazil and Mexico seem to be responsible for more than 20 percent of the inequality decline there, while the Chilean CCT accounts for 15 percent of the national reduction (Soares et al. 2009). These policies also increase school enrollment and attendance while decreasing child labor. This is partly achieved through relaxing income constraints by increasing households' monthly income, thus allowing families to send their children to school instead of work (Skoufias and Parker 2001; Behrman and Parker 2010; Filmer and Schady 2011; Ham 2014). CCTs have also increased the use of preventive health services, particularly for children, which has contributed to significant reductions in the access gap between rich and poor (Fiszbein and Schady 2009, 155). In addition, since most cash transfers are given to the mother rather than to the father, they have the potential to increase the bargaining power of women in the household (Cruces, Epele, and Guardia 2008).[6] They also have the potential to protect recipients from exploitative jobs. A poor farmer in the province of Mendoza in Argentina remembered that since the national CCT had been implemented, the landlord found it almost impossible to find people to work for him in exchange for a small percentage of the production of red peppers (Interview Argentina #13). This small transfer increases the bargaining power of recipients, giving them more ability to reject unpaid or low-quality jobs.

The main critics of CCTs argue that recipients become dependent on them and therefore have fewer incentives to look for a job in the formal labor market. Empirical research on the relationship between CCTs and labor demand has shown either inconclusive or insignificant results (Medeiros, Britto, and Soares 2008; Garganta 2011; Bertranou and Maurizio 2012, 5; Soares 2012, 23–25; Alzúa, Cruces, and Ripani 2013). CCTs have no (clear) effect on the beneficiary's decision to look for a job. I asked thirty-nine Bolsa Família recipients whether, if they had the option, they would choose to work in the formal labor market (*cartera assinada)* or to stay in the welfare policy – 87 percent (34) said they would choose the formal labor market. Some of the justifications for choosing the formal labor market over Bolsa Família were that "in the formal labor market you earn more money and you access all your rights, such as vacation and unemployment; it is also more stable" (Interview Brazil #27), "it would give me more security, I could get sick without fearing losing my job" (Interview Brazil #43), or "Bolsa Família is not enough for supporting four children, and I do not like being unemployed" (Interview Brazil #20). Contrary to the idea that social policy recipients are comfortable with social assistance and do not choose to seek a job in the formal labor

[6] CCTs have also been criticized for being based on, and furthering, maternalist assumptions and gender roles (Molyneux 2006).

market, these interviews suggest that policy recipients would work if offered a good quality job, with adequate salary and working conditions.

Latin American countries have also strengthened their public health systems, with emphasis on preventive rather than curative health care. Chile and Uruguay, in particular, have made significant progress in this area (Huber and Stephens 2012; Pribble 2013). In Brazil, the Worker's Party (*Partido dos Trabalhadores,* PT) increased the funding and the actual coverage of the primary health policy *Estratégia Saúde da Família* (Family Health Strategy). This policy is truly universal: it aims at covering the entire population through health teams in the territory that provide vaccines, general check-ups, and primary health assistance. The challenge has been to move from the goal of universality to actual universal access through building more primary health units across the territory and reaching out to those who cannot access health-care facilities. In Argentina, *Plan Nacer* (Birth Plan) also aims at increasing the actual take-up rate of health provision. The policy reimburses hospitals and clinics for services provided to uninsured women, children, and teenagers, increasing the resources received by primary health providers.

The emphasis on primary health care has produced significant results for human well-being both in Latin America and in other developing regions. Most importantly, good quality, affordable, and accessible primary health care decreases infant mortality rates. This is achieved through preventive actions such as early pregnancy, neonatal, and infant check-ups both at the health center and in the house of the patient (McGuire 2010b). Avoidance of early death, as McGuire (2010b) argues, is necessary for anything else we might want to achieve, and high levels of infant mortality tend to be associated with other sorts of deprivations. Good, free primary health care also promotes social equality by narrowing the gap between provision in the public and private sectors. The better the quality of provision in the public system, the higher the possibility that the middle class may choose to also attend public health clinics for preventive health care and, therefore, the higher the pressure to improve the service. Such improvement is seen not only in the quality of doctors and other professionals but also in the physical condition of the building, the waiting time, and the availability of medicine and medical records for everyone.

