# MULTILEVEL SOCIAL POLICIES AND PARTISAN ALIGNMENTS: CASH TRANSFERS AND HEALTHCARE IN ARGENTINA AND BRAZIL

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**ABSTRACT**

SARA NIEDZWIECKI: Multilevel Social Policies and Partisan Alignments: Cash Transfers and Healthcare in Argentina and Brazil.
(Under the Direction of Evelyne Huber)

This dissertation assesses the performance of social policies in decentralized countries. It explores the factors that shape the successful implementation of non-contributory cash transfers and healthcare in Argentina and Brazil, countries in which subnational governments enjoy high levels of authority. The study finds that effective implementation of major national social assistance and services depend in part on partisan alignments across the different territorial levels – subnational governments enhance national policies either when they are political allies of the national government or when the policy has no clear attribution of responsibility and therefore possesses no electoral risk for the opposition. Furthermore, positive policy legacies and strong territorial infrastructure enhance the implementation of national social policies. The empirical foundation for this argument includes a pooled time series analysis of all provinces in Argentina and all states in Brazil and case studies that build on fifteen months of field-research in two provinces and four municipalities in Argentina, and two states and four municipalities in Brazil. In these places, the author conducted 235 original interviews with key national and subnational politicians and almost 150 structured interviews with social policy recipients.

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| | |
|---|---|
| ACA: | Patient Protection and Affordable Care Act |
| ANSES: | Administración Nacional de la Seguridad Social (National Social Security Administration) |
| AUH: | Asignación Universal por Hijo (Universal Child Allowance) |
| BF: | Bolsa Família (Family Allowance) |
| CAPS: | Centro de Atención Primaria (Primary Health Center) |
| CCT: | Conditional Cash Transfer |
| CEPAL: | Comisión Economica para América Latina y el Caribe (Economic Commission for Latin America and the Caribbean, ECLAC) |
| CIC: | Centro de Integración Comunitaria (Community Center) |
| CLT: | Consolidação das Leis do Trabalho (Consolidation Labor Law) |
| CMAS: | Conselho Municipal de Assistência Social (Municipal Council of Social Assistance) |
| CORAS: | Conselho Regional de Assistência Social (Regional Councils of Social Assistance) |
| CRAS: | Centro de Referência da Assistência Social (Reference Center of Social Assistance) |
| CREAS: | Centro de Referência Especializado de Assistência Social (Specialized Reference Center of Social Assistance) |
| ESF: | Estrategia Saúde da Família (Family Health Strategy) |
| FASC: | Fundação de Assistência Social e Cidadanía (Social Assistance and Citizen Foundation) |
| FEDEM: | Federación de Entidades No Gubernamentales de Niñez y Adolescencia (Federation of NGOs for Children and Adolescents) |
| FNAS: | Fundo Nacional de Assistência Social (National Fund of Social Assistance) |
| FPE: | Fundo de Participação dos Estados (State Participation Fund) |
| FPV: | Frente para la Victoria (Front for Victory) |
| FUNDEC: | Fundação Municipal de Desenvolvimento Comunitário (Municipal Foundation for Community Development) |
| GDP: | Gross Domestic Product |

| | |
|---|---|
| ICMS: | Imposto sobre Circulação de Mercadorias e Prestação de Serviços (Tax on Goods and Services) |
| IGD: | Índice de Gestão Descentralizada (Index of Decentralized Management) |
| INDEC: | Instituto Nacional de Estadísticas y Censos (National Statistics and Census Institute) |
| IPRU: | Imposto Sobre a Propriedade Predial e Territorial Urbana (Real State Tax) |
| ISS: | Imposto Sobre Serviços (Tax on Services) |
| LOAS: | Lei Orgânica da Assistência Social (Social Assistance Law) |
| MDS: | Ministério do Desenvolvimento Social e Combate à Fome (Ministry of Social Development) |
| NASF: | Núcleo de Apoio á Estrategia De Saúde da Família (Support for the Health of the Family) |
| OECD: | Organization for Economic Cooperation and Development |
| PAB: | Piso de Atenção Básica (Primary Care Baseline) |
| PACS: | Programa de Agentes Comunitários de Saúde (Community Health Agents Program) |
| PAMI: | Programa de Atención Médica Integral (Comprehensive Medical Attention Program) |
| PDT: | Partido Democrático Trabalhista (Democratic Labor Party) |
| PIS: | Plan de Inclusión Social (Social Inclusion Plan) |
| PJ: | Partido Justicialista (Peronist Party) |
| PJJHD: | Plan Jefes y Jefas de Hogar Desocupados (Unemployed Heads of Households Program) |
| PMAQ: | Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (Quality Improvement of Primary Care) |
| PMDB: | Partido do Movimento Democrático Brasileiro *(*Brazilian Democratic Movement Party) |
| PN: | Plan Nacer (Birth Plan) |
| PP: | Partido Progresista (Progressive Party) |
| PPS: | Partido Popular Socialista (Popular Socialist Party) |
| PR: | Proportional Representation |

| | |
|---|---|
| PROESF: | Programa de Expansão e Consolidação da Saúde da Família (Expansion and Consolidation of Family Health) |
| PROMIN: | Programa Materno Infantil y Nutrición (Maternal and Child Nutrition Program) |
| PSDB: | Partido da Social Democracia Brasileira (Brazilian Social Democratic Party) |
| PT: | Partido dos Trabalhadores (Workers' Party) |
| RAI: | Regional Authority Index |
| RS: | Rio Grande do Sul |
| SENARC: | Secretaria Nacional de Renda de Cidadania (National Secretary of Income and Citizenship |
| SCyE: | Seguro de Capacitación y Empleo (Employment and Training Insurance) |
| SUAS: | Sistema Único de Assistência Social (Unified Social Assistance System) |
| SUS: | Sistema Único de Saúde (Unified System of Health) |
| UBS: | Unidades Básicas Tradicionais (Traditional Basic Health Units) |
| UCR: | Unión Cívica Radical (Radical Civic Union) |
| UMAS: | Unidades Municipais de Assistência Social (Municipal Units for Social Asistance) |
| USF: | Unidade Saúde da Família (Family Health Unit) |
| VAT: | Value Added Tax |

# CHAPTER 1: INTRODUCTION. SOCIAL POLICY ACROSS MULTIPLE LEVEL

On July 9, 2012 Texas Republican 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 this reform "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 2012). In 2009, a year before the passing of Obamacare, the Argentine federal government also faced resistance to one of its core social policies, a conditional cash transfer (CCT) for families in poverty named *Asignación Universal por Hijo* (Universal Child Allowance, AUH). Seeing the program as a federal imposition, the opposition province of San Luis obstructed its implementation, using its own employment program to compete with the federal one. In the words of the province's former 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 conditional cash transfer *Bolsa Família* (Family Allowance, BF) in 2003, the state of Goiás hindered its implementation, promoting instead its own state cash transfer.

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

These stories show how multiple levels of authority mediate the process through which policies on paper become realities for citizens. The question is, then, under what conditions are national policies more successfully implemented across subnational units in decentralized countries? In such countries, social protection that individuals receive comes from both national and subnational levels of government. Whereas social insurance is almost exclusively under the purview of national governments, subnational levels of government actively participate in the design and implementation of social assistance and social services.

This dissertation identifies the principal factors that shape the successful implementation of national social policies by studying the main cash transfers and primary healthcare policies in Argentina and Brazil. These policies are representative of the expansion of social states in much of Latin America. Since the early 2000s, candidates from left parties have been 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 left platform (Levitsky and Roberts 2011, 2, 11). This development has been particularly salient in the most advanced welfare states of Argentina, Brazil, Chile, Costa Rica, and Uruguay, which introduced more broadly targeted social policies (Huber and Niedzwiecki forthcoming; Huber and Stephens 2012; Pribble 2013). The policies implemented in the last decade have been referred to as "basic universal" policies to differentiate them from pure universal policies found in Scandinavian countries (Esping-Andersen 1990). Basic Universalism should guarantee basic welfare, and social policies should be good-quality and broadly targeted (Molina 2006).[2] The more universal social assistance and services are, the more they can promote social inclusion and

[2] Instead of being dichotomous, universalism exhibits different levels. Pribble (2013) developed a scheme that includes pure universalism, advanced universalism, moderate universalism, and weak universalism. Advanced universal policies are broadly targeted, of good quality, financially sustainable throughout time, and their administration is transparent rather than discretionary.

the development of human capital. These policies "ensure that those at risk of poverty and social exclusion gain the opportunities and resources necessary to participate fully in economic, social and cultural life and to enjoy a standard of living and well-being that is considered normal in the society in which they live" (European Union 2010). Therefore, the study of non-contributory schemes is particularly relevant for understanding the more pressing needs of citizens.

This speaks to one of the basic responsibilities of a democratic government – the provision of welfare. A failure to cover the most basic needs of its population can hinder a government's legitimacy (Singh 2010, 9) and the full development of citizenship rights (Marshall 1950; O'Donnell 1993, 136; Rueschemeyer 2004, 76). In order to promote the well-being of the general population, social policies need to first reach the targeted population. However, policies are implemented unevenly across subnational units in decentralized countries. This is because while some states, provinces, and municipalities engage in activities to enhance the implementation of national policies, others actively hinder their implementation. The main argument of this dissertation is that the extent to which social policies are successfully implemented in decentralized countries depends on partisan alignments at the different territorial levels. Subnational governments are interested in enhancing the implementation of an upper-level policy either when they are political allies or when the policy cannot be easily attributed to the opposition federal government and therefore there are no clear electoral risks for the subnational opposition party or government level. In short, this dissertation makes two central contributions. Incongruity of partisanship across territorial levels has consequences for social policy provision, and attribution of policy responsibility matters for the possibility of cooperation.

**Main Argument in Brief**

This dissertation studies the implementation of national social policies and the interaction between multilevel partisan politics and social policy making and implementation. When attribution of responsibility is clear, subnational opposition governments have incentives to hinder the implementation of national policies. In other words, when recipients of a given policy can identify the national government as responsible for a given policy, there are more chances that the federal government obtains electoral gains. In this context, the policy will be obstructed in opposition subnational units. As in many federal and decentralized countries, subnational levels of government in Argentina and Brazil have the authority to design and implement policies of their own.[3] These policies can be put at the service of the national policy or in direct competition against them. Subnational governments that lack the resources to compete against national policies can instead affect the policy by omission, refusing to advance it in spite of their proximity to potential recipients.

Structural factors also shape successful social policy implementation; in particular, policy legacies and territorial infrastructure. In terms of policy legacies, when previous policies generated processes and actors' interests that are similar to the current policy, then the implementation of the current policy will be enhanced. Conversely, when previous policies created processes and interests that are contrary to the new policy, the implementation of the new policy will be held off. In addition, strong infrastructure in the territory enhances the implementation of national policies. This includes both institutions and the personnel who staff them as well as civil society organizations that operate in the territory and monitor the implementation of social policies. Overall, in aligned subnational units, with positive policy

[3] From the 1980s until the late 1990s, a number of social assistance programs in Brazil were designed at the municipal and state levels. In Argentina, before 2001, 28 provincial employment programs coexisted with 20 federal programs (Borges Sugiyama 2013; Fenwick 2008, 89, 160).

legacies, and strong territorial infrastructure we should encounter successful implementation of national social policies.

**Literature & Contribution**

This dissertation brings together theories on welfare states and multilevel governance in order to construct an analytic framework that explains the factors that shape policy implementation in decentralized countries. Welfare state theories have addressed the political determinants of social policy regimes and their outcomes, but have mostly restricted their analyses to national-level variation (Esping-Andersen 1990; Haggard and Kaufman 2008; Huber and Stephens 2001; Huber and Stephens 2012; McGuire 2010b). Yet, the wide dispersion in welfare outcomes (World Bank Group 2011), state capacity (Charron and Lapuente 2013; Ziblatt 2008), and levels of democracy (A. Borges 2007; Gervasoni 2010b; Gibson 2012; Giraudy 2010) within countries justifies the focus on lower levels of government. In addition, left partisanship has been a central variable for explaining variation in the design of social policies in advanced industrial democracies (Esping-Andersen 1990; Huber and Stephens 2001) and in Latin America (Huber and Stephens 2012; Pribble 2013). However, ideology does not shape social policy implementation in contexts of non-programmatic party systems, much less in multilevel party systems where party competition is denationalized and left and right parties join widely different coalitions at the different territorial levels (Calvo and Escolar 2005; Krause and Alves Godoi 2010; Leiras 2007; Miguel and Machado 2010; Ribeiro 2010).

In scaling down the unit of analysis (Snyder 2001), this dissertation also incorporates multilevel governance theories, particularly by studying the role of partisan dynamics to explain vertical competition on policy areas. While there is research on subnational resistance to federal policies in the United States (e.g Gormley 2006; Miller and Blanding 2012; Regan and Deering 2009), as well as studies on horizontal fiscal (Oates 2005; Weingast 2007) and policy competition

(Borges Sugiyama 2013), there has not been systematic research on competition between national and subnational levels on social policy areas.[4] To do so, I build upon research on fiscal federalism that includes the role of party alignments for encouraging or hindering national-subnational cooperation (Garman, Haggard, and Willis 2001; Jones, Sanguinetti, and Tommasi 1999; Larcinese, Rizzo, and Testa 2005; Riker and Schaps 1957; Rodden 2006; Wibbels 2005). I contribute to this literature by incorporating the analysis of social policy implementation to that of fiscal and macroeconomic policymaking. In particular, I incorporate the mechanisms through which subnational governments can resist national policies – through bureaucratic obstacles or through direct policy competition. To my knowledge, this topic that has been omitted in the literature, with partial exceptions (Leibfried, Castles, and Obinger 2005, 340). In this process, the formal characteristics of decentralization are the framework that shapes these possible strategic interactions.[5] However, the question is not *who* has the authority to do *what*, but *when* do subnational units enhance or hinder nationally designed policies in contexts of high levels of subnational authority.

**Methodology, Research Design, and Selection of Cases**

The analytic framework developed in this dissertation is tested through the combination of statistical analysis and case studies. The use of mixed-methods allows for increasing both external and internal validity. While the statistical analysis enhances external validity and aids the discussion of alternative explanations (King, Keohane, and Verba 1994), the case studies corroborate the findings of the quantitative analysis, improve the measurement of the variables,

[4] Leibfried (2005, 340) is a partial exception mentioning that the effect of local experimentation with social policy can both hinder or enhance welfare state expansion.

[5] While decentralization brought the state closer to people, it also produced potential challenges to the implementation of national level policies (Amenta 1998; Eaton 2012; Huber 1995; Schneider 2006).

and, most importantly, identify the causal mechanisms that lead to such results (Lieberman 2005; Ragin 1989). Pooled time series analysis measures the average effect of partisan alignments on the successful implementation of social policies across the 24 provinces in Argentina and 27 states in Brazil from the time that the first policy was implemented in each country (1994 in Brazil and 2007 in Argentina) until 2012. The case studies analyze the main health policies and conditional cash transfers and their implementation across countries, states or provinces, and municipalities.

Both research strategies employ the same dependent variable, social policy implementation, which is defined as the degree to which policies effectively provide social protection to the targeted population. To measure the dependent variable, I observe levels of coverage of the policy as a percentage of the targeted population. The targeted population ranges from the entire population in the country (in the case of the health policy in Brazil) to families in poverty (in the case of the conditional cash transfer in Argentina). These policies exhibit variation in coverage across states or provinces and municipalities, as well as across time. The case studies analyze the trajectory of four national social policies ranging from moderate universalism to advanced universalism and their interactions with four subnational cash transfers.[6]

I select cases across countries, states or provinces, and municipalities. National cases include Argentina and Brazil, which are the two most decentralized countries in Latin America, meaning that subnational government between the national and local levels enjoy significant regional authority both in their own territory (self-rule) and in the country as a whole (shared-rule) (Hooghe et al. Forthcoming). In addition, these two countries share similar trajectories in terms of welfare state development – they originated in the 1930s with employment-based social

[6] See chapter 3 for the level of universalism in the selected policies, based on Pribble (2013) schema.

insurance, underwent neoliberal reforms during the 1980s, and have expanded their social protection systems since the 2000s (Huber and Stephens 2012; Huber and Niedzwiecki forthcoming). At the subnational level, I select cases that are average in the main control variables and show variation in partisan alignments – states, provinces, and municipalities with similar levels of GDP per capita and population density but with different alignments to the national government.[7]

The case studies build on fifteen months of field research in Argentina and Brazil, where I conducted 235 in-depth interviews with elected officials, high-level technocrats, community leaders, and policy experts at the national, state, and municipal levels. In these places, I participated in councils, forums, and meetings that tackled social protection issues. In addition to elite-interviewing and participant observation, I also conducted almost 150 structured interviews with social policy recipients. Finally, I conducted archival research in the main newspapers of the opposition province in Argentina and opposition state in Brazil.

**Dissertation Overview**

The dissertation is divided into seven chapters. After this introduction, chapter 2 lays out the analytic framework and contribution to the literatures of welfare states and multilevel governance. I argue that partisan alignments, policy legacies, and territorial infrastructure shape social policy implementation in decentralized countries. This chapter details the mechanisms through which these three variables affect policy provision. This framework contributes to previous research by incorporating partisan dynamics across territorial levels and by including national-subnational competition on social policy.

[7] In the case of municipalities, I also select cases with different alignments to the state or province.

Chapter 3 describes the dependent variable and research design. It first lays out the measurement and variation of the dependent variable across policies, states, and time in Argentina and Brazil. Then it discusses why a mixed-methods research design is an accurate choice for unraveling the factors that shape social policy implementation. Finally, the chapter proceeds to explain the case selection strategy. The selection of cases across states and municipalities, aligned and not aligned to the national government, and social policies, attributable and non-attributable to the national government, represent all possible causal combinations of the main argument of the dissertation.

Chapters 4 through 6 provide empirical evidence for the theoretical framework that guides this dissertation. Chapter 4 includes a regression analysis of the determinants of social policy implementation across all provinces in Argentina and all states in Brazil from the 1990s to 2012. It analyzes an original dataset of social policy coverage, partisan alignments, policy legacies, and territorial infrastructure, as well as a number of control variables including decentralization, level of democracy, and GDP per capita. This original dataset is analyzed through the use of Prais-Winsten Panel Corrected Standard Errors regression. In addition, I include the results of fixed and random effects models for robustness checks.

The following chapters test the theoretical framework through case studies. Chapter 5 studies the role of partisan alignments on policies that enjoy clear attributability in Argentina and Brazil. This is the case of conditional cash transfers Asignación Universal por Hijo and Bolsa Família. The opposition province of San Luis in Argentina and the opposition state of Goiás in Brazil hold off the implementation of these national cash transfers through providing direct policy competition and through putting forward bureaucratic obstacles. Conversely, aligned governments enhanced these policies by designing complementary subnational policies and by investing their own resources on the improvement of these conditional cash transfers. This

differentiated reaction in opposition and aligned subnational governments responds to the fact that the national government successfully takes credit for this policy. At the same time, the legacies of previous national and subnational policies, as well as strong territorial infrastructure enhance the implementation of these policies.

Chapter 6 shows that when attributability is blurred, partisan alignments are irrelevant for shaping the implementation of national social policies. This is the case of primary health policies in Brazil (*Estrategia Saúde da Família*, Family Health Strategy, ESF) and Argentina (*Plan Nacer,* Birth Plan, PN). This chapter focuses on the sources of such blurred attribution of responsibility. In addition, it details the role of policy legacies and territorial infrastructure for the successful implementation of these policies across the selected subnational units. In terms of policy legacies, while Brazil's primary health policy competes against a previous primary health strategy and high complexity health provision, there are no comparable negative legacies in Argentina's Plan Nacer because the policy funds public providers of both primary and high complexity healthcare. In addition, the presence of good quality primary health centers and an active civil society monitoring the implementation of these policies enhances their implementation.

The conclusions summarize the main findings and discuss the implications of this dissertation for the well-being of the population, the generalizability of the argument, and possible avenues for further research. In terms of implications and relevance of the topic, the more universal social assistance and services are, the more they will promote the development of human capital and decrease intergenerational reproduction of poverty and inequality. The chapter also reflects on the generalizability of the argument as any country in which subnational governments have a role in the implementation of national policies or, put it differently, any

country in which subnational governments can design and fund their own policies. Finally, the conclusions discuss possible topics for future research.

# CHAPTER 2: ANALYTIC FRAMEWORK & CONTRIBUTION TO THE LITERATURE

National policies in decentralized countries go through multilevel territorial channels before reaching the targeted population. This is particularly true for social assistance and social services, for which states, provinces, and municipalities actively participate in the implementation of national policies and can even design policies of their own. These subnational policies can be put at the service of a given national policy or in direct opposition to it. A major consequence of these multilevel interactions is that national policies are implemented unevenly across subnational units. Acknowledging these multilevel processes, this dissertation studies the conditions under which national non-contributory social policies are more successfully implemented in decentralized countries.

In this chapter I present a theoretical framework that answers this issue, identifying three factors that shape the successful implementation of national social policies – partisan alignments, territorial infrastructure, and policy legacies. Successful implementation of national policies is shaped by partisan alignments at the different territorial levels. Subnational governments will enhance the implementation of an upper-level policy either when they are political allies of the national government, or when the policy cannot be easily attributed to the opposition and therefore there are no clear electoral gains for any political party or government level. Nevertheless, agency is not unbounded. Structural variables such as territorial infrastructure and policy legacies also influence the extent to which national social policies are successfully implemented. Territorial infrastructure is composed of institutions and their personnel, along with civil society organizations through which information and policies flow. Effective territorial

infrastructure facilitates the implementation of social policies. With regards to policy legacies, the more compatible that previous policies are with a new one, the more fluid its implementation.

To construct this framework, I bring together literatures of welfare states and multilevel governance. In what follows, I outline the ways in which these literatures contribute to tackling the factors that shape social provision in decentralized countries, as well as their limitations. Next, I detail the analytic framework that guides this dissertation.

**Welfare States and Multilevel Governance: Contributions and Limitations**

Welfare State theories that originated in advanced industrial democracies have studied the political determinants of social policy outputs but have mostly restricted their analyses to national-level variation (e.g: Esping-Andersen 1990; Huber and Stephens 2001). Looking at subnational dynamics is paramount given the wide dispersion that exists within countries in terms of party systems (Calvo and Escolar 2005; Krause et al. 2010; Wilson 2012), state capacity (Charron and Lapuente 2013; Ziblatt 2008), and levels of democracy (A. Borges 2007; Cornelius 1999; Gervasoni 2010b; Gibson 2012; Giraudy 2010; Snyder 1999). In addition, by incorporating the role of partisan dynamics to explain vertical competition on policy areas, this research also contributes to multilevel governance theories. While the literature on fiscal federalism incorporated the role of party alignments for encouraging or hindering cooperation, this research has been limited to the study of macroeconomic policymaking (Garman, Haggard, and Willis 2001; Larcinese, Rizzo, and Testa 2005; Rodden 2006; Wibbels 2005; Jones, Sanguinetti, and Tommasi 1999). In addition, the literature on subnational resistance to federal policies has overall omitted policy competition between national and subnational governments (e.g: Gormley 2006; Miller and Blanding 2012; Regan and Deering 2009).

### *Welfare States*

Since Esping-Andersen's (1990) groundbreaking work, advanced industrial democracies can be categorized into different types of welfare regimes. Scandinavian countries grounded in universal welfare state regimes are the most redistributive and show the lowest poverty levels among advanced industrial democracies. Even Bismarckian, or contributory-based, welfare regimes fare relatively well in terms of generosity and inclusion, but not in terms of redistribution (Bradley et al. 2003; Esping-Andersen 1990; Huber and Stephens 2001). In the Latin American context, Bismarckian regimes have neglected big portions of the population who are outside the formal labor market. At the same time, classic-Scandinavian universalism may be too idealistic mainly because Latin American states lack the capacity to broadly tax their population as their Northern-European counterparts do. Basic universalism has been proposed as an alternative (Filgueira et al. 2005; Huber and Stephens 2012). According to this principle, everyone should have the right to basic welfare and social policies should be of good-quality and broadly (not narrowly) targeted. Nevertheless, this research has focused exclusively on national-level processes, avoiding the question of the relative success of these policies when implemented in different regions within a given country.

Left partisanship has been the central variable to understand types of social policy in advanced industrial democracies (Esping-Andersen 1990; Huber and Stephens 2001; Korpi 1978) and in Latin America. Since left-parties accessed power in the early 2000s, some Latin American countries have moved towards more universalistic social policies (Huber and Stephens 2012; Huber and Niedzwiecki forthcoming; Pribble 2013). However, it remains unclear whether ideological commitment at the national level is reproduced at subnational levels of government. In addition, policy legacies also shape social policy development (Myles and Pierson 2001; Pierson 1996). Although policy legacies research has mostly focused on institutional and policy

innovation, rather than on the implementation of new policies, the same arguments apply in both cases. Positive feedback dynamics increase the cost of switching from one alternative to the other over time (Pierson 2004, 19). In Pierson's words: "the depth and interrelatedness of accumulated investments may make the adoption of previously plausible alternatives prohibitively costly – especially if the institution in question has been in place for some time" (Pierson 2004, 152). The cost of switching policies increases over time in part because they reshape the political process: new policies produce new politics (Pierson 1993, 595; Schattschneider 1935). Huber and Stephens (2001) summarized this process with the term "policy ratchet effect," by which policy reforms create supporters of a policy which make it harder to change its direction. Policy legacies influence social policy by empowering certain actors and weakening others (Pribble 2013, 3). I argue in the analytic framework of this chapter that the legacy of previous policies is different across the territory and shapes the degree to which the national government can reach the subnational arena to implement such policies.

Welfare theories originated in OECD countries justifiably took state capacity and democracy for granted. When such theories travelled to the developing world, these two variables had to be incorporated to the analysis to account for welfare variation (Huber and Stephens 2012; Repetto 2001). The capacity of the state to implement policies seems paramount for welfare development. State capacity allows responsive officials to deliver things that citizens need (Norris 2012, 8; Repetto 2001; Skocpol and Finegold 1982). One aspect of state capacity – infrastructural power – is defined by Mann (1988, 5) as "the capacity of the state to actually penetrate civil society and to implement logistically political decisions throughout the realm." Such territorial penetration is necessary for social development (Mann 1988, 16–18). Soifer summarizes indicators of infrastructural power along security, extraction, and service provision lines. For the latter, he includes socioeconomic data such as differences in literacy or

immunization rates within a country (Soifer 2006; Soifer 2012). This operationalization assumes that territorial control automatically translates into positive socio-economic outcomes, which is not always the case. The relationship between territorial reach and welfare outcomes needs to be explained. To achieve this, I understand territorial infrastructure as the actual territorial presence of state and non-state actors and institutions for the provision of social policies and services.

The state is not alone in reaching the most vulnerable population and organized civil society can be an ally in this endeavor. Since Alexis' de Tocqueville's *Democracy in America* ([1835, 1840] 1945), civic associations have been central for the study of effective democratic institutions. Inspired by Tocqueville's ideas, Putnam analyzed how "civic-ness" shapes the quality of governance. The formation of civic and political organizations is one of the clearest materialization of such civic attitudes (Putnam 1993, 89) and the channel through which individual inclinations have a real effect on the outcomes of political interactions. Singh (2010) agrees with Putnam in that citizen involvement could enhance outcomes. She argues that subnationalism, conceptualized as "a 'we-feeling' associated with a subnation that is located within the geographic boundaries of a sovereign state", enhances the well-being of individuals by overcoming collective action problems and thus facilitating social welfare (Singh 2010, 4, 16).

Democracy is often considered a pre-condition for the development of an active civil society and of welfare development more generally. Previous research showed that the record and quality of democracy matters for social policy development (Bangura and Hedberg 2007; Garay 2010; McGuire 2010b), when it appears in tandem with state capacity (Norris 2012), left parties (Huber and Stephens 2012), policy legacies, and economic performance (Haggard and Kaufman 2008). Democracy enhances policies that expand human capabilities and makes the most basic needs more visible. Democratic regimes achieve these goals through accountability mechanisms. In addition, freedom of expression and association, together with citizen's

expectations of social rights, influence the different stages of policy making (McGuire 2010b, 296). Nevertheless, the effect of democracy on welfare outcomes is not consistent across the type of outcomes (Norris 2012) and across the territorial boundaries of the state.

Studies of welfare states at the national level eschew the question of what happens when the national government is considered to be democratic, but democracy is uneven across the states and provinces. In order to account for such complexity, several authors have analyzed the existence of subnational regimes with different degrees of electoral competition across subnational states (A. Borges 2007; Cornelius 1999; Gervasoni 2010b; Gibson 2012; Giraudy 2010; Snyder 1999). Initial analyses on the relationship between subnational regime type and welfare outcomes either show that there is no direct significant correlation between subnational democracy and health outcomes (McGuire 2010a) or that the relationship is opposite to expected; more democratic subnational units have higher levels of inequality than more authoritarian ones (Remington 2011). In the section on the analytic framework, I argue that subnational regime type shapes the territorial level that holds de-facto authority over the polity. In general, subnational authoritarian states and provinces will concentrate authority thus weakening the local or municipal level.

Overall, this study contributes to welfare state theories by highlighting the multilevel political processes that take place in the implementation of national social policies in decentralized countries.

### *Multilevel Governance*

In the 1950s, there was a common agreement within first generation theory of fiscal federalism that public agents at the various levels of government with access to fiscal tools would follow welfare-maximizing policies. The second generation theory of fiscal federalism relaxes this assumption and incorporates the role of institutions and political processes (Oates 2005).

Nevertheless, both the first and second generation theories by and large assume that the effect of changes in institutions is homogeneous throughout a given national territory. My work joins this second generation research contributing to it by looking at processes also from a bottom-up logic. The effect of decentralization reforms, in fiscal or social policy arenas, does not only depend on rules and national contexts, but also on subnational- national political dynamics.

In this way, my research builds on the literature on fiscal federalism that incorporated the role of party alignments in encouraging or hindering cooperation. Riker and Schaps (1957) argue that lack of partisan alignments between the federal and subnational governments endangers intergovernmental cooperation; and others have added that if national leaders are able to discipline subnational co-partisans, then cooperation across territorial levels is more easily attained (Diaz-Cayeros 2004; Filippov, Ordeshook, and Shvetsova 2004; Garman, Haggard, and Willis 2001; Jones, Sanguinetti, and Tommasi 1999; Larcinese, Rizzo, and Testa 2005; Rodden 2006; Wibbels 2005) Along these lines, Rodden (2006) notes that political parties encourage cooperation to achieve fiscal discipline and macroeconomic stability: "If voters use national party labels to punish politicians across all levels of government for poor macroeconomic performance, governors or first ministers at the provincial level who share the partisan affiliation of the central executive will face disincentives to seek destructive bailouts" (Rodden 2006, 120). I contribute to this literature by incorporating the analysis of social policy implementation to that of fiscal and macroeconomic policymaking. In particular, I consider the strategic interactions between national and subnational executives for the successful implementation of federal cash transfers and social services.

In doing so, this study builds on the literature on state resistance to federal policies in the United States. Such resistance has been explained by the role of federal (unfunded) mandates (Derthick 2001; Gormley 2006; Grogan 1999; Krane 2007; Posner 2007; Regan and Deering

2009), socio-economic factors (Shelly 2008), opposition advocacy groups and constituencies (Palazzolo et al. 2007), and ideology and/or opposition party control (Miller and Blanding 2012; Nicholson-Crotty 2012; Palazzolo et al. 2007; Regan and Deering 2009; Rigby and Haselswerdt 2013; Rigby 2012) . Most of these studies include individual analyses of federal policy areas such as Affordable Care Act (Haeder and Weimer 2013; Regan and Deering 2009; Rigby and Haselswerdt 2013; Rigby 2012), ID requirements (Regan and Deering 2009), No Child Left Behind (Shelly 2008), Medicaid (Grogan 1999), economic stimulus package (Miller and Blanding 2012), and election administration (Palazzolo et al. 2007). However, to my knowledge, this literature does not incorporate negative cases (in which there is no subnational resistance to national policies) to account for the fact that the same subnational unit sometimes obstructs and sometimes enhances different national policies.[8] This study fills this gap in the literature by incorporating both types of cases. In addition, this study incorporates a prevalent form of subnational resistance that has been omitted in the literature – direct policy competition. While there is research on horizontal fiscal (Oates 2005; Weingast 2007) and policy competition (Borges Sugiyama 2013), there has not been systematic research on vertical competition on social policy areas. This is surprising given that subnationally designed policies in open competition or complementing national policies are a relevant variable to account for the performance of such national policies.[9]

The few studies on the relationship between multilevel politics and social policy outside of the United States have limited the scope of their analysis to either top-down or bottom-up

[8] Gormley (2006) is an exception analyzing environmental, health, and education policies. The author argues that the difference in the level of conflict among these areas depends on federal mandates and federal funding.

[9] Leibfried, Castles, and Obinger (2005, 340) can be considered a partial exception, since they do mention that local social policy experimentation can hinder or enhance welfare state expansion.

approaches. Some of this research has focused on hierarchical central-subnational variables such as the type of federalism and decentralization (Biela, Hennl, and Kaiser 2013; Fenwick 2008), in combination with the characteristics of welfare state consolidation (Leibfried, Castles, and Obinger 2005) or ideological commitment of the center (Chapman Osterkatz 2013),[10] and the conflict between equality and decentralization (Finegold 2005; Mathias 2005; Smulovitz 2012). Other research has focused on interactions from a subnational perspective by focusing on policy diffusion across local units (Borges Sugiyama 2013), as well as the role of sub-state nationalism (Singh 2010), the role of partisan ideology (Turner 2011), and the role of an activist state governor (Tendler 1997), and public sector entrepreneurship (Grindle 2007) on welfare.[11] My research innovates through analyzing the interaction between political and policy forces operating both from the central to the subnational levels, and from the subnational to the central levels. The formal characteristics of decentralization are the framework that shape possible strategies for national and subnational actors, and the effect of these institutions depends upon multilevel interactions. As Obinger et al. (2005, 30) put it, federalism is mediated by the political context. In this way, this study contributes to the works that part ways with normative models of federalism to engage in a positive analysis of how federations actually work (see Beramendi 2009). The question is not *who* has the authority to do *what*, but *when* do subnational units enhance or hinder nationally designed policies in contexts of high levels of subnational authority.

While decentralization and federalism brought the state closer to the people, they also produced potential challenges to the implementation of national level policies (Amenta 1998; Eaton 2012; Huber 1995; Rigby and Haselswerdt 2013; Schneider 2006). Amenta (1998)

[10] In her case studies, Chapman Osterkatz (2013) analyzes the effect of ideology, capacity and decentralization on primary health reform in subnational governments in Brazil and Spain.

[11] Bonvecchi (2008) partly incorporates both national and subnational perspectives by analyzing the determinants of autonomous (from the national government) subnational social policy innovation.

analyzed the uneven implementation of the New Deal in the United States. The author argues that the states which were less receptive to these national social policies where the least democratic states, with patronage parties, and with lack of left partisan ideology, social movements, and influential bureaucrats. In addition, the more centralized and higher incentives the policy exhibited, the better its implementation. Along similar lines, Schneider (2006) argues that market reforms in Brazil were implemented faster (and following market-governing strategies) in states with autocratic budgeting processes than in states with more democratic budgeting institutions. For Tarrow, a decentralized bureaucracy or what he calls "a diffuse bureaucratic system" is a poor system for the implementation of central policies due to "its lack of a uniform and able civil service, the jurisdictional gaps between its agencies, and its politization from below" (Tarrow 1977, 40–41).

In close relation to the debate on how government structure shapes outcomes, my research also contributes to the literature on the appropriate level for the production and provision of public goods and services, which has mostly focused on the demand side (Musgrave 1959; Olson 1969; Tiebout 1956). The main argument for supporting subnational provision of public goods, as opposed to central provision, is that subnational levels of government are closer to their constituents and thus have more information about the preferences of local residents. Nevertheless, there is nothing that precludes the national government (in principle) from assembling such information (Oates 2005, 359) and true preferences are not always revealed (Tiebout 1956). Conversely, economies of scale and interregional spillovers support the case for centralization of provision (Marks 2011). The trade-off is therefore between economies of scale and spillover, and heterogeneity of preferences (Alesina, Angeloni, and Schuknecht 2005, 277). Breuss and Eller (2004) show how previous research presents contradictory theoretical and empirical results on the question of the optimal assignment of policy tasks. Therefore, causal

mechanisms that explain policy allocation entail a case-by-case examination (Breuss and Eller 2004; Schakel 2009; Watts 2006, 322–23). My research sheds light on the type of variables and mechanisms that we ought to observe when assessing the appropriate level of social policy authority distribution, with particular attention to the supply side, namely political alignments, territorial infrastructure, and policy legacies.

### *Alternative Explanation: Economic Development*

The level of economic development is one of the main explanations of variation in social protection.[12] Although it is true that advanced industrial democracies fare better than developing countries in terms of socio-economic outcomes, between and within country differences show the significant effect of policies. According to the logic of industrialism, socioeconomic factors account for "welfare state effort" (Wilensky 1974). Nevertheless, not all countries with the same level of economic development advance the same type of social policies. This is true both for high-income countries (Esping-Andersen 1990; Huber and Stephens 2001) and for Latin American countries (Filgueira 2007; Huber and Stephens 2012; Martínez-Franzoni 2008; Pribble 2013). For advanced industrial democracies, Esping-Andersen (1990) defines three ideal types of welfare regimes: liberal, conservative, and social democratic; and each regime shows differences in the quality of social rights, (de)commodification, social stratification, and the relationship between state, market, and family. These classifications do not correspond to different levels of economic development.

Recent studies argue that types of welfare states can also be found at the subnational level (Armingeon, Bertozzi, and Bonoli 2004; Rodrigues-Silveira 2012). However, subnational

[12] See Skocpol (1986) for a literature review of the effect of economic development on welfare state development.

social policy divergence is not significant enough to warrant the application of different types of welfare regimes. National levels of governance still standardize social insurance schemes as well as more universalistic social policies. This is true not only for Brazil and Argentina, but also for federal OECD countries (Mathias 2005). Central governments intervene in the affairs of subnational units (Gibson 2012), so subnational levels of government remain embedded within the national welfare state. What we see is different degrees to which national and subnational social policies are implemented throughout the territory, but not different types of subnational welfare states.

The analytic framework developed in this dissertation is constructed from these literatures. Welfare states theories provide the mechanisms through which policy legacies and partisanship shape social policy. When these theories travelled to non-OECD countries, they also incorporated state capacity and democracy as preconditions for successful social policies. Multilevel governance theories assist this dissertation in incorporating the multiple territorial structures and political configurations through which the policy travels. The next section builds from these bodies of literature to construct a unified analytic framework to explain social policy implementation in decentralized countries.

**Unified Theory: Analytic Framework**

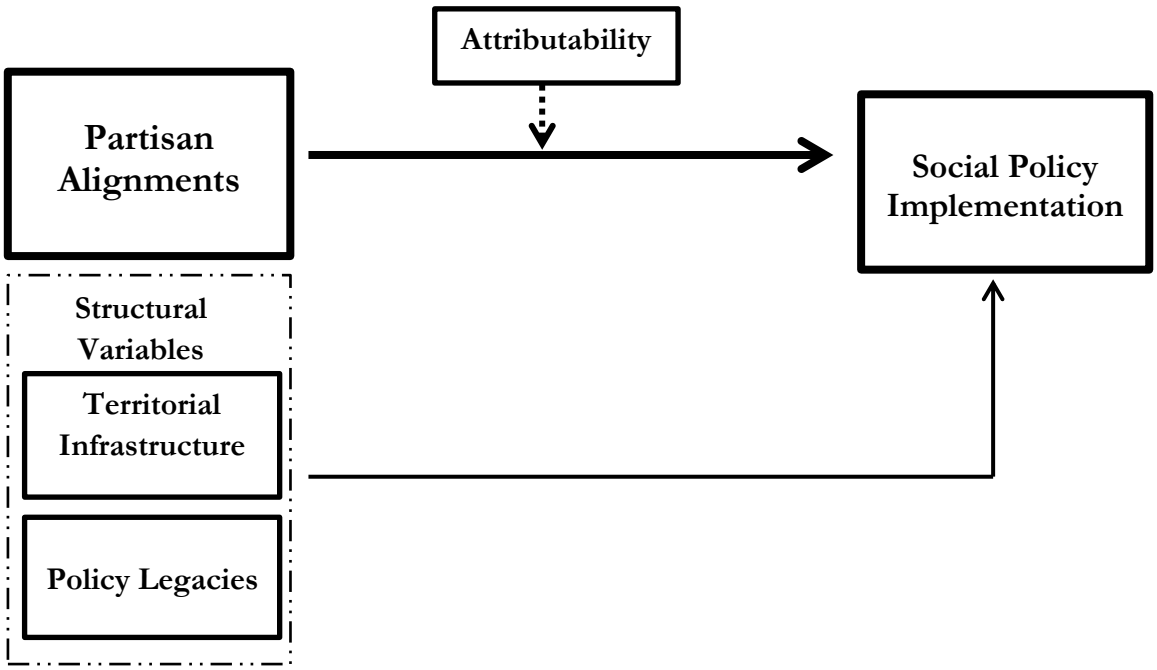
This study analyzes the factors that shape non-contributory national social policy implementation in decentralized countries. In particular, it focuses on the conditions under which these policies are more successfully implemented across its territory. The main argument of this dissertation, represented in figure 2.1, is that partisan alignments across territorial levels shape social policy implementation when the policy is easily attributable to a party or government level. Attributability, therefore, is necessary for partisan alignments to have a causal

effect. Subnational governments aligned with the president will be interested in enhancing the implementation of national-level policies. States and provinces in the opposition, conversely, will hinder the implementation of a given policy by presenting bureaucratic obstacles or by open policy competition, but only when the policy has a clear electoral gain. When recipients of the policy can identify where the policy is coming from and thus potentially reward that party or government level, subnational opposition will obstruct the implementation of that policy.[13]

Structural variables also shape successful social policy implementation. Effective territorial infrastructure facilitates the implementation of social policies. Territorial infrastructure includes institutions and the personnel who staff such institutions, but also civil society organizations in the territory through which information and policies flow. Additionally, policy legacies enhance the implementation of social policies when previous processes and empowered actors' interests at the different subnational levels are not contrary to the new policy. Conversely, entrenched interests in previous policies that are contrary to the current one will obstruct the implementation of the policy. The next sections will unpack the mechanisms through which partisan alignments, territorial infrastructure, and policy legacies shape social policy implementation in decentralized countries.

[13] This does not mean that policy recipients will automatically vote for the national incumbent, since there are other issues that shape voting behavior. Nevertheless, only when recipients can attribute policy responsibility to the national government, they will be able to reward that party or government level in the elections.

**Figure 2.1: Analytic framework**




***Partisan Alignments***

Partisan alignments shape the successful implementation of social policies. Politically aligned subnational units will always be interested in enhancing national-level policies. Opposition subnational units will only enhance national policies' implementation when there are no clear electoral risks. Conversely, when recipients can identify where the policy is coming from, opposition subnational units will hinder the implementation of such policies because they cannot benefit from them electorally. The assumption is that politicians are motivated first and foremost by getting themselves or their parties reelected (Mayhew 2004); as well as by continuing their careers in (particularly subnational) government (Mayhew 2004; Samuels 2002). To achieve these aims, they seek government and go through parties (Aldrich 2011, 5, 15). In federal countries, the electoral fates of national executives influence the electoral chances of subnational politicians (Campbell 1986; Carsey and Wright 1998; Wibbels 2005). In addition, recent literature has shown that citizens reward national incumbents who provide conditional

cash transfers (Baez et al. 2012; De La O, Ana L. 2013; Hunter and Power 2007; Zucco 2013). Therefore, co-partisan governors have incentives to boost the implementation of national level policies in which recipients identify the federal government as the main provider.[14] According to Rodden, this is because voters focus retrospectively on the party label of the federal executive to reward subnational leaders: "When voters do this, the reelection chances of legislators and subnational politicians are driven in part by the value of the national party label. In this way, co-partisans of the national executive can hurt their own reelection chances by taking actions…that reduce the value of the party label by undermining national collective goods" (Rodden 2006, 125).