Although individual policies cannot counteract the effect of economic cycles, a battery of noncontributory policies can act as a safety net against social and economic risks and therefore have a more sustainable effect on the well-being of the population. By contrast, a failure to cover the most basic needs of the population can hinder a government's legitimacy and the full development of citizenship rights (Marshall 1950; Singh 2015, 14). By providing basic income and access to good quality social services, these policies contribute to developing a social protection floor (Bertranou 2010, 10). They have been referred to as "basic universal" policies. To reach this category, policies should guarantee basic welfare, and they should be of good quality, broadly targeted, and financially sustainable. Their administration should be transparent rather than discretionary

(Filgueira et al. 2005; Molina 2006; Huber and Stephens 2012; Pribble 2013). The more universal social assistance and services are, the more they can promote social inclusion and the development of human capital.

This is particularly important in Latin America, where the levels of poverty and inequality are high, in spite of recent improvements. Measured by the international poverty line of $2 a day, in 2011 there were 76.6 million people (13 percent) living in poverty in Latin America (World Bank 2015). In addition, Latin America is the most unequal region in the world. In the late 1990s, it exhibited a Gini coefficient of 0.53. By 2010, the Gini coefficient fell to 0.50, and this decline is higher than the increase in inequality in the 1990s. However, the levels of inequality are still higher than in the rest of the world. In the mid-2000s, Latin America was 65 percent more unequal than the OECD countries, 36 percent more unequal than East Asia and the Pacific, and 18 percent more unequal than Sub-Saharan Africa (Lustig 2009; Lustig, Lopez-Calva, and Ortiz-Juarez 2013). By 2010, Argentina, Venezuela, and Uruguay were among the least unequal countries in the region, with Gini coefficients of 0.39, 0.44, and 0.45, respectively. Bolivia and Honduras were among the most unequal countries with Gini coefficients of 0.56 and 0.67, respectively. Brazil reached worldwide records of inequality, when its Gini coefficient reached 0.63 in the 1970s and 1980s, and it has progressively decreased since 1998, reaching 0.54 in 2009 (Lustig, Lopez-Calva, and Ortiz-Juarez 2013). Finally, most jobs in Latin America are in the informal sector, meaning that most people do not have access to social benefits through work contributions (International Labour Organization 2016). In the context of these high levels of poverty, inequality, and informality, the study of noncontributory and nondiscretionary schemes is crucial for understanding and responding to the more pressing needs of the population.

SUBNATIONAL VARIATION IN SOCIAL POLICY IMPLEMENTATION

Noncontributory social policies fulfill one of the basic responsibilities of a democratic government as understood by most of the world – the provision of welfare to the most vulnerable segments of the population. In order to fulfill this basic responsibility, policies actually need to reach the targeted population. Yet in reality, policies are implemented unevenly across subnational units. To put it differently, national policies are implemented in some subnational units only partially. This partial implementation is not because they are distributed clientelistically through the targeting of some recipients over others for electoral gains. These policies are implemented following strict criteria. And yet they are unevenly implemented. As a result, the transformative potential of noncontributory social policies on the degree of poverty, inequality, and human capital development has been limited.

Figures 1.1–1.4 represent within-country variation in the implementation of the national social policies analyzed in this book. They show coverage of CCTs and health policies (i.e., actual number of people receiving the program) as