Allied governors and mayors can enhance the implementation of national policies by signing agreements to share databases of potential recipients and by putting their own policies, institutions, and personnel at the service of national policies. On the contrary, resistance to national policies due to partisan opposition can take the form of bureaucratically hindering the reach of the central government or direct policy competition. In the words of a former governor and former national vice-president of Argentina: "social programs function much better when the national, provincial, and municipal governments are all of the same political color" (Interview Cobos).

The signing of agreements (or the lack thereof) between federal and subnational governments is one mechanism through which subnational units can hinder or enhance the implementation of national policies. Signing agreements that allow for sharing the lists of beneficiaries of provincial social policies enhances the implementation of national policies because the federal government does not need to find every new recipient, since it has access to

[14] Contrary to macroeconomic adjustment policies in which national and subnational politicians potentially fear for the negative electoral consequences of these policies, cash transfers and social services are examples of policies for which politicians generally want to claim credit.

a database of potential candidates. Nevertheless, subnational governments can undermine the implementation of a policy by refusing to sign such agreements and therefore imposing additional obstacles for the federal government to reach the targeted population. In addition, not signing agreements with the federal government can impose additional bureaucratic steps to recipients.

Subnational units can also hinder or enhance the implementation of a given policy by presenting direct policy competition or complementing their own programs with the national ones. For this to be an option, states and provinces need to have access to sources of funding, and have discretion over policy innovation.[15] Subnational entities can enhance upper-level policies by adapting their already existent programs. The nationally-aligned Mendoza's province in Argentina, for instance, made its employment program coordinate with the national employment program by providing infrastructure and personnel. Conversely, San Luis' employment program directly competes with CCT Asignación Universal por Hijo. And *Renda Cidadã* in Goiás directly competed with Bolsa Família until recently. Competition in both cases was manifested through not sharing databases as well as offering a higher transfer than the federal policy. To receive Renda Cidadã, for example, people could not be included in the Unified Registry, a fact that excluded them from any policy that came from the federal government, Bolsa Família being one of them. Along the same lines, San Luis hinders Asignación Universal por Hijo by refusing to share lists of beneficiaries of provincial social programs. In this way, people living in the province of San Luis and recipients of Asignación have an extra formality; every six months they have to present a certificate of negativity, a proof

[15] In both Argentina and Brazil, the executive is the central actor for social policy implementation. Governors and mayors have the discretion to design and implement innovative policies. Subnational legislatures do not generally block executive policy initiatives (Borges Sugiyama 2013, 6).

signed by both the federal and the provincial governments that shows they are not beneficiaries of the provincial program. This means that every six months, all family allowances are cancelled and they can only be re-activated after receiving this piece of paper. The Secretary of Social Development in the province explained the reason why the province does not share the list of beneficiaries of provincial social policies with the federal government: "this is our *Plan de Inclusión* [Social Inclusion provincial program], our data-base, our people, and this is very sensitive data" (Interview Tula Barale).

A final way through which opposition states and municipalities can hinder national social policies is through obstructing the functioning of federal institutions in the territory. The use of social assistance and employment institutions funded by the Argentine federal government in provinces and municipalities is a clear picture of this mechanism. Federal institutions, such as *Oficinas de Empleo* (Municipal Employment Offices) of the Ministry of Labor, and the *Centro de Referencia* (Reference Centers) of the Ministry of Social Development, are more relevant when the main agent in the territory is an ally. In 2012, in the opposition province of San Luis, there were no employment offices, while in the allied province of Mendoza there were at least fifteen. An employment training policy such as *Plan Jóvenes con Más y Mejor Trabajo* (More and Better Jobs for Young People) that works through employment offices is expectedly more successful in Mendoza's municipalities than in San Luis'. At the same time, the representative of the National Ministry of Social Development in the provinces, Centro de Referencia, is active throughout the province in Mendoza, while in San Luis, it only articulates in municipalities governed by the Peronist-*Frente para la Victoria* (Interviews Calderón, Jacomet). A policy that lands in the territory through Centros de Referencia such as *Argentina Trabaja* (Work Argentina) is therefore more successful in Mendoza than in San Luis.

The previous three mechanisms through which social policies are implemented unevenly across allied and opposition subnational governments due to subnational resistance only take place when recipients can identify the national government as the main responsible for the policy. Policy recipients can reward national incumbents and their subnational allies with their votes only when they can establish that the federal government is responsible for such policies.[16] The stronger attributability, the harder it is for subnational opposition governments to claim credit; and the higher the incentives to hinder the implementation of such policies. The weaker attributability, the easier it is for opposition parties to claim credit for the policy and its outcomes.[17] In this case, opposition subnational governments are interested in enhancing the implementation of such policy. Attribution of responsibility at the aggregate level can be shaped by (1) politicians' strategies, (2) the characteristics of the political system, and (3) the type of policy.[18] First, politicians adopt a distinctive set of strategies for maximizing credit-claiming opportunities (Weaver 1986).[19] As a result, attribution of responsibility is not fixed; it may change over time when there is an active political strategy. For conditional cash transfer Bolsa Família, for example, Brazil's federal government has engaged in efforts to share responsibility, through offering subnational government to collaborate with the policy in exchange of adding the logo of the state in the ATM card that recipients use every month. This recent weakening of

[16] The relationship between attribution of responsibility and voting behavior is well established in the literature (see for example Abramowitz, Lanoue, and Ramesh 1988; Lau and Sears 1981; Sigelman and Knight 1985).

[17] Low clarity of responsibility also makes blame avoidance easier (Travits 2007). Nevertheless, in the case of social policies, politicians generally want to claim credit, and not avoid blame.

[18] The literature based on psychological attribution focuses on individual-level characteristics to explain differences in attribution of blame and credit (See for example: Abramowitz, Lanoue, and Ramesh 1988; Lau and Sears 1981; Tyler 1982).

[19] Weaver (1986) and Maestas et al. (2008) focus on strategies for blame-avoidance.

attribution of responsibility has weakened the effect of partisan alignments for the implementation of this policy.

Second, majority governments with cohesive one-party rule enhance clarity of responsibility, while minority and coalition governments diffuse responsibility (Powell and Whitten 1993). We should therefore expect attributability to be clearer in Argentina than in Brazil where the party system is highly fragmented. Along similar lines, multilevel systems may further blur responsibility (Anderson 2006; Maestas et al. 2008). Finally, attribution of responsibility depends on the type of policies. In cash transfers, compared to services, credit claiming is easier because policy recipients are the direct beneficiaries of transfers. In addition, the provider's logo appears in the ATM Card or the provider directly distributes the cash transfer.[20] For health services, such as *Plan Nacer* (Birth Plan) in Argentina or *Estrategia Saúde da Família* (Family Health Strategy) in Brazil, recipients cannot identify who is the provider because they are not the direct recipients of the funds, and therefore it is in the best interest of an opposition province or municipality to fully implement this policy. It is a win-win situation: they receive the funds for the implementation of that policy at no political cost.

It should be noted that in addition to the potential electoral benefits that opposition governors receive from hindering the implementation of national social policies, there could also be economic and political costs associated with this behavior. Theoretically, the main cost for the subnational unit is economic: if they resist a national policy, they will have to fund a subnational alternative. This would be avoided if the subnational unit complemented or simply fully implemented the national policy. The political costs, in turn, depend on the national

[20] Nevertheless, in contexts of high politicization over the passing and/or implementation of a social service, we should expect clear attributability. This is the case of Affordable Care Act ("Obamacare") in the United States, which will be analyzed in chapter 7, the conclusions to this dissertation. In this case, the incumbents claim credit for it and the opposition rejects it, in a context of a polarized debate over this issue.

government's and recipients' reaction. The national government could potentially retaliate through denouncing these actions in the mass media or through withholding funds to the subnational unit. Recipients can change their electoral preference if they consider that their subnational government is depriving them of a national policy that could provide them welfare.

Empirically, I have only encountered the economic cost of funding a competing subnational policy. The economic cost of resisting a national policy is higher when that policy is universalistic, compared to narrowly targeted. Resisting universalistic national policies requires more resources, and the national government will eventually reach the population through media advertisements and word of mouth. More narrowly targeted national policies are easier to defeat with alternative subnational policies. In the cases in which the subnational unit provides an alternative to the national policy, voters actually benefit from choosing the more convenient of the two policies. In the words of a recipient of a provincial program in Argentina, when asked whether she would change to the national program: "It is not in my best interest to change, here [with the provincial program] I earn 855 pesos and there [with the national program] I would earn 200 pesos" (Interview Argentina #44). If the subnational unit does not have the resources to provide an alternative, such as in the case of most municipalities, not supporting the national policy means not putting the personnel at the service of the national policy. In a poor opposition municipality in Argentina, the Secretary of Social Development explained that the municipality saw no role in itself in the implementation of Asignación Universal: "Anses [the national social security administration] does everything, the municipality has no role…I do not even know how we could complement this national policy" (Interview Fernandez). Conversely, in an aligned neighboring municipality, the official occupying this very same position explained their active role in the implementation of this policy: "When the program started, we needed to sign-up the community...We coordinated with Anses, we provided the territorial structure here in Las

Heras…So we organized two weeks of sign-up campaigns in different parts of the municipality, with neighborhood organizations, pensioners' organizations, centers of social and cultural development, sports clubs (…) in two weeks we went neighborhood by neighborhood informing everybody" (Interview Serú).[21]

Contrary to welfare state theories where there is a focus on social policy design (Esping-Andersen 1990; Huber and Stephens 2001) and to the studies of social policy implementation in OECD countries (Rigby and Haselswerdt 2013; Turner 2011), I argue that it is not necessarily ideology that matters for social policy implementation, but partisan alignments between national and subnational governments. This is particularly true in Argentina, where parties are ill defined ideologically. The major party, the Peronist party, has changed its traditionally labor-based ideology during market-reforms in the 1990s. The party has been defined as a party with weak structure that allows for the flexibility to replace the weak union-based linkages with personal-based clientelistic networks (Levitsky 2003). In addition, electoral dynamics and coalitions vary throughout the provinces thus promoting different party systems and a de-nationalization of party competition (Calvo and Escolar 2005; Leiras 2007).

For Brazil, Ames (2001) argues that the only ideological parties are those on the left, while center and right parties are motivated by distribution of resources. Center and right parties in Brazil are pragmatic; they will not oppose the implementation of universalistic policies if it benefits themselves or their parties. If they oppose the implementation of universalistic policies, it is for a logic of political competition, to maintain their base, but not for ideological considerations. At the same time, Brazil has a highly fragmented party system and therefore

[21] It should be noted that it is generally at the intermediate level (states and provinces) where partisan opposition to the federal government has a greater effect. Municipalities cannot realistically compete with the federal government, but they could potentially resist state or provincial policies, and decide to not put the territorial infrastructure under their control at the service of the national policy.

national and subnational governments form coalitions to win elections and govern. The number of coalitions between right and left parties has increased since the 1986 elections, reaching more than 60 percent of all coalitions for gubernatorial elections (Krause and Alves Godoi 2010, 43, 55). In addition, the same party can join widely different coalitions at the three territorial levels (Krause and Alves Godoi 2010; Peixoto 2010; Ribeiro 2010). Even the *Partido dos Trabalhadores* (Workers' Party, PT) has made a strategic move since 2003, making alliances with parties far from its ideological positioning (Interview Olivio Dutra; Hunter 2010; Miguel and Machado 2010). The regional differences in the coalitions of the PT are also significant. While in the state of Rio Grande do Sul the PT mostly makes alliances with the left, in Goiás the PT is mostly aligned to right parties (Miguel and Machado 2010, 356–57).

*Unit of Analysis*

In countries with more than one subnational level; partisan alignments of *which* level(s) matters for the implementation of social policies? The level that controls politics in the territory. In other words, a central policy will be successfully implemented if it has the support of the level(s) that has de facto authority over the territory, whether it be the province or state, the municipalities, or both. While legal authority varies by country and by the design of the policy, de facto authority will depend on the characteristics of the subnational unit. In particular, it will depend on the level of pluralism. In large federations, one can find different levels of democracy across states and provinces (A. Borges 2007; Cornelius 1999; Gervasoni 2010b; Gibson 2012; Giraudy 2010; Snyder 1999). In less pluralistic provinces or states, access to the territory is more centralized in the province, and fewer actors are involved. In this context, partisan alignments of the state or province are central to understand the success of national social policies. In more democratic contexts, municipalities have a more central role, and therefore partisan alignments of *both* the state and municipalities matters.

Legal authority sets the boundaries of how much de facto authority can be concentrated or shared. Municipalities are constitutionally stronger in Brazil compared to Argentina, so one does not find the kind of power concentration in Brazilian states as the one that exist in Argentine provinces. While municipalities have been defined as autonomous by 1994 Constitution (Art. 123) in Argentina, the extent of their autonomy is decided by each province (Dalla Via 2010, 145; Smulovitz and Clemente 2004, 42). Therefore, Argentine federalism empowers provinces (Gibson 2012, 75).[22] In Brazil, 1988 constitution gave equal authority to both levels. This is translated in the amount and type of resources to subnational units. In particular, a good amount of revenue comes from state and local taxes. In Argentina, federal transfers finance more than half of all provincial budgets (except from Buenos Aires) and a large majority of such transfers are automatic and unconditional (Gervasoni 2010a, 311). Municipalities collect a minor cleaning and sewage tax and depend on transfers from the province.

Besides from the general rules of fiscal federalism, each policy by design decentralizes responsibilities to different levels. While Brazil is gradually implementing the unified social assistance and health systems that give municipalities the main role as welfare policy and basic health care providers; in Argentina, social policies have varied the level in charge of implementation.[23]

The level of political pluralism and the formal rules of fiscal and policy decentralization define the territorial unit that is crucial for social policy implementation. They define which level

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[22] Provinces have authority to decide upon provincial constitutions, electoral laws and districts, and have discretion over municipal affairs (Gibson 2012, 75; Hooghe et al. Forthcoming).

[23] The main social assistance policies in Argentina have been implemented by different territorial levels and institutions. Since 2009, Asignación Universal por Hijo has been directly implemented by the federal government, while the previous *Plan Jefes y Jefas de Hogar Desocupados* (Unemployed Heads of Households Program, PJJHD) in 2002 was implemented by provinces.

(intermediate or local) effectively controls territorial politics. While in Argentina it can be monopolized by the provinces or shared with the municipalities, in Brazil it is mostly the latter. Therefore, partisan alignments of those particular levels matter most. In addition, parties (particularly the Peronist Party) in Argentina are more centralized and disciplined than in Brazil (with the exception of the PT). Nomination and electoral rules boost these differences. In the closed list PR system in Argentina, provincial party leaders control the rank order of the party list, but national party leaders can also intervene. In Brazil, the open list electoral system encourages candidates to employ personal vote strategies though making political alliances with subnational executives (Garman, Haggard, and Willis 2001, 214; Krause and Alves Godoi 2010). Therefore, we would expect the effect of partisan alignments to be larger in Argentina than in Brazil, but significant in both cases. Besides from partisan alignments, national social policies face different territorial infrastructure and policy legacies in their process of implementation. These variables are the focus of the next section.

### ***Structural Variables***

*Territorial Infrastructure*

Successfully implemented policies are those that cover the targeted population. To administer to its population, the state needs the infrastructure to be able to reach the territory (Mann 1988; Soifer 2012). By being closer to people, subnational governments are in an exceptionally advantageous position. Territorial presence shapes social policy implementation from the initial provision of information (where to go, what to bring to sign up), to delivering the policy itself in an adequate quality, and to the identification of those who should be included but are excluded. For this, state actors need to know the territory and be able to reach it. And civil society organizations can be allies in this task.

Territorial infrastructure is conceptualized as the institutions that are present in the territory at the time when the policy is created. Such territorial infrastructure takes three forms: state institutions, civil society organizations, and the relationships between the two. First, territorial infrastructure includes health, education, and social assistance institutions and professionals. Second, it also includes civil society organizations located in the territory. Organized civil society flourishes in more democratic and participatory contexts. Finally, territorial infrastructure is strengthened when civil society organizations and the state work in close collaboration. As Stepan (2001) noted, there are four possibilities in the relationship between the state and civil society: authoritarian states may diminish the capacity of civil society, state and civil society are strengthened simultaneously, state and civil society are weakened simultaneously, or civil society weakens the state.[24]

The City of Porto Alegre, in the Brazilian state of Rio Grande do Sul, is an example of state and civil society strengthened simultaneously (Baiocchi 2005). Councils and Participatory Budgeting processes, in which state and civil society representatives participate, monitor the implementation of national policies by making sure that funds are implemented non-discretionarily and that the quality of the provision is adequate. Overall, Brazilian civil society participates more actively than Argentine groups in the monitoring of social policies. This is in part because social assistance and health policies in Brazil normatively require the organization of Councils for the control of these policies. In addition, the participation of civil society for the implementation of universalistic health policies in Brazil has a long tradition, through the *Movimento Sanitarista* (Health Wokers' Movement) during the drafting of 1988 Constitution (Niedzwiecki 2014).

[24] Stepan (2001) was referring to the bureaucratic authoritarian regimes in Argentina, Brazil, Chile, and Uruguay, mostly characterized by increase in state power *vis-à-vis* civil society.

Information and policies flow through the channels of civil society and state institutions to reach the actual or potential recipient. More effective territorial infrastructure decreases exclusion. This means good quality institutions that are accessible throughout the territory, no matter how remote the location. The Brazilian National Secretary for Citizen Income put it in the following terms:

> Not even a rights-based perspective guarantees that people have access…Every type of policy generates some type of exclusion, even universal policies…even if you have no budgetary constraints, you have exclusion. Because those who are hard to reach, will most probably not be reached (Interview Da Silva de Paiva).

*Policy Legacies*

Previous policies influence the implementation of current ones depending upon actors' interests and institutional dynamics. Actors adapt to institutional environments by adopting new strategies; their own identities are shaped in this process, and those who do not adapt may be less likely to survive. In these ways, policies "select" actors (Pierson 2004, 152). Policies also produce institutional dynamics that are more difficult to reverse the longer the policy has been in place and the more these practices affect actors' interests. Previous policies that target the same population can advance the reach of the current policy by automatically transferring its recipients from the previous to the current policy, or by generating institutional mechanisms that smooth the implementation of the new policy. Universal policies generally leave stronger legacies, because they are generally backed by institutional infrastructure that allows for keeping track of their recipients. This process strengthens itself throughout time and generates repeated practices that make any change in an opposite direction a difficult task to accomplish. At the same time, positive legacies facilitate the implementation of current policies by using the same institutions as the base. More narrowly targeted policies are generally more unstable in terms of personnel

and time horizon, and therefore do not develop the kind of territorial institutional structure that we find in universalistic policies.

Current policies benefit from the coverage and institutional practices of previous policies. The implementation of Bolsa Família did not start from scratch; there were 4.2 million families receiving other programs, such as *Bolsa Escola* (3,601,217), *Bolsa Alimentação* (327,321), *Cartão Alimentação* (346,300), and *Peti* (1,000) (Soares and Sátyro 2010, 43). Some of these families were to be incorporated to Bolsa Família. In addition, these programs were present in the great majority of the municipalities (Da Silva e Silva and Santos de Almada Lima 2010, 113). Therefore, many of these municipalities had already developed institutions for the provision of social assistance, health, and education conditionalities that enhanced Bolsa Família when it was launched. A similar process is found in Asignación Universal por Hijo in Argentina. Recipients of the previous non- contributory conditional cash transfers, Plan Jefes y Jefas de Hogar Desocupados and *Plan Familias* (Families Plan), who needed it, were automatically transferred to Asignación Universal. Immunization and school enrollment conditionalities of the previous policies had also started training schools and health centers in the provinces on the practice to abide by conditionalities. In both cases, there was fertile ground left by previous national cash transfers for the implementation of current ones.

Nevertheless, policy legacies can also hinder the implementation of new policies when strong interests from previous policies are contrary to the current one. A clear example of such a mechanism is the primary health policy in Brazil, Estrategia Saúde da Família. This policy faces organized opposition from hospitals, previous *unidades básicas tradicionais* (traditional basic health units, UBS), doctors and patients, who have strong interests invested in the previous or alternative systems. Those who support a hospital-centered health provision want to avoid a flow of resources from hospitals to primary health centers. Previous basic health facilities resist a

modification in the type of provision. Lastly, doctors, mostly for salary concerns and because their previous training is in line with the old system, prefer to stay in the previous basic provision model or in hospitals instead of being incorporated in Estrategia Saúde da Família. The result is that in contexts of a strong previous presence of hospitals and traditional basic health units the implementation of Estrategia Saúde da Família is more challenging than in contexts that never introduced the previous system and do not have high-complexity health centers.

**Conclusions**

This chapter has focused on the analytic framework that explains the factors that shape non-contributory social policy implementation in decentralized countries. In this way, this study makes a central contribution: incongruity of partisanship across territorial levels has consequences for social policy provision when there is clear attribution of policy responsibility. States and provinces opposed to the president's party are not interested in enhancing upper level policies when recipients of the policy can identify where the policy is coming from and thus reward that party or government level in elections. These units will hinder the implementation of such policies by presenting bureaucratic obstacles or by open policy competition. When the policy does not have a clear electoral winner, because recipients cannot identify where the policy is coming from, cooperation between levels will be more easily attained and the policy will be more successfully implemented.

At the same time, actors are bounded by structural factors; territorial infrastructure and policy legacies. The more developed the infrastructure in the territory, the more successful policies will be. And positive legacies from previous policies enhance the implementation of the current policy. This dissertation is a significant contribution both to welfare state and multilevel

governance theories alike. It highlights the importance of observing multilevel dynamics in the process of social policy implementation. Welfare state theories focused mostly on national-level variation. Multilevel governance approaches, particularly the literature of fiscal federalism and decentralization, neglected national – subnational competition on social policy.

This chapter will guide the rest of the dissertation. The next chapter focuses on the research design; it defines, measures, and describes the dependent variable, discusses the appropriateness of the combination of regression analysis and case studies for the question at hand, and explains the multilevel case selection strategy. In particular, by selecting cases across attributable and non-attributable policies as well as aligned and opposition subnational units, I include all possible combinations of the main argument of this dissertation.

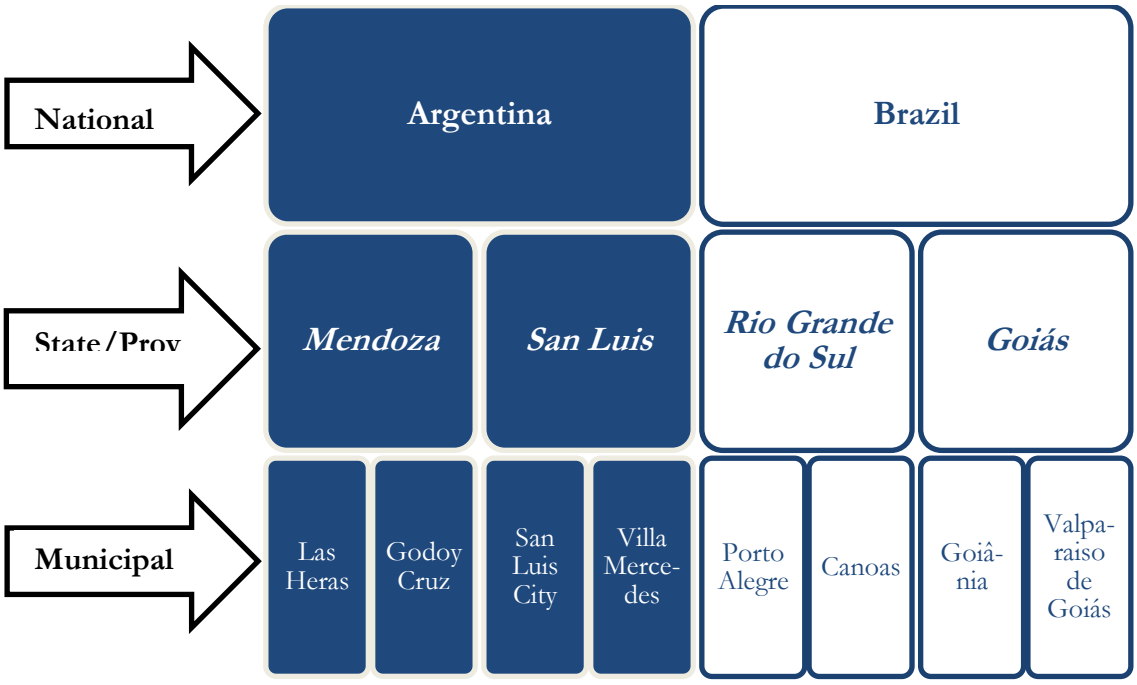
# CHAPTER 3: MIXED-METHODS AND MULTILEVEL RESEARCH DESIGN

The previous chapter developed the theory that guides this dissertation. The successful implementation of major national non-contributory social assistance and basic healthcare policies depends in part on whether either (1) governors are allied with the national executive (and therefore have no wish to compete with or block their initiative), or (2) voters are unable to attribute the policy credibly to national policy makers (and thus there is no clear electoral risk for opposition governors to supporting the national policy). Positive policy legacies and strong territorial infrastructure also contribute to social policy performance in decentralized countries. The dependent variable, social policy implementation, is measured as levels of coverage as a percentage of the targeted population. This will be the focus of the next section.

This theory is tested through a multilevel case study and a statistical analysis, which will be described in the following sections of this chapter. The case study includes three levels, country level, provincial or state level, and municipal level, and a comparison across social policy sectors and time. The multilevel case selection strategy is represented in figure 3.1. At the national level, I have selected the two most decentralized countries in the region, Argentina and Brazil, which also share similar trajectories in terms of welfare state development. At the subnational level, I conducted field research from September 2011 to December 2012 in two provinces and four municipalities in Argentina, and two states and four municipalities in Brazil. In these places, I studied four national and four subnational policies. The focus is on non-contributory social policies, as policies that are not earnings-dependent and are therefore targeted to people who would not be able to make sufficient contributions if it was insurance

based and who do not have sufficient income to purchase the services in the market. Besides the multilevel case study, I also include pooled time series analysis of 24 provinces in Argentina and 27 states in Brazil in the period since the first analyzed social policy was implemented in each country (1994 in Brazil and 2007 in Argentina) until 2012.

**Figure 3.1: Multilevel case selection strategy**




The mixed-methods analysis draws from original qualitative and quantitative data. Original qualitative data was collected during fifteen months of field-research. I conducted 235 in-depth interviews with elected officials, high-level technocrats, community leaders, and policy experts at the national, state, and municipal levels. The interviews lasted on average an hour and a half, during which interviewees reflected on the trajectory of a given policy in that place. Table 3.1 summarizes these interviews by locale. In addition, I conducted 148 structured interviews with social policy recipients on their personal experience as users of the analyzed policies. Their geographic distribution is described in table 3.2. These interviews were carried out in the home of the recipients, in social assistance centers, health centers, and hospitals. In addition, I

conducted archival research at the main newspapers in the province of San Luis (Argentina) and the state of Goiás (Brazil). Finally, I participated as an observer in activities in Brazil and Argentina organized by provincial/state and municipal government levels, as well as NGOs and universities to discuss issues related to social protection.[25] For the statistical analysis, I constructed an original dataset at the state or provincial level and across time, that includes indicators of social policy implementation, territorial infrastructure, policy legacies, and partisan alignments, as well as a number of control variables.

**Table 3.1: Number of interviews to public officials and policy experts by Place**

| Place | Number of Interviews |
|---|---|
| **Buenos Aires – Argentina** | 13 |
| Province of Mendoza | 28 |
| *Municipality of Las Heras* | 17 |
| *Municipality of Godoy Cruz* | 16 |
| Province of San Luis | 20 |
| *Municipality of San Luis City* | 7 |
| *Municipality of Villa Mercedes* | 4 |
| **Brasília – Brazil** | 20 |
| State of Rio Grande do Sul | 27 |
| *Municipality of Porto Alegre* | 34 |
| *Municipality of Canoas* | 15 |
| State of Goiás | 15 |
| *Municipality of Goiânia* | 13 |
| *Municipality of Valparaíso de Goiás* | 6 |
| **Total** | **235** |

[25] In the state of Rio Grande do Sul in Brazil I participated in meetings of the municipal health councils in Porto Alegre and Canoas, in the regional health council in Bom Fim, in the social assistance council in Porto Alegre, in meetings between *Centro de Referência da Assistência Social* (Reference Center of Social Assistance, CRAS Extremo Sul) and NGOs, in meetings between CRAS and recipients for updating Bolsa Família's registry, in the municipal forum for the rights of children, in the network of social protection institutions in Porto Alegre, and in a lunch to introduce a local councilor in Vila Pinto. In the state of Goiás, I participated in meetings at the social assistance council in Goiânia, in the state health council, and in activities at the health center in Vila Pedroso. In the province of Mendoza in Argentina, I participated in meetings between the NGO Fedem and the provincial office for the right to food, in a *Centro de Integración Comunitaria* (Community Center, CIC-Borbollón) meeting for the implementation of Argentina Trabaja program, and in visits to vulnerable households with CIC-Borbollón and the secretary of health in Godoy Cruz. In the province of San Luis, I participated in visits to recipients of the workfare programs with the Ministry of Social Inclusion, in territorial promotions in a catholic church organized by *Administración Nacional de la Seguridad Social* (National Social Security Administration, Anses), and in the house of a community leader in San Luis City, and in the territorial campaign organized by the City of San Luis.

**Table 3.2: Interviews to social policy recipients by province or state.[26]**

| Country | Province/State | # Interviews |
|---|---|---|
| **Argentina** | Province of Mendoza | 22 |
| | Province of San Luis | 34 |
| | City of Buenos Aires | 36 |
| **Brazil** | State of Rio Grande do Sul | 26 |
| | State of Goiás | 30 |
| **Total** | | **148** |

This chapter proceeds as follows. I first describe the measurement of the dependent variable, social policy implementation. In the following section, I explain why the choice of a mixed-methods research strategy is accurate for unraveling the factors that shape social policy implementation. In this section, I also set the scope of this research as decentralized countries. I close the chapter by describing the multilevel case selection strategy. At the subnational level within Argentina and Brazil, I select states, provinces and municipalities with similar levels of GDP per capita and population density but with different partisan alignments to the central government. I also select the main non-contributory conditional cash transfers and primary health care policies. The selection across territorial levels, aligned and not aligned to the national government, and social policies, attributable and non-attributable to the national government, represent all possible causal combinations of the main argument of the dissertation.

## Definition and Measurement of the Dependent Variable. Social Policy Implementation

To ensure that individuals in risk of poverty enjoy an adequate standard of living, social policies need to be effectively implemented. The dependent variable, social policy implementation, is defined as the degree to which policies effectively provide social protection to the targeted

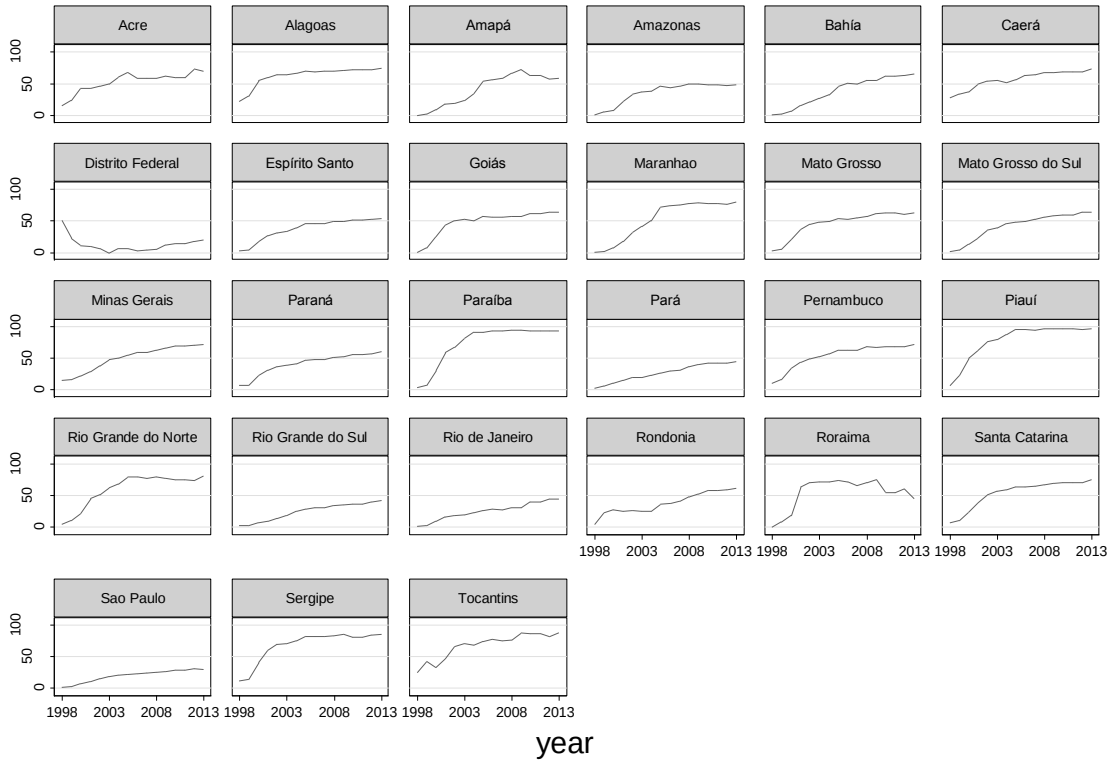
[26] For anonymity reasons, no further details are provided on the interviews to social policy recipients.

population. The concept of social policy implementation is continuous in nature; national and subnational units implement social policies to a certain extent. In addition, there is no substantive reason to think that social policy implementation could be translated into typologies. In other words, there is no clear threshold to differentiate successful from unsuccessful social policy implementation.

The operationalization of social policy implementation is also continuous through levels of coverage of national policies as a percentage of the targeted population. An observation of the four national policies analyzed in this research will clarify this operationalization. The primary health policy in Brazil, *Estrategia Saúde da Família* (Family Health Strategy), targets the entire population and therefore its coverage is calculated as a percentage of total population. Figure 3.2 shows the trajectory of this policy in each of the 27 states in Brazil, and across time.[27] Although there is variation across time within states, there is also a difference between more and less successful states. While 17 states had comfortably reached more than half of the population in 2013, seven states were still below 50 percent of coverage. Brasília (Distrito Federal), Pará, Rio Grande do Sul, and São Paulo were among the worst performers.

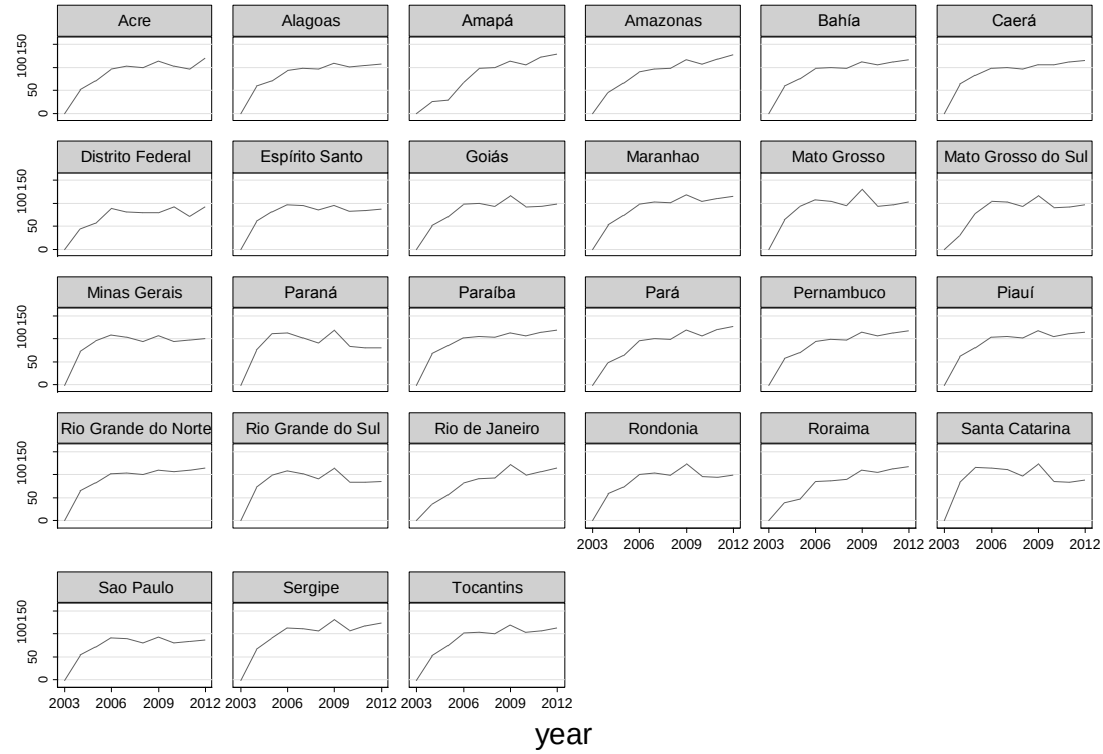
[27] The original data in all the graphs is not transformed (by standardizing it, for example) to keep its substantive meaning.

**Figure 3.2: ESF coverage as a percentage of total population (1994-2013).**



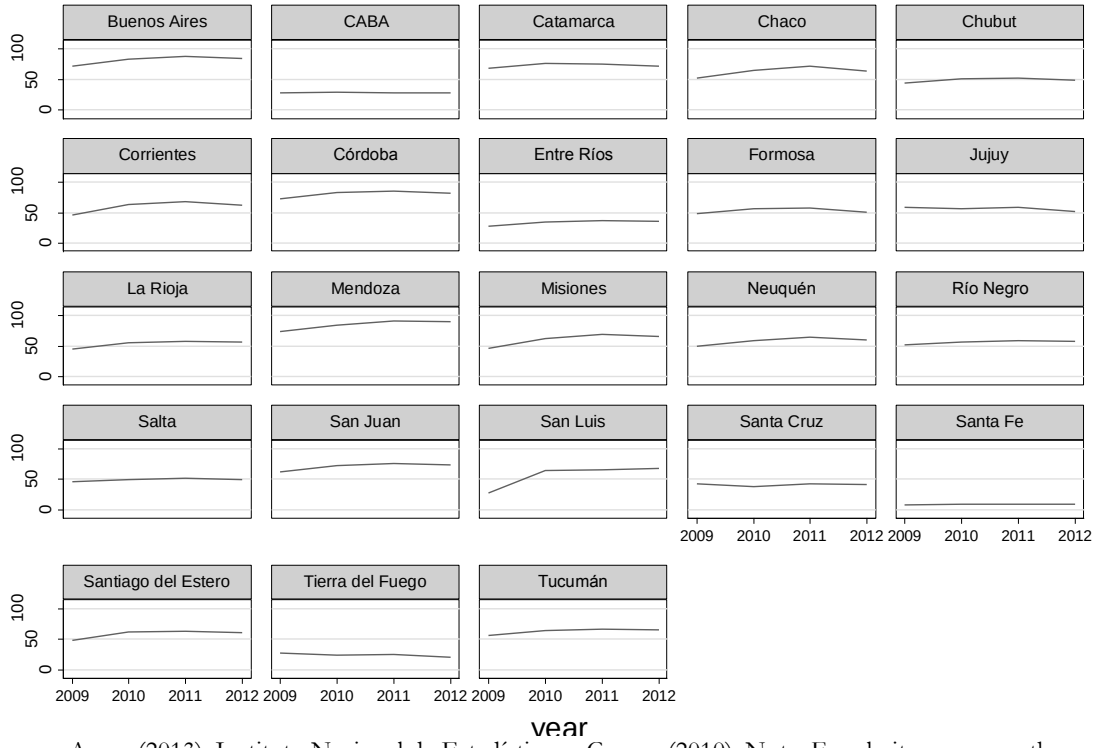

Source: Brasil (2014)

**Figure 3.3: Bolsa Família coverage as a percentage of targeted population (2003-2012).**



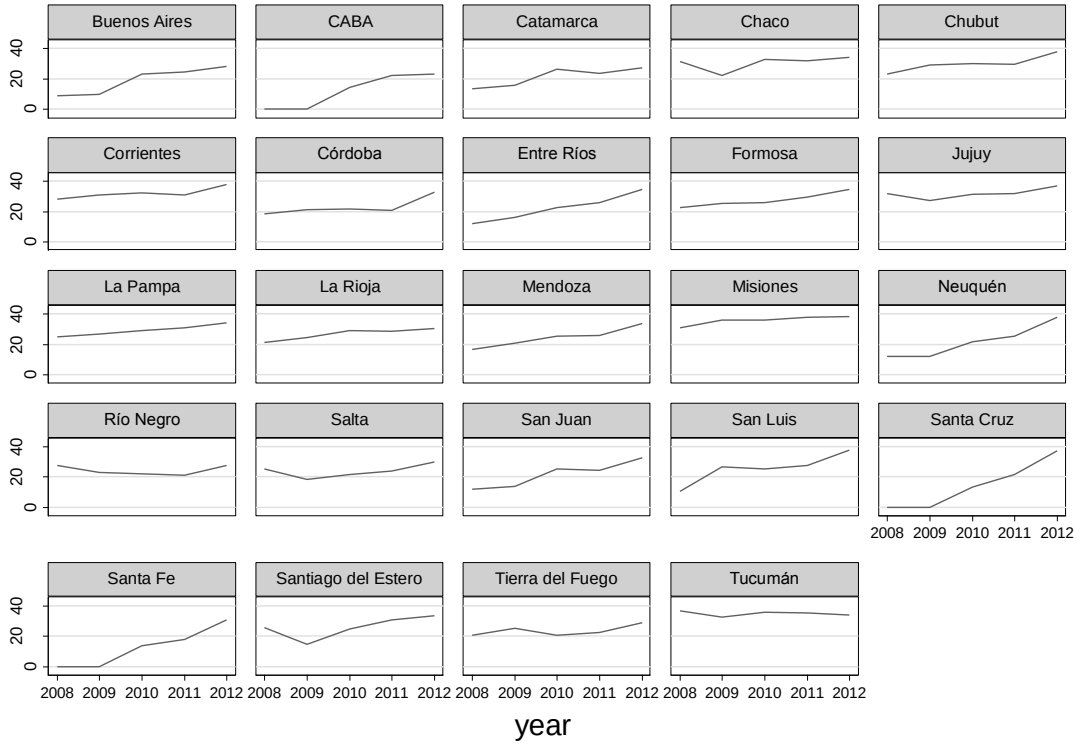

Source: Brasil (2012b)

**Figure 3.4: AUH coverage (2009-2012) as a % of people with unsatisfied basic needs (2010)**




Source: Anses (2013), Instituto Nacional de Estadísticas y Censos (2010). Note: For clarity purposes, the province of La Pampa has been excluded because it reaches levels of coverage higher than 140 percent.

**Figure 3.5: Degree of implementation of Plan Nacer in Argentina (2008-2012).**




Source: Argentina (2013)

When the targeted population is narrower, such as in Brazil's *Bolsa Família* (Family Allowance) and Argentina's *Asignación Universal por Hijo* (Universal Child Allowance), the denominator is also narrower. Brazil's 2010 Census has determined the quantity of people who should be receiving Bolsa Família. Successful implementation is therefore measured as a percentage of this population.[28] Figure 3.3 depicts the level of implementation of this conditional cash transfer across Brazilian states from 2004 to 2012. Although the largest variability in the dependent variable takes place in the first years of the implementation of this policy, there are changes in the patterns across states thereafter too. While the general tendency is to increase coverage across time, with differences in each trajectory, cases such as São Paulo, Paraná, and Santa Catarina lag behind.

The Argentine conditional cash transfer Asignación Universal por Hijo is also measured as a percentage of a narrower population: people living with unsatisfied basic needs as calculated by the country's 2010 census. Figure 3.4 represents the variation across provinces and time in the implementation of Asignación. Provinces such as Buenos Aires, Catamarca, Córdoba, and Mendoza have quickly reached 100 percent of coverage. Conversely, other provinces such as the City of Buenos Aires, Santa Fe, and Tierra del Fuego have reached only 25 percent of the targeted population.