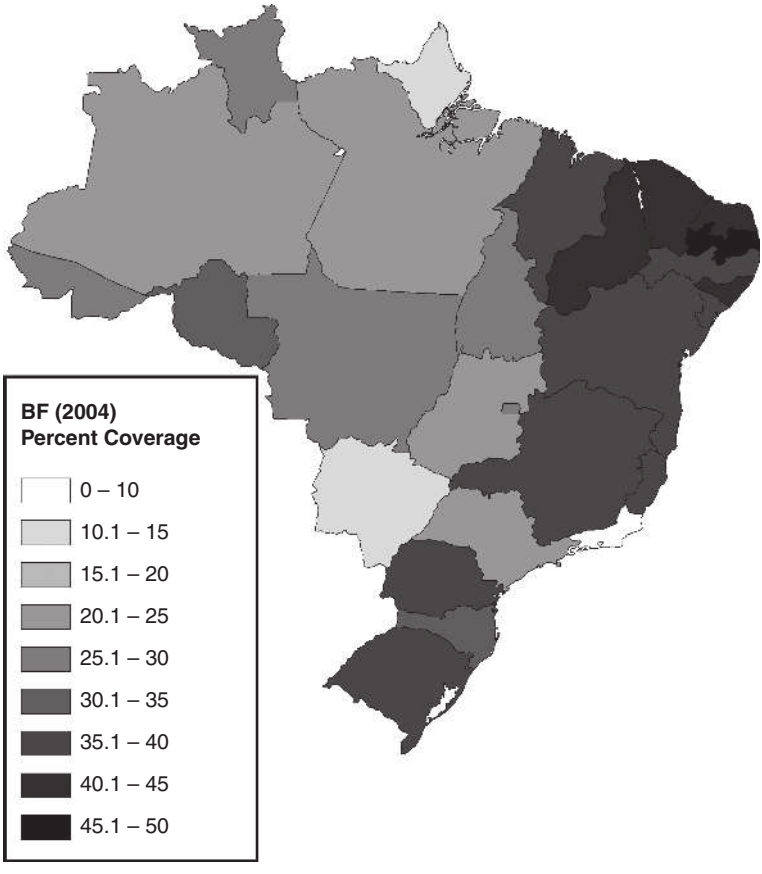

FIGURE 1.1 Bolsa Família percent coverage (2004)
Source: Brasil. Ministério do Desenvolvimento Social e Combate à Fome (2015).

a percentage of the targeted population in the first year of available data for all states and provinces.[7] The CCT Bolsa Família in Brazil (Figure 1.1) covered almost half of the targeted population in the Northeastern states of Piuaí, Ceará, Río Grande do Norte, Paraíba, and Alagoas in 2004, the first year of available data for all states. In the states of Río de Janiero, Amapá, and Mato Grosso do Sul the CCT reached less than 15 percent of the targeted population, and close to 20 percent in the states of Amazonas, Goiás, Pará, and São Paulo. Its coverage ranges from a minimum of 1 percent to a maximum of more than 90 percent from 2004 to 2015. The CCT Asignación Universal por Hijo in Argentina (Figure 1.3) reached all poor families the first year it was implemented in the provinces of Santa Cruz and La Pampa (the darkest two

[7] For a description of the dependent variable, targeted coverage across time, see Chapter 3.

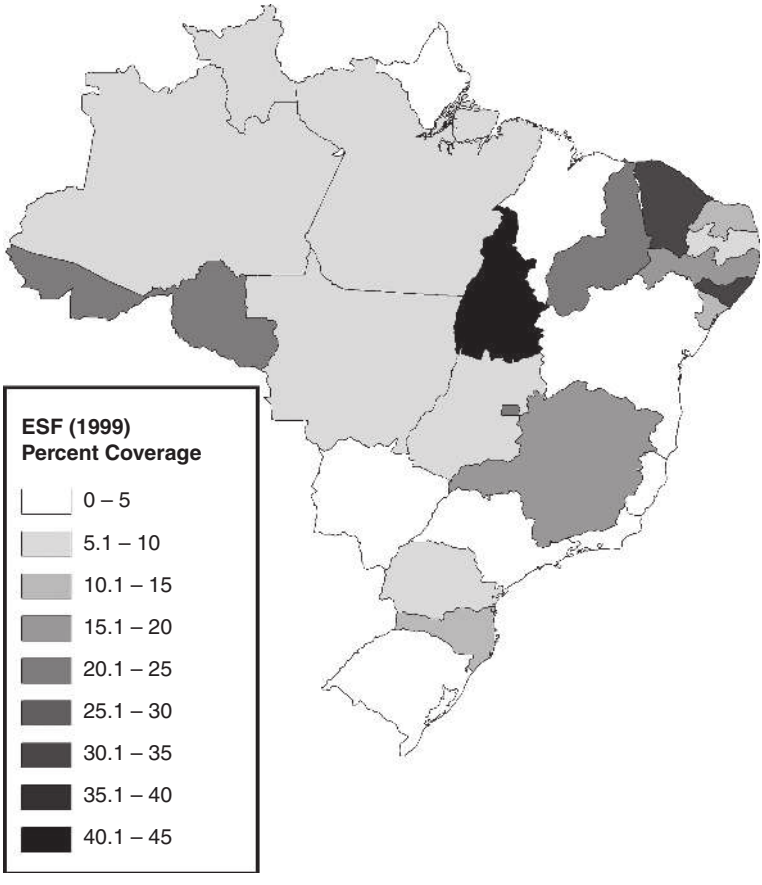

FIGURE 1.2 Estratégia Saúde da Família percent coverage (1999)
Source: Brasil. Ministério da Saúde Sistema de Informação de Atenção Básica (2015).

provinces in the map), while in the province of San Luis (the lightest in the middle of the country) it reached fewer than 10 percent. There is wide variation in the implementation of this CCT across provinces, ranging from fewer than 10 percent to more than 100 percent.[8] As a result, some citizens living in poverty in the low-coverage states and provinces are deprived of potentially transformative CCTs.