The measurement of the successful implementation of the health policy in Argentina, *Plan Nacer* (Birth Plan), has been constructed by the Argentine Health Ministry. It is measured as the average of the percentages of coverage of ten medical practices. The following ten percentages are averaged: pregnant women with the first prenatal checkup before the 20$^{th}$ week of gestation, new borns' health check-ups (Apgar score of 6 or better five minutes after delivery), new born babies who are not underweight, vaccine coverage of pregnant women (including

[28] For Bolsa Família, the income per capita of a family is self-declared.

tetanus and test for sexually transmitted diseases), fully evaluated cases of maternal mortality or death of infant under one year of age, vaccine coverage in babies under 18 months (measles-mumps-rubella), sexual and reproductive counseling to puerperal women within 45 days after giving birth, children's complete health check-ups (this counts as two percentages – for children under age one and between one and six in age), and personnel trained in indigenous medicine. The result across provinces and time is presented in figure 3.5. While the trajectory of each province varies, some provinces score better than others. The provinces of Chaco, Chubut, Corrientes, Jujuy, La Pampa, Misiones, and Tucumán have surpassed 30 percent of coverage for some time. Conversely, the City of Buenos Aires, Catamarca, and Rio Negro have barely surpassed 20 percent of coverage.

**Mixed-Methods Research Design**

The case study of two states, two provinces, and eight municipalities is nested within a statistical analysis of 24 provinces in Argentina and 27 states in Brazil. This allows for the combination of two different types of questions: 1) What is the average effect of partisan alignments on social policy implementation in Argentina and Brazil?, and 2) Do partisan alignments explain successful social policy implementation in the selected states and municipalities in Argentina and Brazil? While quantitative analysis tackles the first set of questions, qualitative methodology focuses on the second set of research question (Goertz and Mahoney 2012, 43).

Mixed-methods research allows for combining the counterfactual view of causation prevalent in qualitative analysis, and a constant conjunction between cause and effect with affinities with quantitative research (Goertz and Mahoney 2012, chapter 6). For the first view of causation, this research includes policies that are attributable to a particular government level, as well as policies in which recipients cannot identify the responsible entity. In addition, it includes

states and municipalities aligned and non-aligned to the federal government. In this way, the counterfactual view of causation can be assessed. For the second view of causation, regression analysis will assess the degree to which effects always follow causes, or the constant conjunction view of causality. Besides these different views of causality, in this research the relationship between the independent variables and social policy implementation is probabilistic, additive, and linear in form. This has two important consequences for the research design. First, the statistical models have the form of Ordinary Least Squares and its derivatives. Second, process tracing is conducted with an additive approach of causality. I explore whether the factors of interest contributed to the outcome in particular case studies, without making any assumptions regarding whether the factors are necessary for the outcome (Goertz and Mahoney 2012, 109).

Having determined the probabilistic form of causality between the dependent and independent variables, I begin with a regression analysis of 24 provinces in Argentina and 27 states in Brazil across time. The statistical analysis guides and complements the case study analysis, allows for enhancing external validity, and aids the discussion of alternative explanations (King, Keohane, and Verba 1994). The aim of the regression analysis is not to attain the highest R-squared, but to test which variables statistically significantly predict changes in the dependent variable. If the theory is accurate, significant correlations should be found in regressions. To respect the unit homogeneity assumption of statistical analysis, I run the regressions for each country separately. It is reasonable to assume that the relationship between the independent variables and social policy performance is the same throughout Brazil and Argentina, when the regressions of each country are run separately and throw similar results. I run Prais Winsten regressions (panel corrected standard errors and first order autoregressive corrections) to deal with contemporaneous correlation of errors across units (Beck and Katz 1995). In addition, I include fixed and random effects models for robustness checks. Fixed effect

models deal with violations of unit homogeneity assumptions through the inclusion of dummy variables for each state or province. The downside of this model is that it only accounts for variation within states throughout time, and therefore does not allow for the inclusion of invariant variables within units across time. For this reason, the statistical analysis also includes random effects models that allow for the inclusion of such variables by averaging the across states and across time effect of the independent variables on the dependent variable.

The statistical analysis is conducted at the provincial or state level. Two reasons motivate this decision. First, intermediate units in both Brazil and Argentina have overall more capacity than local units to hinder the implementation of national level policies. They can do so by implementing state policies in direct competition with the national ones or by presenting bureaucratic obstacles. Therefore, partisan alignments are particularly relevant at the intermediate territorial level. Second, data availability makes the analysis at the local level an unfeasible endeavor. There are around 1,922 municipalities in Argentina (Falleti 2004, 69) and around 5,500 in Brazil (Montero and Samuels 2004, 6), for which reason measuring the variables across all municipalities across time would be unfeasible. The decision to choose the provincial or state level as the unit of analysis for the statistical analysis comes with a problem of aggregation, since it obviates significant variation at the local level.[29] To deal with this challenge the case studies include the analysis of data at the state and local levels, thus studying mechanisms at the three levels of government. The qualitative analysis will therefore assess the degree to which the conclusions in the statistical analysis are valid in spite of the higher level of aggregation.

[29] This problem is exemplified by Rodrigues-Silveira (2013, 7–8) for urbanization figures in Brazil. When the level of analysis is the region, the mean of urbanization is 82.7 and the standard deviation is 9.0; when the level of analysis is the municipality, the urbanization mean is 63.8 and the standard deviation is 22.

Case study comparison, counterfactuals, and process tracing included after the regression analysis corroborate the findings of the quantitative analysis, improve the measurement of the variables, and, most importantly, asses the causal mechanisms that lead to such results (Lieberman 2005; Ragin 1989). Collier, Brady and Seawright (2010, 253) show how "causal-process observations" provide information about mechanisms; and Goertz and Mahoney (2012, chapter 8) explain how process tracing is particularly adequate for observing causal mechanisms that lead to causation.[30] Following the aim of enhancing the validity of casual inference, I develop comparisons both between countries across subnational units, as well as within countries across time and subnational units. The comparison of subnational units across countries reduces the effects of diffusion or interdependence (Snyder 2001, 96–97). In addition, the subnational comparative method enhances the probability of developing valid causal inferences by increasing the number of observations and constructing controlled comparisons (Snyder 2001, 94). Measuring social policy implementation at the national level obscures the fact that social policies are implemented unevenly throughout a given territory. In this way, looking below the national level makes for a more accurate analysis of social policy implementation and the effect of strategic interactions between the national and subnational levels.

### *Scope Condition - Decentralized Countries*

The scope of this research is narrowed to decentralized countries. I do not expect subnational politics in territorially centralized countries to have a significant effect on the implementation of national social policies. Conversely, decentralized countries transfer authority to subnational levels of governments thus making them relevant actors in the policy implementation process. In

[30] For an example of the use of process tracing to assess the causal mechanisms behind regression results, see Rueschemeyer, Huber, and Stephens (1992)

particular, only decentralized countries provide the opportunity of subnational governments to design and implement their own social policies (Bonvecchi 2008), a fact that is crucial for the performance of national policies.

Decentralization includes devolution of authority to subnational units in administrative (social services), fiscal (revenues), and political (representation) realms (Falleti 2010a, 17). The Regional Authority Index or RAI (Hooghe, Marks, and Schakel 2010) uses two dimensions to define subnational authority. Self-rule is the authority that a subnational government exercises in its own territory. Shared rule is the authority that a subnational government co-exercises in the country as a whole. This distinction has been widely used in the literature of decentralization and federalism (Elazar 1991).

**Multilevel Research Design - Case Selection Strategy**

This research selects cases across countries, states or provinces, and municipalities, as well as across social policy areas. Given that case studies are carried out after the statistical analysis, the main interest of the case selection strategy is to show variation in the variables of interest and be representative of a broader population (Lieberman 2005). Therefore, I select cases which are average in the main control variables and show variation in partisan alignments. The selection of cases based on the values of independent variables also follows the characteristics of the causal model. As Goertz and Mahoney (2012, Chapter 14) argue, if the causal model is on necessary and sufficient conditions, then selection on the dependent variable is advisable. My causal model is not about necessity and sufficiency but average effects, for which reason I select on values of the independent variables. In addition, since the aim of case selection is to demonstrate the robustness of causality from cause to effect (Lieberman 2005, 444), selecting on values of the independent variables avoids "cherry-picking" cases that support the causal argument. The next

section presents the case selection strategy across multiple territorial levels, as illustrated in figure 3.1 at the beginning of this chapter.

### *Case Selection at the National Level*

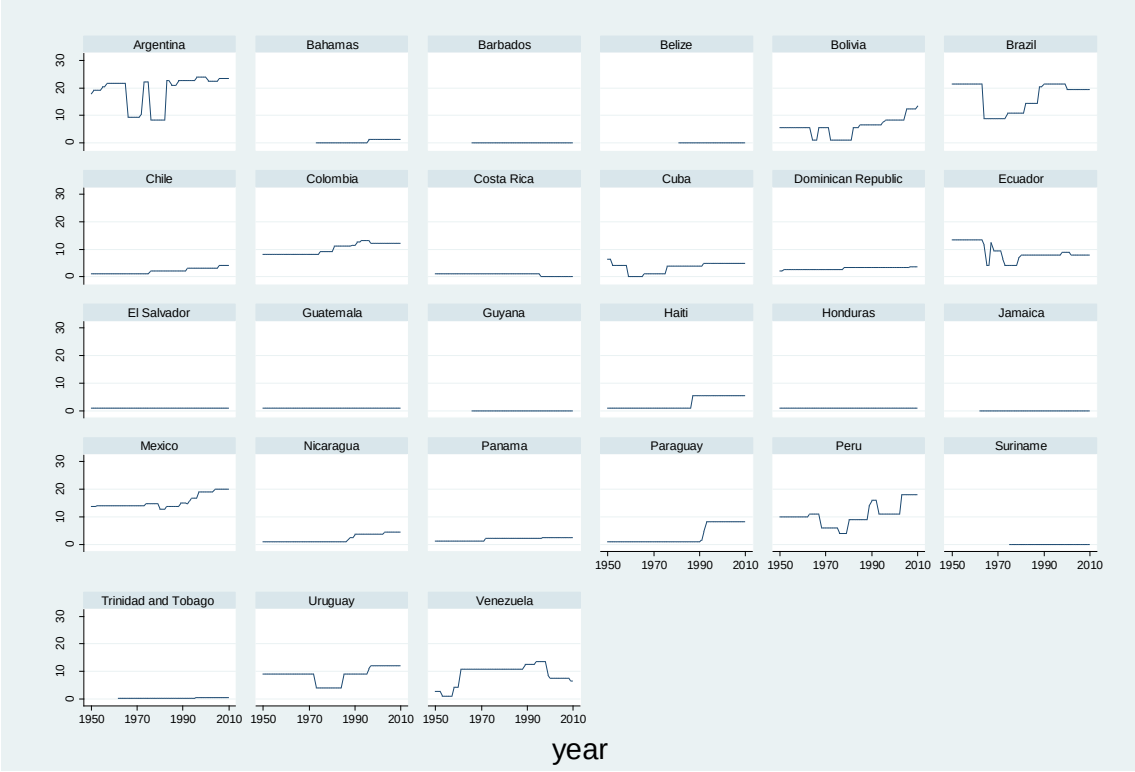
At the national level, I include Argentina and Brazil, which are the two most decentralized countries in Latin America, and two countries that share similar trajectories in terms of welfare state development.[31] Figure 3.6 displays the level of regional authority in 27 countries in Latin America from 1950 to 2010 (Hooghe et al. Forthcoming). Argentina and Brazil score consistently higher in the Regional Authority Index. This means that in these countries subnational government between the national and local levels enjoy significant regional authority both in their own territory (self-rule) and in the country as a whole (shared-rule). Since my interest is in states, provinces, and municipalities that have leverage over social policies, the time frame of this analysis starts after the most recent process of decentralization is constitutionalized, 1994 in Argentina and 1988 in Brazil. In 1994 Constitution in Argentina, municipalities become autonomous entities, and in 1988 Constitution in Brazil, municipalities, states and the federal level have equal judicial status.

Argentina is divided in 23 provinces, which are further divided into municipalities, and the Autonomous City of Buenos Aires. Provinces have authority over municipalities, provincial institutional set-up, residual powers, the judicial system, primary and secondary education, health, housing and sanitation, social assistance and food programs, and some other major responsibilities such as environment and industrial development. The City of Buenos Aires shares similar competencies as the rest of the provinces since 1996, though it was not given

[31] The analysis of decentralization is partly taken from the country profiles in Hooghe et al (Forthcoming). The analysis of Argentina's and Brazil's social policy trajectories is partly taken from Huber and Niedzwiecki (forthcoming) and Niedzwiecki and Huber (2013)

control over the police until 2010 and does not have residual powers. Municipalities have more limited competencies. Although they have been defined as autonomous by 1994 Constitution (Art. 123) and all municipalities elect assemblies and mayors, the extent of their autonomy is decided by each province (Dalla Via 2010, 145; Smulovitz and Clemente 2004, 42). Therefore, there is wide variation in terms of municipal autonomy across provinces. In terms of fiscal autonomy, municipalities collect a minor cleaning and sewage tax and depend on transfers from the province. Federal transfers finance more than half of all provincial budgets (except from Buenos Aires) and a large majority of such transfers are automatic and unconditional, called *coparticipación* (Gervasoni 2010a, 311). Provinces also co-determine legislation and policies through the directly elected Senate with ample and symmetric powers and diverse councils that discuss national policies, such as *Consejo Federal de Educación* for education policies and *Consejo Federal de Salud* for health policies.

**Figure 3.6: Regional authority country trends in Latin America**




Source: Hooghe et al. (Forthcoming)

Brazil is divided in 26 states, which are further divided into municipalities, and the Federal District of Brasília. States, municipalities, and the federal government have equal juridical status since 1988 constitution. The three levels have concurrent competencies in social policy, which means that they can all legislate but none has specific obligation; and healthcare, education, and pension has been decentralized. Brasília has competencies more similar to states than municipalities, but while states have their own constitution, Brasília is regulated by organic law. A good amount of revenue comes from state and local taxes, as well as national transfers. States control the rate of state value added tax (*Imposto sobre Circulação de Mercadorias e Prestação de Serviços*, ICMS) and municipalities control the rate of a tax on services (*Imposto Sobre Serviços*, ISS) and real state (*Imposto Sobre a Propriedade Predial e Territorial Urbana*, IPTU). The Fiscal Responsibility Law of 2000 controls the fiscal balance of the three levels of government,

including spending and borrowing. Federal transfers to states and municipalities includes constitutionally mandate sharing of taxes, as well as non-constitutional specific-purpose taxes. While some of the wealthier states fund most of their expenditures through own revenues, poorer states are highly dependent on federal transfers (Rodden 2006, 193–94).[32] In addition, states co-determine legislation through the directly elected national senate with broad authority. Both municipalities and states co-determine national policy though councils in health, education, social assistance, transportation, and justice, among others. Councils are generally composed of representatives of the government, citizens, and providers.

Besides from being the most highly decentralized countries in Latin America, Argentina and Brazil share similar trajectories in terms of welfare state development. Together with Chile, Uruguay, and Costa Rica, they have built the most advanced welfare states in the region (Mesa-Lago 1978; Mesa-Lago 1989; Huber and Stephens 2010; Huber and Stephens 2012). These social states find their origin in the 1930s and 1940s, with an employment-based social insurance and stratification of welfare state programs, particularly along occupational lines. In addition, they have undergone neoliberal reforms during the 1980s and 1990s, and have expanded their social protection systems since the 2000s.

Import Substitution Industrialization strategies initially financed social security systems through a combination of employer, employee, and state contributions. During the 1930s and 1940s, Argentina and Brazil expanded their social states through the cooptation of labor, as analyzed by Huber (1996). Powerful leaders (Juan Perón and Getúlio Vargas) mobilized and coopted the newly organized urban working classes (Collier and Collier 1991). The Peronist

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[32] The main federal transfer to states is the *Fundo de Participação dos Estados* (State Participation Fund, FPE), funded with 21.5 percent of the net revenues of the three main national taxes, namely: personal, corporate, income, and VAT taxes. The distribution of this fund follows a redistributive criteria among states (Rodden 2006, 193).

Party in Argentina established a major social protection system that included pensions and the expansion of the union-run mutual health insurance (*obras sociales*), and of public hospitals (Lloyd-Sherlock 2000; Rock 1985). Vargas' regime in Brazil set the foundation for urban sector incorporation into the social security system and the military's bureaucratic-authoritarian regime expanded coverage to the rural sector in 1971 (Malloy 1979). Nevertheless, in neither of these two countries this was a citizenship right, and the informal and rural sectors were generally excluded or received cash and healthcare that were low and of poor quality.[33] The results were stratified and fragmented social protection systems. In addition, these systems proved to be financially unsustainable, due to a declining ratio of workers to pensioners and the low levels of contribution (Cruz Saco and Mesa-Lago 1998, 7–8; Kay 1999, 406). The crisis of social security systems, together with high levels of debt and decreases in the price of primary commodities, incentivized the retrenchment of social policies in the 1980s and 1990s.

International Financial Institutions prescribed a reduction of government expenditure, privatization, deregulation, and liberalization of trade and financial markets. In social policy, the blueprint was to narrowly target the provision of social assistance, partially or fully privatize social security, and increase the participation of private providers in healthcare and education. These prescriptions influenced policies mostly through conditionality of funds, but the receptivity varied in Argentina and Brazil. While Argentina partly privatized its pension system, Brazil did not engage in any major reform (Niedzwiecki 2014). Social assistance remained narrowly targeted to the poor in both countries. As a result of neoliberal reforms, including deregulation of the labor market, the number of workers in the informal sector increased, and therefore these contributory based systems excluded even larger portions of the population.

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[33] Argentina's 1954 introduction of pensions for rural workers and the self-employed, and Brazil's 1971 expansion of non-contributory pension were noticeable exceptions.

Poverty and inequality levels also increased. ECLAC's figures show that in the early-1990s, more than 40 percent of Brazil's population lived below the poverty line and 16 percent of the Argentine population. Inequality similarly rose to a Gini of over 0.55 in Brazil and 0.44 in Argentina (Huber and Stephens 2012). In addition, these reforms aggravated the crisis of social security. In 2004, active contribution to the pension system was 45 percent in Brazil and 24 percent in Argentina (Mesa-Lago 2008, 38).

The discontent generated by market-oriented policies, together with the consolidation of democracy, the rise of left parties, and the commodity export boom of the 2000s paved the road for the expansion of social policies (Huber and Stephens 2012). The Worker's Party in Brazil deepened the trend that had started under Fernando Henrique Cardoso. This party expanded the conditional cash transfer program Bolsa Família to 23 percent of all Brazilian families in 2011. Primary health care, through Estrategia Saúde da Família, was also strengthened under the PT government. In addition, the pension sector improved its fiscal imbalances and its distribution profile by imposing stronger limits on benefit ceilings and equalizing the benefits for new entrants to the public and private sectors. Finally, the legal minimum wage, which is also used to calculate many transfers targeted to the poor, consistently increased since Cardoso's administration (Kingstone and Ponce 2010, 113).

Comparably, in Argentina the left of center faction of the Peronist Party (*Frente Para la Victoria*) also moved towards a more universalistic direction in its social policies. Similar to Brazil's Bolsa Família, Argentina's Asignación Universal por Hijo is a conditional cash transfer implemented by this government, which is also not distributed clientelistically. Primary healthcare has also received emphasis through the distribution of first aid kits and through the reimbursement to public clinics and hospitals for services provided to uninsured pregnant women, children, and teenagers. The most salient reversal to market-oriented reforms was in

the area of pensions. There was an expansion of coverage to those with insufficient contributions in exchange for a payment plan; and the government fully nationalized the pension system in 2008 (Arza 2009; Niedzwiecki 2014).

In Argentina the Peronist party has been the promoter of both retrenchment and expansion policies. This was possible because the Peronist party has generally enjoyed majorities in both chambers and has a flexible structure that allowed it to change from union-based linkages to personal-based clientelistic linkages (Levitsky 2003). This factors couple with decentralized electoral dynamics, by which party competition is de-nationalized and there are different party systems across provinces (Calvo and Escolar 2005; Leiras 2007). In Brazil, there is no majority party like the Peronist party that can implement policies alone. The party system is fragmented in Brazil, and even the major parties form broad coalitions to win elections and govern.[34] These coalitions can include parties of the left and right and vary widely at the different territorial levels– the same party can be aligned with another party at a given level and in opposition to the same party at another level (Krause and Alves Godoi 2010; Peixoto 2010; Ribeiro 2010). Even the PT has made alliances with parties far from its ideological positioning since it was elected for the Presidency in 2003 (Hunter 2010). The next section expands on subnational party strategies by detailing the case selection strategy within countries: across states or provinces, and municipalities.

### *Case Selection at the Provincial or State Level*

At the intermediate level, I have selected two states in Brazil and two provinces in Argentina with similar values on socioeconomic variables; and with variation in political alignments and

[34] The main parties are arguably the *Partido dos Trabalhadores* (Worker's Party, PT), the *Partido da Social Democracia Brasileira* (Brazilian Social Democratic Party, PSDB), and the *Partido do Movimento Democrático Brasileiro* (Brazilian Democratic Movement Party, PMDB).

level of subnational democracy.[35] I do so by selecting cases with similar GDP per capita and population density. Controlling by these variables allows me to rule out explanations based on economic development and industrialism. These cases also show variation in the level of opposition to the national government and in the level of electoral contestation. I do not intend these states and provinces to be representative of the broader national context. They represent different political dynamics in the evolution of social welfare that can enlighten the analysis of those factors in other subnational units, and other decentralized countries.

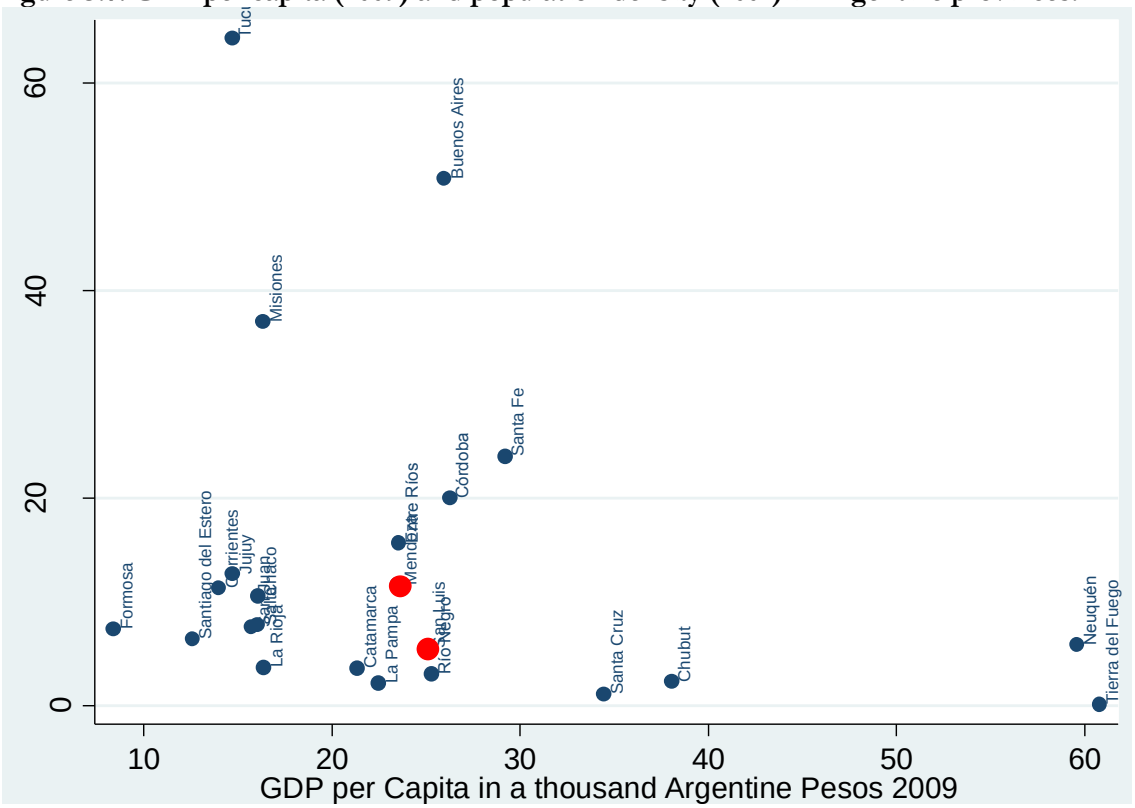
In Argentina, I select the provinces of Mendoza and San Luis, two middle income provinces with similar population densities, as illustrated in figure 3.7. In terms of electoral trajectories, while San Luis has been in opposition to the national government since 2003, Mendoza has generally been an ally to the national government. Adolfo Rodriguez Saá, a former governor in San Luis and very influential figure in the province, ran as a presidential candidate against the Kirchners in 2003 and 2007, and his brother (also a former governor) in 2011 elections. Conversely, Mendoza has been an ally of former presidents Carlos Menem, Fernando de la Rúa, and after 2006 was part of the *Radicales-K*, the radicals who supported Kirchner. That is why the then governor, Julio Cobos, ran as the vice president of Cristina Kirchner in 2007 elections. In the wake of a political falling out that resulted in the dissolution of the *Radicales-K* and Cobos' detachment from "kirchnerismo" the province has been fully kirchnerista since the 2011 elections, as indicated in table 3.2. In terms of the level of subnational democracy, Mendoza is considered one of the most democratic provinces, while San Luis one of the most authoritarian (Bill Chavez 2003; Gervasoni 2010b; Giraudy 2009). While there has been party

[35] Different authors have defined subnational regimes in different ways, ranging from subnational authoritarianism (Gibson 2012) and undemocratic regimes (Giraudy 2010), to electoral competitiveness (A. Borges 2007), and hybrid regimes (Gervasoni 2010b).

alternation in Mendoza, San Luis has been governed by the Rodriguez Saá family or close collaborators since 1983 (Samper 2006).

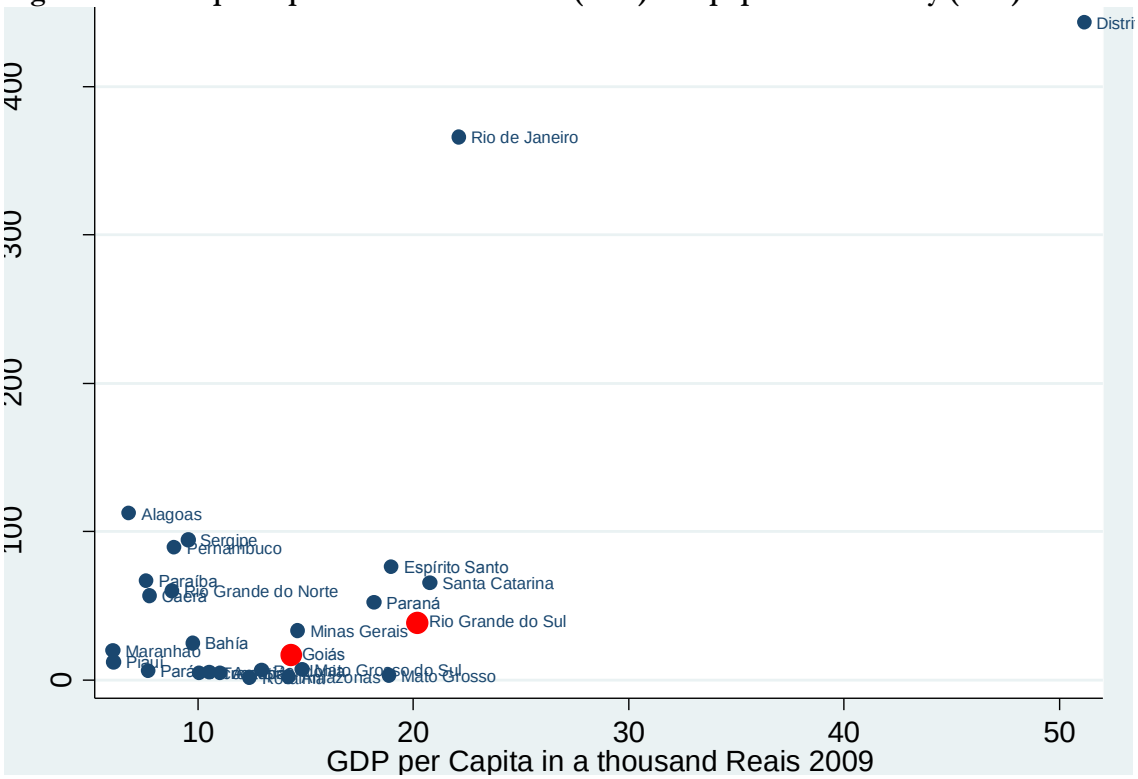
In Brazil, I also choose two middle income states with similar population densities, Rio Grande do Sul and Goiás, as illustrated in figure 3.8. At the same time, these states show differences in terms of political alignments and level of subnational democracy. At this point, a remainder is in order: both partisan alignments and levels of subnational democracy are less clear in the Brazilian context, compared to the Argentine context. In Brazil, the same party can join widely different coalitions throughout states. Therefore, the position of a given party towards the federal government depends on each state. Having said this, the selected cases do show variation in terms of partisan alignments. In Goiás, politics are relatively polarized between the PSDB and the PT-PMDB coalition (Dias Bezerra, Paiva Ferreira, and Ribeiro 2011, 5). Goiás' governor (PSDB) presents open opposition to the federal government since 2003, when the PT occupied the presidency. This incumbent alliance headed by the PSDB included around 11 parties in 2010 elections, and its main opposition has been an alliance between the PMDB and the PT. Conversely, in Rio Grande do Sul the current PT governor, in power since 2010, is fully aligned with the president, as indicated in table 3.3. The position of previous governors towards the federal government is more ambivalent since alliances are not long lasting in Rio Grande do Sul, but leaning towards opposition to the federal government.

**Figure 3.7: GDP per capita (2009) and population density (2001) in Argentine provinces.**




Note: Buenos Aires City is not shown for presentation purposes. Source: Ministerio del Interior and INDEC

**Figure 3.8: GDP per capita in Brazilian states (2008) and population density (2010).**




Note: The state of São Paulo is not shown for presentation purposes. Source: IPEA and IBGE

In terms of levels of subnational democracy, Brazilian states do not show the kind of undemocratic characteristics that Argentine provinces do. Therefore, the variance of this variable is also lower in Brazil.[36] In spite of this fact, Rio Grande do Sul is more democratic than Goiás. Rio Grande do Sul shows high degrees of alternation of power in the governorship, and has been defined as pluralist with relevant role of the left (Borges 2007) and as a case of "broadened competition" (Montero 2007). Since 1982, different parties have occupied the seat of the governor, including PMDB, PSDB, PT, and *Partido Democrático Trabalhista* (Democratic Labor Party, PDT), and no governor has been reelected. Conversely, Goiás has had less alternation, with PSDB (in coalition with *Partido Progresista,* Progressive Party, PP) controlling state politics for the last 15 years. Goiás has been defined as a "dominant machine" (Borges 2007) and as a case of "conservative competition" (Montero 2007), or as a "hyper-presidential region" (Krause 2008). Politics in Goiás has been dominated by Iris Rezende Machado and PMDB during 1982-1997 period, and Marconi Pirillo and PSDB from 1998 to the present.[37] The same two people are the main political actors today, Marconi Pirillo will be the PSDB candidate for 2014 elections, while Iris Rezende is the main candidate for the PMDB-PT coalition (Interviews Arantes, Cassiano).

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[36] This difference may be due to the fact that Argentine provinces have the authority to decide on electoral rules, including dates, district design, and reelection rules, as well as on the organization of municipalities. Brazilian states do not have this option, since all these decisions are constitutionalized. Therefore, there is more room for variation in level of democracy among Argentine provinces than Brazilian states. I thank André Borges for pointing out this difference. A significant difference between Argentina's San Luis and Brazil's Goiás, the two less democratic subnational cases, is that the opposition can realistically win an election in the latter but not in the former.

[37] Iris Rezende, for instance, made extensive use of decrees in certain areas that could not be overridden by the weak legislature; he appointed the mayor of the main cities, the state Audit Courts; and he had extensive powers (and made use of them) to create and eliminate public positions, as well as hire and fire public employees. In addition, municipalities were weaker during this period because the governor could directly intervene municipalities and because most mayors shared the party of the governor (Krause 2008).

### *Case Selection at the Municipal Level*

I select two municipalities or local subnational units within each state or province. To analyze municipalities that have potential leverage over social policies, I choose the most urban and developed units. The two selected municipalities per state or province are also geographically close to each other. At the same time, I select cases with different political party trajectories. Tables 3.3 and 3.4 display partisan alignments of the selected provinces, states, and municipalities in 2012, the year in which field research was conducted.

**Table 3.3: Partisanship affiliation of the governor and mayors in relation to the national and provincial governments in the selected cases in Argentina (year: 2012).**

| Province/ Municipality | Party of the Mayor | Party of of Governor | Party of the President |
|---|---|---|---|
| **Mendoza** | | | |
| Las Heras | *Frente para la Victoria (FPV)* | *FPV* | |
| Godoy Cruz | *Unión Cívica Radical (UCR)* | | *FPV* |
| **San Luis** | | | |
| San Luis City | *FPV* | *Frente Justicialista Unión y Libertad* | |
| Villa Mercedes | *Frente Justicialista Unión y Libertad* | | |

**Table 3.4: Partisanship affiliation of the governor and mayors in relation to the national and state governments in the selected cases in Brazil (year: 2012).**

| Province/ Municipality | Party of the Mayor | Party of Governor | Party of the President |
|---|---|---|---|
| **Rio Grande do Sul** | | | |
| Porto Alegre | *Partido Democrático Trabalhista* | *PT* | *PT* |
| Canoas | *Partido dos Trabalhadores (PT)* | | |
| **Goiás** | | | |
| Goiânia | *PT* | *PSDB* | |
| Valparaíso de Goiás | *Partido da Social Democracia Brasileira (PSDB)* | | |

For Argentina's San Luis, I choose San Luis City and Villa Mercedes. San Luis City is the capital of the province and has been mostly headed by opposition to the province's governors. This is one of the few municipalities not controlled by the provincial government. The

municipality is currently aligned with the party of the President, as table 3.2 illustrates. Villa Mercedes, in contrast, is a bastion of the Rodríguez Saá family, where no other party has governed the municipality since the return of democracy in 1983. Therefore, the municipality is currently aligned with the governor and in opposition to the federal government. In the province of Mendoza, I have selected Las Heras and Godoy Cruz. Las Heras is a Peronist- *Frente para la Victoria* bastion and therefore the three levels of government are aligned.[38] Conversely, the municipality of Godoy Cruz in Mendoza is a radical stronghold, currently opposing both the provincial and the federal governments.

In Brazil, in the state of Rio Grande do Sul, I choose Porto Alegre and Canoas. Porto Alegre is the capital of the state and the PT was government for 16 consecutive years, when in 2005 an opposition alliance between PPS and PMDB was elected. Since 2010, the local government is in the hands of a PDT mayor. Today Porto Alegre represents a good example of the complexity of alliances throughout territorial levels in Brazil. The municipal government is opposition to the PT at the state level (in 2012 local elections the PDT competed against the PT) but is part of the PT coalition at the federal level. The bordering municipality of Canoas, is the second largest city (after Porto Alegre) from the metropolitan area. It was dominated by PMDB and PSDB groups until a coalition led by PT won elections in 2009 and 2012. As in the case of Las Heras in the Argentine province of Mendoza, in Canoas the three levels of government are fully aligned.

In the state of Goiás, I choose Goiânia and Valparaíso de Goiás. Goiânia is the capital city and mayors have been mostly aligned to the federal PT. The municipality has had overall alternations between PMDB and PT since the transition to democracy and until these parties made a coalition in 2008 that continues to control the local government. The current mayor

[38] In Las Heras, the Peronist party has won the elections for mayor since 1987 (Ruggeri 2012, 59)

belongs to PT (Dias Bezerra, Paiva Ferreira, and Ribeiro 2011, 3–4).[39] At the same time, the municipality has been in open opposition to the state government since 2001. Goiânia's partisan alignments are comparable to San Luis City in Argentina. Vaparaíso de Goiás is located in the surroundings of Brasília and was funded as a municipality in 1995, after being separated from its neighboring Luziânia. Since it was funded, two of its mayors have been PSDB, aligned to the state's government and in open opposition to the federal government. For these characteristics, Vaparaíso de Goiás is comparable to the current situation in Villa Mercedes, in the Argentine province of San Luis.

### *Case Selection across Social Policies*

Within the states, provinces, and municipalities described above, I select national and subnational non-contributory social policies, ranging from moderate universalism to pure universalism.[40] I only include non-contributory social policies since contributory schemes are generally designed and implemented at the national level. In addition, I do not expect contributory schemes (such as contributory pensions or contributory health insurance) to be broadly targeted. Particularly in Latin America, contributory schemes exclude large segments of the population that are either unemployed or work in the informal labor market. Therefore, I choose the main non-contributory conditional cash transfers and primary health policies in each country. These policies are designed and mostly funded by the federal government, and implemented by the central government, states and/or municipalities. At the same time, when

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[39] It was leaded by a PT governor from 2001 to 2004 and since 2010, and by PMDB during 2005-2009 (in coalition with PT since 2008). The current mayor, Paulo García, was Iris Rezende Machado's vice-mayor in 2009 elections. Rezende Machado renounced in 2010 to run for governor and left Paulo García as the mayor.

[40] Appendix 3.1 codes the level of universalism of the selected national social policies adapting Pribble (2013) coding scheme.

national policies are implemented, they encounter policies designed and implemented by subnational units. To study the dynamics of cooperation or competition between national and subnational policies, I also select the main state or provincial non-contributory cash transfers in each state or province. Table 3.5 displays the selection of policies by design and implementation entity.

**Table 3.5: Selection of non-contributory social policies.**

| **Design and Funding** | | **Implementation** | | |
|---|---|---|---|---|
| | | **National** | **Provincial/State** | **Municipal** |
| **National** | Argentina | Asignación Universal por Hijo | Plan Nacer | Plan Nacer |
| | Brazil | Bolsa Família | | Estrategia Saúde da Família* Bolsa Família |
| **Provincial /State** | | | *Plan de Inclusión Social* (San Luis) *Esquinas* (Mendoza) *Renda Cidadã* (Goiás) | *Esquinas* (Mendoza) *RS Mais Renda Mais Igual* (Rio Grande do Sul) |

*Estrategia Saúde da Família divides funding between the three levels of government.

For Argentina, I include two national policies: Asignación Universal por Hijo and Plan Nacer. While Asignación is a conditional cash transfer implemented by Anses, the national social security institution, Plan Nacer is a health policy implemented through provinces and municipalities in charge of health centers and hospitals. At the same time, each of the two provinces have designed, funded, and implemented their own cash transfers: *Plan de Inclusión Social* (Social Inclusion Program) in San Luis is a workfare program, and *Esquinas-Plan de Inclusión de Jóvenes* (Corners-Program for the Inclusion of the Youth) in Mendoza is a training program. While the implementation of this policy in San Luis is in the exclusive hands of the province, the implementation of this policy in Mendoza is shared between the province and the municipalities.

Plan Nacer directly intervenes in the provision of public health, and particularly affects resources received by primary healthcare providers.[41] It entails transfers from the federal government to health providers (provinces and municipalities) to deliver pregnancy, birth and neonatal health coverage to pregnant women and immunizations and general health coverage for children under the age of six with no health insurance. In 2012, the federal government extended coverage to uninsured women until the age of 64 and children and teenagers until the age of 19 (Argentina 2012d). Its targeted coverage is broad, there are no quotas or limits in the quantity of recipients, and the policy is distributed to all those who meet the eligibility criteria. Plan Nacer is mostly funded by the World Bank. Normatively, 60 percent of the funds are transferred after a province qualifies and the other 40 percent is conditional upon particular results. Subsequently, the province transfers the resources to health providers based on quantity and type of medical services actually offered the previous month. Plan Nacer increased its actual coverage after the implementation of Asignación Universal por Hijo, since the health check-up conditionality of the latter expanded the coverage of the former.

Asignación Universal por Hijo, enacted in 2009, is a conditional cash transfer program that targets pregnant women and families with children under the age of 18 who are currently unemployed or under-employed (including single tax system tax payers' and domestic service) and who earn less than the minimum salary (roughly US$480).[42] The monthly cash transfer is more than US$75 per child per month up to a maximum of three children per family and pregnant women since the 12th week of pregnancy. This amount of transfer equalizes the highest amount of family allowance received by those children of workers who work in the formal labor

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[41] Argentina's health system includes three components: a publicly-financed sector (administered by provinces and big municipalities), social insurance funds (*obras sociales,* administered by unions) and a private sector.

[42] Official exchange rate US$1=$6, as of November 20, 2013. All conversions are taken at this rate.

market (and receive a contributory family allowance) and those who work in the informal market or are outside the labor market altogether (and receive universal family allowance). According to CEPAL, the level of monthly transfers positions this policy as one of the most relevant CCTs in the region (CEPAL 2013). While 80 percent of the total sum is paid through an ATM card, the other 20 percent is in a bank account and is contingent upon health check-ups and school attendance. The policy is funded through the nationalized pension funds invested in a "guarantee fund" and regular contributions in the formal labor market.[43]

Asignación is implemented throughout the national territory. In the provinces of San Luis and Mendoza, this national policy interacts with subnationally designed and funded cash transfers: Plan de Inclusión Social (PIS) in San Luis and Plan de Inclusión en Derechos para Jóvenes (called *Esquinas* or Corners) in Mendoza. PIS was launched in 2003 in San Luis, in a context of high unemployment and poverty levels. It provides a monthly check of around US$40 in exchange for six hours of daily work in a place determined by the provincial government. Most beneficiaries work planting trees by the road, in safety activities, in health centers, schools or municipalities. By 2012, it was a narrowly-targeted policy that reduced its coverage in 75 percent since 2003 (Ministerio de Inclusión Social, San Luis 2012). Similarly, Mendoza's Esquinas is a training program implemented since 2008 and narrowly targeted to vulnerable young people. Depending on the recipients' age, it provides a monetary incentive that varies by activity. The activities include finishing school, starting college, receiving work training, or developing a project.

In Brazil, I select policies that are parallel to those selected for Argentina. The two national policies are a primary health policy (Estrategia Saúde da Família) and a conditional cash

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[43] These funds are called *Fondo de Garantía de Sustentabilidad del Sistema Integrado Previsional Argentino* and *Sistema Integrado de Jubilaciones y Pensiones*.

transfer (Bolsa Família). These policies are mostly implemented by municipalities but also by states. As it is the case in Argentina, when national policies are implemented, they encounter subnationally designed and funded policies. I therefore select the main cash transfers in the selected states: Renda Cidadã (Citizenship Income) in Goiás and RS Mais Renda Mais Igual (More and Better Income) in Rio Grande do Sul.

Estrategia Saúde da Família is the universal primary health policy in Brazil since 1994.[44] The federal government defines the guidelines and regulations of ESF, which are enforced through the conditionality of federal transfers to states and municipalities; and municipalities are in charge of implementing it.[45] The aim of this policy is to strengthen preventive healthcare. This includes immunization, nutritional controls, and basic medical and dental assistance to children; prenatal, cancer of the womb, and dental controls to women; and health check-ups to populations in risk such as people with high blood pressure, diabetes, or tuberculosis. The policy is implemented through *Unidade Saúde da Família* (Family Health Units, USF) which include, at a minimum, a team of a primary care physician, a nurse, a nurse auxiliary, and four health agents (*Agente Comunitário de Saúde*).[46] This team is responsible for the health of no more than 4,000 people in a defined territory. ESF is characterized by the "active search" (*busca ativa*) to find and register patients, an activity for which the health agent in the community is responsible. Health

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[44] This policy emerged from a 1991 program called *Programa de Agentes Comunitários de Saúde* (Community Health Agents Program, PACS), that took its original idea from local experiences in basic health care provision (Borges Sugiyama 2013, 8)

[45] The health system in Brazil is divided into two tiers: private and public. The public system, *Sistema Único de Saúde* (Unified Health System, SUS), is free and universal. In simplified terms, the municipal level is in charge of primary health, the state is in charge of medium complexity procedures, and the federal level deals with high complexity procedures. Nevertheless, this division is not always clear, and the largest cities have also taken on responsibilities on medium and high complexity services.