This variation in implementation levels is also present in health services. The primary health policy in Brazil, Estratégia Saúde da Família (Figure 1.2) had a particularly slow start. For the first year in which there is available data for all states, eight states had covered less than 5 percent of the targeted population. Alagoas, Ceará, and Tocantins, conversely, were among the most

[8] Percent coverage is higher than 100 because population living below the poverty line is underestimated by official figures since 2007 and can therefore be lower than coverage.

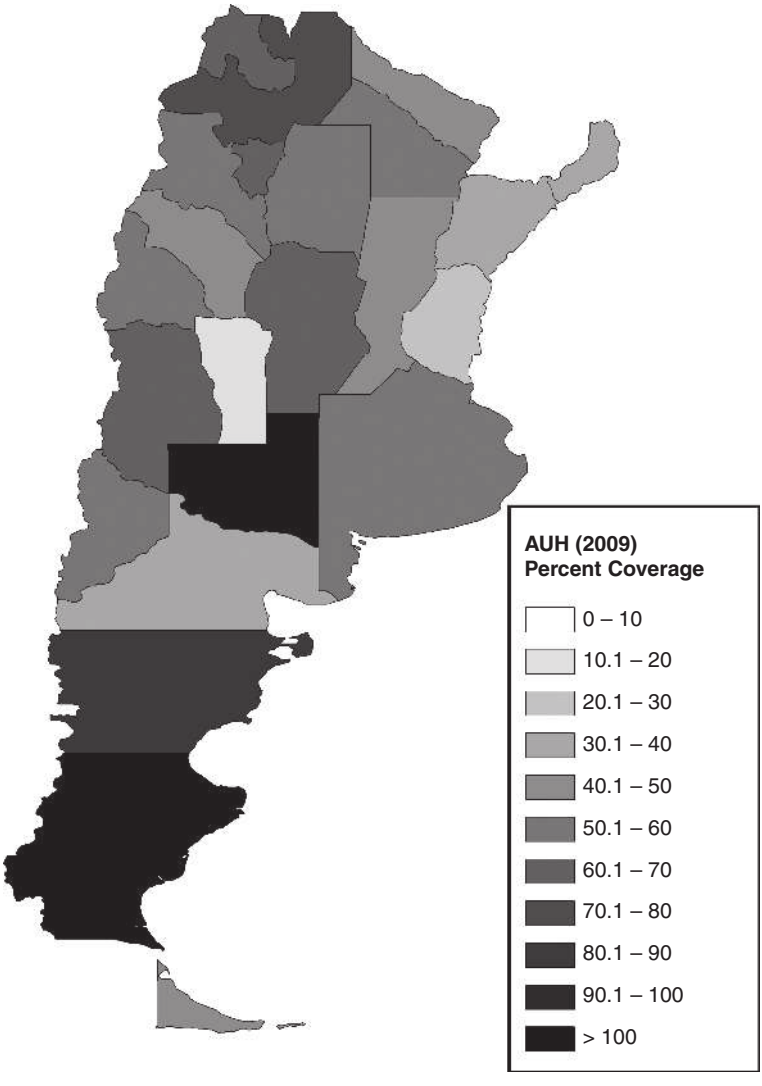

FIGURE 1.3 Argentina. Asignación universal por Hijo percent coverage (2009)
Sources: Anses (2015) and Argentina. Ministerio de Economía y Finanzas Públicas (2014).

successful with coverage between 30 and 40 percent of the population. The average standard deviation of this variable through 2015 is around 25 percent, and it covers almost the full possible range of values across time (0–98 percent). In Argentina, the implementation of health policy Plan Nacer (Figure 1.4) by 2010 had been more successful in the Northern provinces of Tucumán, Chaco, Jujuy, Corrientes, and Misiones (which started implementing