[46] Some USF also include a dental team (*Equipe de Saúde Bucal*) composed of a dentist, an assistant, and a technician on dental hygiene.

check-ups in the patients' house or in the health unit count towards Bolsa Família health conditionalities.

Bolsa Família is a conditional cash transfer broadly targeted to poor families that has been implemented since 2003. The amount of the transfer depends upon the economic situation of the family. The Basic Benefit *(Benefício Básico*) of US$35 is for families who live in extreme poverty.[47] Besides from this basic income, families with children of up to 15 years old or with pregnant women receive US$16 per child up to a maximum of five children, families with children in the ages of 16 and 17 receive US$19 up to a maximum of two teenagers (Brasil 1993, Arts. 12-15). Bolsa Família is inscribed within the legislation of the *Sistema Único de Assistência Social* (Unified Social Assistance System, SUAS) by which all levels of government (national, intermediate, and local) are responsible for social provision. The federal government funds and designs national policies, states support and coordinate municipalities and provide social services where they are needed, and municipalities are in charge of implementation (Brasil. Presidência da República, Casa Civil 1993, Arts. 12-15).[48] For the implementation of Bolsa Família, the *Ministério do Desenvolvimento Social* (Ministry of Social Development, MDS) at the national level is in charge of administering the policy, and municipalities are in charge of controlling the conditionalities of health check-ups, school attendance, and updating of registration in the *Cadastro Único* (Single

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[47] All monetary calculations are made at the exchange rate as of January 24, 2013. US$1=BR$2.

[48] The 1988 Constitution gave social assistance the status of public policy, the same status as health and social security. The 1993 Organic Law of Social Assistance (Lei Orgânica da Assistência Social, LOAS, Law 8742) regulates this constitutional article. Finally, in 2005 the Unified Social Assistance System or SUAS aimed to further homogenize social assistance provided by municipalities, states, and the federal government towards compliance with social rights. These last two legal instruments explicitly mention the central role of social assistance councils (in which civil society also participates) and in intergovernmental negotiations through commissions to define and control social provision (Brasil 2009b). In addition, SUAS divides social provision into basic and special. Basic social provision is supplied by Reference Centers for Social Assistance (Centros de Referência de Assistência Social, CRAS) as well as a network of training and emergency services. Special social provision is offered to children and adults in social risk though a network of emergency institutions (Brasil 2005c, Art. III). The federal government enforces these regulations through transferring specific with strings attached to them.

Registry). All families with monthly income per capita below half a minimum salary should be included in the Single Registry. Such registry helps identifying potential Bolsa Família recipients.

When Bolsa Família was implemented in states and municipalities, some of these subnational units had non-contributory cash transfers of their own that coordinate or compete with these national policies. In Goiás, Renda Cidadã is implemented by the state and exists since 2000, initially as a cash transfer of around US$40 that could only be used to buy food and other essential goods and services, conditioned upon school attendance and family check-ups. From 2000 to 2010, the quantity of recipients was halved and the program was interrupted a number of times (Secretaria de Cidadania e Trabalho, Goiás 2012). The cash transfer in the state of Rio Grande do Sul was launched in 2012, to complement Bolsa Família with roughly US$25 per month to enhance middle school attendance and job training activities. The policy is designed to be administered by the state and implemented by municipalities.

Overall, I select eight non-contributory social policies, four in Argentina and four in Brazil. Four of these policies have been designed and are mostly funded by the federal government, and the remaining four are state or provincial policies. In terms of policy sectors, I choose two health policies (Estrategia Saúde da Família and Plan Nacer) and six social assistance cash transfers. From the cash transfers, four are conditional cash transfers targeted to families (Asignación Universal por Hijo, Bolsa Família, Renda Cidadã in Goiás, and RS Mais Renda Mais Igual in Rio Grande do Sul), one is a training program (Esquinas in Mendoza), and one is a workfare program (Plan de Inclusión Social in San Luis). The decision to include social policies and not social sectors (such as health-care, social assistance, or employment) makes the process of zooming in political processes more feasible. At the same time, these national policies make a direct intervention in the overall sectors, such as Plan Nacer and Estrategia Saúde da Familia in primary health care, and Asignación Universal and Bolsa Família in social assistance.

The selection across territorial levels and social policies represents all possible causal combinations of the main argument of this dissertation. The extent to which social policies are successfully implemented in decentralized countries depends in part on partisan alignments at the different territorial levels. Subnational governments are interested in enhancing the implementation of an upper-level policy either when they are political allies, or when the policy cannot be easily attributed to the opposition and therefore there are no clear electoral gains. Therefore, I include states, provinces, and municipalities with different alignments to the federal level, and I also include policies that can be attributed to the federal government, and policies for which recipients cannot identify who is responsible and therefore cannot reward that party or government level in the elections. There are four possible combinations between attributability and partisan alignments that, in turn, produce different effects on social policy performance. These combinations are represented in table 3.6.

**Table 3.6: Possible combinations of partisan alignments and attributability and its effect on policy implementation**

| Attribu-tability | Align-ments | Effect on Policy Implementation | Cases: Policy-Place |
|---|---|---|---|
| Yes | + | **Positive** | AUH-MZA; AUH -LH; AUH -SL City<br>BF-RS; BF-Canoas; BF-POA; BF-GYN |
| Yes | - | **Negative** | AUH -SL; AUH -VM; AUH -GC<br>BF-GO; BF-VG |
| No | + | **Irrelevant** | PN-MZA; PN-LH; PN-SL City<br>ESF-RS; ESF-POA; ESF-CA; ESF-GYN |
| No | - | **Irrelevant** | PN-SL; PN-VM; PN-GC<br>ESF-GO; ESF-VG |

***Policies***
AUH: Asignación Universal por Hijo (Argentina); PN: Plan Nacer (Argentina)
BF: Bolsa Família (Brazil); ESF: Estrategia Saúde da Família (Brasil)
***Places***
Mza: Province of Mendoza, Argentina; LH: Municipality of Las Heras; GC: Municipality of Godoy Cruz
SL: Province of San Luis, Argentina; SLC: Municipality of San Luis City; VM: Municipality of Villa Mercedes
RS: State of Rio Grande do Sul, Brazil; POA: Municipality of Porto Alegre; CA: Municipality of Canoas
GO: State of Goiás, Brazil; GYN: Municipality of Goiânia; VG: Municipality of Valparaíso de Goiás

## Conclusions

This dissertation analyzes the determinants of social policy implementation in decentralized countries. Social policy implementation is the degree to which policies effectively provide social protection to the targeted population, measured as coverage as a percentage of the targeted population. This chapter also described the research design of this dissertation. It is a multilevel and mixed-methods analysis. I select cases across countries, states, provinces and municipalities, as well as across non-contributory social policies. At the national level, I choose the most decentralized countries in the region, Argentina and Brazil, which also share similar welfare state development trends since their origin in the 1940s to the present. At the subnational levels, I choose units with similar levels of GDP per capita and population density, but with different partisan alignments. In terms of social policy selection, I choose eight non-

contributory social policies, four of which are national and the remaining are subnationally designed and funded, and they belong to a range of sectors, including health and social assistance.

These policies are studied through mixed-methods. The next chapter uses cross-sectional time-series analysis to study the average effect of partisan alignments on social policy implementation in 27 Brazilian states from 1996 to 2012 and 24 Argentine provinces from 2007 to 2012. The following chapters use in-depth case study analysis of conditional cash transfers, first, and of health policies, later, across two states, two provinces, and eight municipalities. The case-study analysis will assess the validity of the correlations in the regression analysis and, most importantly, will assess the mechanisms through which partisan alignments affect social policy implementation.

# CHAPTER 4: STATISTICAL ANALYSIS OF THE FACTORS THAT SHAPE SOCIAL POLICY IMPLEMENTATION IN ARGENTINA AND BRAZIL

This chapter analyzes the determinants of social policy implementation across states in Brazil and provinces in Argentina over time. These include political alignments, policy legacies, and territorial infrastructure. The extent to which social policies are successfully implemented depends on partisan alignments at the different territorial levels. Subnational governments become interested in enhancing the implementation of an upper-level policy when they are political allies or, alternatively, when the policy cannot be easily attributed to the opposition. This chapter tests the effects of political alignments on social policy implementation in four different policies: two conditional cash transfers and two health policies in Argentina and Brazil. While recipients of the conditional cash transfers can attribute them to the federal government, recipients of the health policies cannot identify who is responsible for the service. Therefore, partisan alignments are only expected to be significant in the cash transfers in each country.

This chapter also analyzes the effect of structural variables, policy legacies and territorial infrastructure, over the successful implementation of policies. Territorial presence shapes social policy implementation from the initial provision of information (where to go, what to bring to sign up), to the adequate delivery of the policy itself, and to the identification of those who should be included but are excluded. For this, state actors need to know the territory and be able to reach it. By being closer to policy recipients, subnational governments are in an exceptionally advantageous position to deliver social policies. As a result, it is

expected that institutions in the territory have the potential to enhance the implementation of a given policy. Additionally, positive legacies enhance the implementation of social policies. Previous policies that target the same population can advance the reach of the current policy by automatically transferring their recipients from the previous to the current policy or by generating institutional mechanisms that facilitate the implementation of the new policy. Conversely, policy legacies can also hinder the implementation of new policies when strong interests from previous policies are contrary to the current one.

The next section of this chapter presents the operationalization of the dependent, independent, and control variables. Next, it proceeds to explaining the selected statistical technics; and finally it analyzes the regression results.

**Variables and Operationalization**[49]

I have constructed an original dataset that covers the 24 provinces in Argentina (including the federal city of Buenos Aires) from 1994 to 2012, and the 27 states in Brazil (including the federal city of Brasília) from 1988 to 2012. The starting dates mark the passing of constitutions that decentralize authority to states/provinces and municipalities. In the 1994 Constitution in Argentina, municipalities became autonomous entities; and in the 1988 Constitution in Brazil, municipalities, states, and the federal government are at the same hierarchical level.[50] This

[49] Appendix 4.1 to 4.4 include summary statistics, description of variables, and sources.

[50] The collection of subnational data in Brazil and Argentina is challenging particularly due to the high level of missing values. Given that the missingness is non-ignorable and includes continuous series of years, I have decided not to proceed with multiple imputation. When it was safe to assume that the variable is rarely changing, I have proceeded through single imputation. When this assumption was not reasonable, I have proceeded through casewise deletion or the automatic dropping of observations due to missingness. Imputation decisions for each variable are described in Appendix 4.3 and 4.4.

chapter analyzes part of this dataset – from the implementation of the health policies in Brazil (1998) and in Argentina (2004) to 2012.

**Measurement of the Dependent Variable - Social Policy Implementation**

The dependent variable, social policy implementation, is defined as the extent to which policies effectively provide social protection to the targeted population. This is measured as levels of coverage as a percentage of the targeted population. Brazil's 2010 Census has determined the quantity of people who should be receiving *Bolsa Família*. Successful implementation is therefore measured as a percentage of this population. Accordingly, Argentine conditional cash transfer *Asignación Universal por Hijo* is measured as a percentage of people living with unsatisfied basic needs as calculated by the country's 2010 census. The targeted population can also be broader, such as in Brazil's primary health policy *Estrategia Saúde da Família*. This policy targets the entire population and therefore its coverage is calculated as a percentage of total estimated population. The successful implementation of Argentine's health policy *Plan Nacer* is measured by the Argentine Health Ministry as the average of the percentages of coverage of ten medical practices. The following percentages are averaged: pregnant women with the first prenatal checkup before the 20$^{th}$ week of gestation, total number of births, total number of babies who are not underweight, vaccine coverage of women in birth, assessment of cause of prenatal mortality, vaccine coverage in babies, sexual and reproductive counseling to puerperal women, babies' health check-ups, children's health check-ups, and personnel trained in indigenous medicine.

## Measurement of Independent and Control Variables

### *Measurement of Independent Variables*

To measure the main independent variable, partisan alignments, I code the level of opposition of the state or provincial governor towards the president throughout time. This variable is coded from the moment of elections and keeps the same value for two years in Argentina and for four years in Brazil. This is because while governor and president elections are concurrent in Brazil, that is not necessarily true in Argentina where provinces have the authority to set the date of elections. Given the different characteristics of the party system in each country, this variable is coded differently across the two countries. The highly fragmented party system in Brazil produces that national and subnational executives have to form coalitions to win elections. Therefore, in Brazil I code the level of opposition as whether the governor and president belong to the same party (=0), the governor and the president share an alliance with each other's party or a common third party (=1), or none of these options (=2). In Argentina, party tags are less clearly defined and therefore the coding is based on newspaper articles, and two external databases that measure the same variable for the periods 2003-2007 (Gervasoni 2010b) and 2003-2010 (Cherny, Freytes, and Schrelis 2010).[51] I code the level of opposition as whether the governor is fully aligned with the president (=0), the governor's alignment is not fixed (=1), or the governor is fully opposed to the president (=2).

Territorial infrastructure is operationalized as institutions in the territory. Indicators of this concept include schools, community centers, hospital beds, and births attended by professionals, as well as paved roads and access to gas network. These indicators are included

[51] Gervasoni (2010b) measures partisan alignments through a Survey of Experts on Provincial Politics and Cherny, Freytes, and Schrelis (2010) measure alignments though newspaper coding. These databases cover most of the period of interest, from 2003 to 2010. For 2011 and 2012, I consulted the coding with one of the authors of Cherny, Freytes, and Schrelis (2010).

separate in the regression and represent direct measures of infrastructure in the territory. Access to resources represents an indirect measure of state capacity or territorial infrastructure. This includes access to revenue through transfers from the federal government or through direct taxation.

To measure social policy legacies, I use levels of coverage of previous policies or their institutional presence. The operationalization is specific to each policy because the legacies are also specific to each policy. For Bolsa Família in Brazil, I sum the levels of coverage of previous policies which served as valuable information on potential recipients to be incorporated into Bolsa Família's registry. The policies are: Programa de Erradicação do Trabalho Infantil (Peti or Child Labor Eradication Program), Cartão Alimentação, Bolsa Escola, and Bolsa Alimentação. Asignación Universal por Hijo in Argentina received automatic beneficiaries from Plan Familias, which had received recipients from *Plan Jefes y Jefas de Hogar Desocupados* (Unemployed Heads of Households Program). Therefore, the latter workfare program can serve as a legacy for the new policy.

In the case of the Brazilian primary health care policy, the main impediment to implementation is the pre-existence of high complexity health centers (hospitals), operationalized through the number of hospital's beds per one thousand inhabitants. In addition, size of the state (measured through area and population) can also serve as a proxy for the development of high complexity services. This is because larger states and cities tend to have a more developed hospital structure. There are no comparable negative legacies for Argentina's health policy Plan Nacer given that it transfers funds to both primary and high complexity centers. The main positive feedback for this policy comes from the conditional cash transfer Asignación Universal por Hijo, which has produced an increase in the actual health take-up rates since it was implemented.

### *Measurement of Control Variables*

The main alternative explanations to successful social policy provision include ideology, democracy, decentralization, and economic development. I have included ideology of the governor's party in Brazil, by following Krause et al. (2010) party positioning as left, center, or right. This coding is the product of the agreement between seventeen experts, who coded parties every four years, from 1990 to 2006.[52]

Lack of pluralism represents the level of subnational electoral competitiveness or contestation. For Brazil, I updated A. Borges' (2007) index of electoral dominance, calculated through a factor analysis of three variables: share of votes of the governor in the first round, percentage of seats of the governor's party, and a dummy variable indicating whether the incumbent won or lost the election. For Argentina, I use Giraudy's (2009) measure of subnational regimes. This index includes measures of contestation in the executive (effective number of parties and margin victory), contestation in the legislature (effective number of parties and share of votes of the opposition), and turnover (of party and governor).

To measure decentralization, the Regional Authority Index (Hooghe et al. Forthcoming) measures the level of authority of intermediate units (states and provinces) on an annual basis and across two dimensions, self-rule (authority over its own territory) and shared-rule (authority to co-determine the exercise of authority in the country as a whole). Each dimension contains five indicators. The indicators for self-rule include the extent to which a regional government is autonomous rather than deconcentrated, the range of policies for which it is responsible, the extent to which it can set base and/or rate of taxes, the extent to which it can borrow, and the extent to which regions contain independent legislature and

[52] In Argentina, the lack of data on party positioning at the subnational level responds in part to the difficulty of mapping different parties self-identified as Peronists in a left-right continuum. I have therefore decided not to measure nor include this variable for Argentina.

executive. The shared-rule dimension includes the extent to which regional representatives co-determine national legislation, policy, borrowing, the distribution of national tax revenues, and constitutional change.[53] These indicators are aggregated through addition.

Gross Geographic Product (GDP of provinces and states) per capita and poverty rate are used to control for levels of wealth. Finally, to control for demographic and geographic variables, I include distance to the capital, population, population density, and size of the jurisdiction, among other variables.

**Statistical Techniques**

The dependent variables are percentages and linear in nature. Therefore, Ordinary Least Squares and Generalized Least Squares are the appropriate choice of model. Given that we are in a time series context, time trend in the dependent variable needs to be discussed. The coverage of policies as a percentage of the targeted population does not necessarily increase over time for reasons not included in the model. Therefore, only autocorrelation in the errors needs to be corrected in these models. To do this, I include Prais-Winsten regressions: panel corrected standard errors and first order autoregressive corrections, that deal with contemporaneous correlation of errors across states or provinces (Beck and Katz 1995). I also include the results of fixed and random effects models in appendix 4.5.[54]

Fixed effect models deal with violations of unit homogeneity assumptions through the inclusion of dummy variables for each unit. Nevertheless, this model only accounts for variation within states throughout time, and therefore does not allow for the inclusion of

[53] The shared rule dimension differentiates between bilateral and multilateral authority for each of the indicators.

[54] I do not include a lagged dependent variable because it can suppress the explanatory power of other independent variables (Achen 2000).

invariant or rarely changing variables within units across time, such as decentralization (measured through the Regional Authority Index), the area of the state, or the distance to the capital. Random effects allow for the inclusion of invariant variables by averaging the across-states and across-time effect of the independent variables on the dependent variable, by assuming that differences across states on social policy implementation are not correlated with any of the mean differences that exist among the independent variables included in the model.

Before moving further, I introduce below two caveats when comparing the models in the body of the text with the models in the appendix. These caveats are related to the consequences of the fact that variation between units is higher than variation within units. First, it should be noted that the R-square varies throughout the different models. The reason for this difference is that Stata 11 through 'xtreg' function reports $\boldsymbol{R^2}$ that do not have all the properties of the OLS $\boldsymbol{R^2}$ (StataCorp 2009). 'xterg' contains three different types of variation: overall variation ($\boldsymbol{y}$), between states ($\boldsymbol{y\_b}$) and within states ($\boldsymbol{y\_w}$).[55] Stata approximates the estimation of $R^2$ by finding correlations between estimated $\boldsymbol{\hat{y}}$ and $\boldsymbol{y}$ in the overall case, $\boldsymbol{\hat{y}\_b}$ and $\boldsymbol{y\_b}$ in the between calculation, and $\boldsymbol{\hat{y}\_w}$ and $\boldsymbol{y\_w}$ in the within calculation. Stata then squares these calculations to arrive to $R^2$. While fixed effects reports the real within $R^2$ using $\boldsymbol{y\_w}$ and approximates the overall and between variance with correlations-squared, random effects approximates all three with correlations squared. As a consequence, the overall variation in fixed effects models is low because it is estimated from $\boldsymbol{\hat{y}=x*\beta}$, where $\boldsymbol{\beta}$ is estimated from fixed effects, which provides a poor predication of overall $\boldsymbol{y}$. Therefore, the correlation between $\boldsymbol{y}$ and $\boldsymbol{x*\beta}$ is low. Random effects preserve more of the correlation between $\boldsymbol{y}$ and $\boldsymbol{x*\beta}$ and therefore the overall $R^2$ is higher, particularly when most of the variation occurs across

[55] Only overall $R^2$ are reported in appendix 4.5.

units and not cross time since random effects keeps this variation while fixed effects removes it.

Second, the estimate of Rho ($\rho$) throughout the models is also showing that most of the variation takes place across units and not throughout time. $\rho$ is the proportion of unexplained cross-sectional variance over unexplained overall variance. This estimate is consistently higher in the fixed effects compared with the random effects models. In the random effects models, Stata 11 estimates two error variances: variance of the residuals across units ($\sigma\_u$) and variance of the overall error ($\sigma\_e$). Therefore, $\rho = (\sigma\_u^2) / (\sigma\_u^2 + \sigma\_e^2)$. For the fixed effects model, $\sigma\_u$ is the standard deviation of the total unit effect (StataCorp 2009, 463). In other words, the unexplained cross-sectional variance in the fixed effects model includes the variance in the coefficients on the unit dummies. Therefore, the variation is very high, so $\sigma\_u$ and Rho are very high.

With these caveats in mind, the following sections present the results of Prais-Winsten regressions (panel corrects standard errors and first order autoregressive corrections) on the determinants of the main conditional cash transfers and health policies in Argentina and Brazil.

**Results - Determinants of Social Policy Implementation**

The results of the statistical analysis are consistent overall with the analytic framework that guides this dissertation. Opposition parties have a significantly negative effect upon the implementation of social policies when such policies can be attributed to the federal government. Higher levels of territorial infrastructure and positive legacies increase the success of social policy implementation.

**Table 4.1: Determinants of Bolsa Família implementation measured as coverage as a percentage of targeted population (2003-2012). Prais-Winsten Panel Corrected Standard Errors (PCSE).**

| Bolsa Família | PCSE |
|---|---|
| Opposition Parties | -2.88** (1.36) |
| Legacy-Previous policies | .0001 (.0001) |
| Legacy - Estrategia Saúde da Família coverage | 1.25** (.38) |
| TI - Hospital beds per 1,000 inhabitants | 11.51 (9.03) |
| Federal transfers (in R$10,000) | .01** (.004) |
| Ideology of the party of the Governor | -1.87 (1.89) |
| GDP per capita | 4.38** (2.01) |
| Regional Authority Index | -4.58* (2.34) |
| Lack of pluralism | -1.75 (2.16) |
| Total population (in 1,000,000) | -3.85* (1.98) |
| Area of state (in 1,000,000) | 25.51** (10.23) |
| Population density | .09 (.07) |
| Distance to Brasilia (miles) | .01** (.01) |
| $R^2$ | .83 |
| Rho | .61 |
| States | 27 |
| Observations | 189 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. TI: Territorial Infrastructure.

**Table 4.2: Determinants of Estrategia Saúde da Família implementation measured as coverage as a percentage of total Population. Prais-Winsten Panel Corrected Standard Errors (PCSE).**

| Estrategia Saúde da Família | PCSE |
|---|---|
| Opposition Parties | 1.38 (.90) |
| Legacy- Hospital Beds' per 1,000 inhabitants | -8.30* (4.47) |
| TI – High Schools | .02* (.01) |
| Federal Transfers (in R$10,000) | .003** (.001) |
| Ideology of the party of the Governor | -1.56 (1.08) |
| Poverty Rate | -.001 (.13) |
| GDP per capita | -.33 (.52) |
| Regional Authority Index | 2.29** (.78) |
| Lack of Pluralism | -.93 (.57) |
| Total Population (in 1,000,000) | -2.42** (.74) |
| Size of State (in 1,000,000) | -14.21** (2.56) |
| Population density | -.01 (.02) |
| Distance to Brasilia (miles) | .01* (.01) |
| $R^2$ | .68 |
| Rho | .93 |
| States | 27 |
| Observations | 297 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. TI: Territorial Infrastructure

Tables 4.1 and 4.2 present the regression results of the implementation of the two national Brazilian policies analyzed in this dissertation: Bolsa Família and Estrategia Saúde da Família, measured in coverage as a percentage of the targeted population. In terms of the conditional cash transfer Bolsa Família (table 4.1), previous analysis have shown that policy recipients clearly identify where the policy was coming from (Hunter and Power 2007; Zucco 2013). Accordingly, higher levels of opposition between the state and the national government decrease the level of coverage as a percentage of the targeted population. A one unit increase in the level of opposition, from the governor's and president's party being the same to only sharing one party in their coalition, significantly decreases coverage by around 2.88 percentage points. In 2010, a 2.88 percent would translate into around 12,884 families per state.

Structural variables also show expected results. Policy legacies measured as coverage of previous policies enhance the implementation of Bolsa Família, although its effect is not statistically significant. This may be related to the fact that previous policies were narrowly targeted to the extreme poor, and therefore their effect was too small to be significant. In the case of the health policy (Estrategia Saúde da Família), its effect on Bolsa Família's coverage is also positive and significant. Estrategia Saúde da Família health teams, and particularly health agents in the community, have an important role in the expansion of Bolsa Família and the fulfillment of conditionalities (Souza 2012).

Territorial infrastructure enhances the implementation of Bolsa Família. Increases in the quantity of hospital beds per 1,000 inhabitants improves the implementation of Bolsa Família in more than 11 percentage points, but its effect is insignificant. In addition, an indirect measure of territorial infrastructure or state capacity – transfers to states and municipalities – also predicts better implementation. An increase in roughly US$5,000 (R$10,000) in federal

transfers to states and municipalities, increases coverage in 0.01 percentage points, or 44 families per state in 2010.

The main alternative explanations to the successful implementation of Bolsa Família are statistically insignificant. In particular, ideology of the party of the governor has no significant effect on the implementation of Bolsa Família. Increases in the level of state pluralism (or subnational democracy) is also insignificant for predicting changes in the outcome variable.

Table 4.2 shows the factors that shape the implementation of Brazilian primary health policy, Estrategia Saúde da Família. Partisan alignments do not statistically significantly affect the implementation of this policy given that users of the service do not identify which territorial level is responsible for its provision – 78 percent of the 45 users interviewed by the author did not know where the policy was coming from and 15 percent answered that it came from the municipal government. Services such as those provided by this policy have more blurred attribution of responsibility than conditional cash transfers such as Bolsa Família. In addition, Estrategia Saúde da Família has been implemented in Brazil for two decades, a fact that further contributes to this fact. As a result, opposition parties appear insignificant in the regression.

In agreement with the theoretical framework, the existence of previous high complexity centers, measured as hospitals beds per 1,000 inhabitants, are in direct opposition to the implementation of the primary health policy. Therefore, the higher the presence of hospital provision, decreases the coverage of Estrategia Saúde da Família. The negative effect of policy legacies is also captured in the negative sign of the statistically significant coefficients of total population and size of the state. Given that high complexity health systems are generally more developed in larger states (in terms of area and population), it is expected that

the larger the state the more difficult it will be to implement this primary health policy, a topic that will be further developed in chapter 6.

Strong territorial infrastructure, measured as the amount of high schools in the territory, is positive and statistically significant. Schools are used as a place where information on this health policy is distributed, and special activities funded by this policy take place in schools through the program *Programa Saúde na Escola* (Health at Schools). As a proxy of territorial infrastructure, federal transfers statistically significantly predict increases in the health policy coverage.

As is the case in Bolsa Família, the main alternative explanations appear insignificant in this regression. In particular, ideology of the party of the governor, level of subnational democracy, and GDP per capita are insignificant for predicting coverage in the primary health policy.

Tables 4.3 and 4.4 show the determinants of successful social policy implementation in Argentina for conditional cash transfer Asignación Universal por Hijo and health policy Plan Nacer. For the former, the national government successfully claims credit, and therefore the effect of opposition parties is significant and negative. Conversely, party alignments are insignificant in the health policy, for which attributability is blurred.

**Table 4.3: Determinants of Asignación Universal por Hijo implementation measured as coverage as a percentage of people with unsatisfied basic needs (2009-2012). Prais-Winsten Panel Corrected Standard Errors (PCSE).**

| | PCSE |
|---|---|
| Opposition Parties | -2.26* (1.26) |
| Legacy- Plan Jefes y Jefas de Hogar Desocupados (2002-2012) | -.001** (0.00) |
| TI – Paved Roads | .33** (0.11) |
| TI – Community Centers | .70** (0.17) |
| TI – Gas Network | .19 (0.19) |
| Provincial Taxes (in AR$10,000,000) | -.01 (0.01) |
| GDP per Capita | -.28 (0.27) |
| Regional Authority Index | .79 (1.31) |
| Lack of Pluralism | 3.20 (2.15) |
| Size of Province (in 1,000,000 miles) | 20.89 (13.19) |
| Distance to Buenos Aires (miles) | -.02 (0.02) |
| $R^2$ | .74 |
| Rho | .38 |
| Provinces | 24 |
| Observations | 119 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. TI: Territorial Infrastructure.

**Table 4.4: Determinants of Plan Nacer implementation measured through government's indicator of percentage of coverage of medical practices (2007-2012). Prais-Winsten Panel Corrected Standard Errors (PCSE).**

| | PCSE |
|---|---|
| Opposition Parties | .30 (0.83) |
| Legacy-Asignación Universal por Hijo | .09** (0.02) |
| TI – Births Attended by Professionals | .96** (0.46) |
| TI – Paved Roads | .01 (0.09) |
| TI – Gas Network | -.07* (0.04) |
| Provincial Taxes (in AR$10,000,000) | .002 (0.002) |
| GDP per Capita | -.10 (0.12) |
| Regional Authority Index | -3.07 (1.98) |
| Lack of Pluralism | -2.00 (1.23) |
| Size of Province (in 1,000,000 miles) | -3.79 (9.57) |
| Distance to Buenos Aires (miles) | .01 (0.01) |
| $R^2$ | .93 |
| Rho | -.11 |
| Provinces | 24 |
| Observations | 119 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. TI: Territorial Infrastructure

Regarding Asignación Universal por Hijo, 90 percent of the 63 eligible policy recipients who the author interviewed identified the national government as responsible for this policy. Since the federal government can successfully claim credit for this policy, it follows that partisan alignments have a significant effect on its implementation. This is confirmed in the regression analysis. A one unit increase in the level of opposition, from a governor fully aligned with the president to a governor that changes her position, decreases the successful implementation of Asignación Universal por Hijo in 2.26 percentage points, or almost 3,300 children per province in 2014.

Policy legacies, measured as implementation of the previous workfare national program Plan Jefes y Jefas de Hogar Desocupados shows expected results. The government announced the discontinuation of this workfare program and the beneficiaries shifted to Asignación Universal por Hijo, if they still needed income support. Therefore, increases in coverage of this employment program decrease the coverage of Asignación.

Stronger territorial infrastructure also predicts increases in this policy's coverage. The building of one community center (*Centro de Integración Cominitaria,* CIC) in the territory increases the coverage of Asignación in around 0.7 percentage points or more than 1,000 children per province. Community centers located in municipalities are particularly relevant for the implementation of Asignación because they are the place where the community meets by combining a health center, day-care, and all-purpose rooms. As a result, they are a place where information about new policies flow and they also provide healthcare for the fulfillment of Asignación's health conditionalities. In addition, paved roads are also an accurate indicator of infrastructure in the territory. A one percentage increase in the quantity of national roads that are paved increases the coverage of Asignación in 0.33 percentage points.

Finally, alternative explanations such as decentralization, level of provincial democracy, and GDP per capita are insignificant for predicting the successful implementation of Asignación Universal por Hijo.

Table 4.4 shows the regression results for Argentina's health policy Plan Nacer. As a health service, this policy is not clearly attributed to any government level. In personal interviews with Plan Nacer potential recipients, 64 percent of 47 respondents did not know where the policy was coming from.[56] In fact, recipients do not even identify that they are beneficiaries of this policy because federal transfers are directed to health centers and not to individuals. As a result, policy recipients probably do not reward anyone for this policy and even if they wanted to reward someone, they would probably not know who to reward. Therefore, there is no incentive for opposition provinces to impede the full implementation of this policy. This is reflected in the regression results, which shows that the level of opposition of the governor is statistically insignificant for predicting changes in Plan Nacer's coverage.

It should be noted that since Plan Nacer transfers fund both primary and high complexity health centers, there are no negative policy legacies coming from hospitals, which is different to the Brazilian health policy analyzed above. Among the main positive legacies, the implementation of Asignación Universal stands out, which appears positive and statistically significant in the regression. As part of the conditionality for receiving the universal family allowance, recipients need to develop health check-ups and therefore the actual coverage of Plan Nacer increases. Since the implementation of Asignación in 2009, Plan Nacer's national coverage has increased in 50 percent (Argentina 2012c).

[56] Potential beneficiaries are users of the public system. All interviews were conducted at primary health centers or public hospitals.

Territorial infrastructure measured through percentage of births attended by professionals statistically significantly increases the implementation of Plan Nacer. In fact a one percentage increase in the births attended by trained personnel increases Plan Nacer coverage in almost one percentage point. The alternative measures of territorial infrastructure –the percentage of internal roads that are paved and the reach of the gas network – are surprisingly statistically insignificant or show unexpected results. Finally, as is the case in Asignación, decentralization, provincial democracy, and GDP per capita are insignificant for predicting changes in the implementation of Plan Nacer.

**Conclusions**

This chapter has statistically tested the main argument of this dissertation: partisan alignments matter for social policy implementation when the policy is easily attributable to a particular government level. States and provinces opposed to the president's party are interested in hindering upper level policies when recipients of the policy can identify where the policy is coming from and thus reward that party or government level in elections. Clear attributability is generally more salient in conditional cash transfers compared to social services. Therefore, partisan alignments statistically significantly predicted lower levels of coverage as a percentage of the targeted population in the cases of Asignación Universal por Hijo and Bolsa Família, policies which can be attributed to the national government. In the cases where the policies could not be attributed to any government level, such as health services Plan Nacer and Estrategia Saúde da Família, partisan alignments were insignificant. The statistical analysis has also shown that territorial infrastructure and policy legacies also shape the multilevel process of social policy implementation.

The next chapters will tests these hypotheses through case study analysis of the national policies analyzed in this dissertation: conditional cash transfers Asignación Universal

por Hijo and Bolsa Família, and health policies Plan Nacer and Estrategia Saúde da Família. While the next chapter analyzes the cash transfers, chapter 6 focuses on the health policies. These two next chapters will include in-depth studies of the process of implementation of these policies throughout two states and four municipalities in Brazil and two provinces and four municipalities in Argentina.

# CHAPTER 5: NON-CONTRIBUTORY CASH TRANSFERS IN ARGENTINA AND BRAZIL. THE ROLE OF PARTISAN ALIGNMENTS IN ATTRIBUTABLE POLICIES.

This chapter analyzes the mechanisms through which partisan alignments shape the successful implementation of non-contributory cash transfers in Argentina and Brazil, when the government responsible for the policy (what here is referred to as "attributability") is clear. The main argument is that partisan alignments matter for the implementation of social policies, but only when there is clear attribution of responsibility. When recipients can identify the national government as the source of a popular policy, and therefore reward it in the elections, opposition subnational units will hinder the policy's implementation. In addition, territorial infrastructure and policy legacies also shape the successful implementation of non-contributory cash transfers.

The authority to provide social protection in Argentina and Brazil is shared among the national, intermediate, and local levels of government. Each territorial unit can fund, design, and implement its own non-contributory cash transfer. The focus of this chapter is on Argentina's *Asignación Universal por Hijo* (Asignación, or Universal Child Allowance) and Brazil's *Bolsa Família* (Family Allowance) and the ways these two national-level programs interact with subnational policies. This chapter focuses on two provinces (Mendoza and San Luis) and four municipalities (Las Heras and Godoy Cruz in Mendoza, and San Luis City and Villa Mercedes in San Luis) in Argentina, and two states (Rio Grande do Sul and Goiás) and four municipalities (Porto Alegre, Canoas, Goiânia, and Valparaiso de Goiás) in Brazil. These cases have similar levels of GDP per

capita and population density but different partisan alignments to the national and intermediate governments.[57]

While Asignación is designed, funded, and implemented by the national government, Bolsa Família is designed and funded by the national government but implemented by municipalities. The role of partisan alignments is stronger in the implementation of Argentina's Asignación than in Brazil's Bolsa Família. This is in part because partisan alignments are more blurred in Brazil – the party system is more fragmented and therefore national and subnational governments form coalitions to win elections, and these coalitions vary at the national, state, and local levels. Thus the same party can be aligned with another party at a given territorial level and in opposition to that same party at another level (Krause and Alves Godoi 2010; Peixoto 2010; Ribeiro 2010). This high level of party fragmentation also contributes to blurring clear attribution of responsibility (Powell and Whitten 1993), thus further weakening the effect of partisan alignments. In addition, and as is the case in Argentina, the effect of partisan alignments is stronger when a given social policy is initially launched. Bolsa Familia began in 2003, six years before Argentina's Asignación in 2009. Finally, at least since 2012, attribution of responsibility in Bolsa Família is becoming less clear, in part as a result of an active strategy from the federal government to share credit with subnational levels of government; a point analyzed in this chapter. For all these reasons, we should expect partisan alignments to have a weaker role in Brazil than in Argentina on the successful implementation of these conditional cash transfers. With these caveats in mind, subnational units controlled by opposition parties have hindered the implementation of both Bolsa Família and Asignación, including providing direct policy competition and through raising bureaucratic obstacles.

[57] For a thorough description of case selection, see chapter 3.

**Asignación Universal por Hijo – Clear Attributability**[58]

Asignación was created in 2009 by presidential decree as an addition to the contributory family allowance.[59] It is a broadly targeted cash transfer program of around US$75 per child per month, up to a maximum of five children per family, and to pregnant women after the third month of pregnancy (Argentina 2011c).[60] It covers every unemployed or under-employed person (also including single taxpayers and domestic service)[61] earning less than the monthly minimum salary (roughly US$480) with children under the age of 18 or handicapped children. It is paid to the parents or legal guardians. While 80 percent of the total sum is paid through an ATM, the other 20 percent is in a bank account transferred at the end of the year and contingent upon health check-ups, vaccination, and school attendance.[62]

This policy centralizes the responsibility to provide social protection in the hands of the federal government (Mazzola 2012, 107). The national institution in charge of signing-up recipients and of administering cash transfers to bank accounts is the *Administración Nacional de Seguridad Social* (National Social Security Administration, Anses). In all provinces and major

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[58] Asigación includes both child allowance (Argentina 2009) and pregnancy allowance (Argentina 2011c).

[59] Asignación covers those children who are not part of the contributory family allowance system (Law 24,714), and who do not receive any other government cash transfer. Both contributory and non-contributory family allowances are administered by the national social security institution, Anses (Roca 2011).

[60] Official exchange rate US$1=$6 Argentine pesos, as of November 20, 2013. All conversions are taken at this rate. ANSES. "Asignación Universal por Hijo" http://www.anses.gob.ar/destacados/asignacion-universal-por-hijo-1 Accessed November 20, 2013. The value of the transfer has been increased following changes in the highest level of the federal contributory family allowance system (Goldar 2012, 21; Mazzola 2012, 49; Observatorio de Seguridad Social - Anses 2011).

[61] Single tax system taxpayers, self-employed taxpayers, or *monotributistas* refer to people who pay taxes for their small businesses or as individuals.

[62] Health conditionalities are covered through the health policy analyzed in chapter 6, namely Plan Nacer (Argentina 2011c, Art. 14). This means that recipients of Asignación with young children and pregnant women have to be part of Plan Nacer.

towns, Anses offers direct services for Asignación through *Unidades de Atención Integral* (Integrated Assistance Unit). The national government also fully funds this policy through annual earnings from the Sustainability Guarantee Fund of the public pension system and from general social security income from wage contributions and earmarked taxes (Bertranou and Maurizio 2012, 3). Provinces and municipalities do not have a legal role in the implementation of the policy, although they contribute by participating in health and education conditionalities, which are mostly in charge of provinces. Compliance with conditionalities has been loosely enforced.[63] In addition, provinces and municipalities play an unwritten role in the implementation of this policy. They can choose to actively support, hinder, or be indifferent to it, and their decision helps determine success in implementation of this policy.

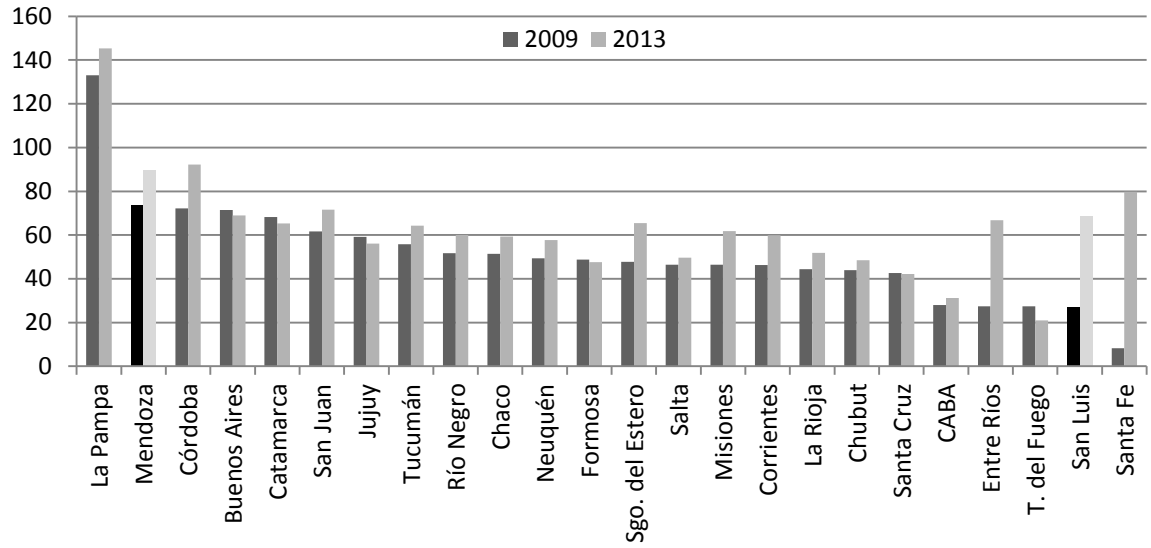
Attributability is clear for recipients. Ninety percent of the 63 eligible recipients who were asked the questions "Where do you think this policy comes from? or Who do you think funds it?" identified the provider of this policy as the federal government. The answers varied, including things like: "Cristina," "Kirchner," "The President," "the national government," or "Buenos Aires." Along the same lines, a recent report published by the Argentine Ministry of Education, reproduced a conversation between a mother and her daughter in the province of Buenos Aires, as they were withdrawing Asignación money from an ATM (Argentina 2011b, 35):

- Mom, Who is paying for this?
- Cristina, my child, she is helping us – the mother answers
- But, Why? If you work…
- She helps us so that you can go to school. Besides, the money I earn from ironing clothes is not enough.

[63] Compliance is monitored through the *Libreta Nacional de Seguridad Social, Salud y Educación* (Notebook for Social Security, Health and Education)(Bertranou and Maurizio 2012). Although normatively recipients could lose the entire transfer if they do not comply with conditionalities (Argentina 2009), currently only the 20 percent is withheld.

As a consequence of this clear attribution of responsibility, opposition subnational units have an incentive to hinder the implementation of this policy. Figure 5.1 shows levels of coverage in 2009 and 2013 as a percentage of people living with unsatisfied basic needs, according to 2010 Census, as a proxy of the targeted population. Since there are people who are not included in the "unsatisfied basic needs" category, yet earn less than the minimum salary and therefore qualify for the policy, coverage reaches levels higher than 100 percent.

**Figure 5.1: Asignación coverage in 2009 and 2013 as a % of people living with unsatisfied basic needs in 2010.**




Sources: Anses (2013) and Instituto Nacional de Estadísticas y Censos (2010)

The two provincial case studies, the aligned Mendoza and the opposition San Luis, exhibit different values for the dependent variable when the policy was launched in 2009.[64] While the aligned province of Mendoza reaches more than 70 percent of the targeted population in the first months, the opposition province of San Luis reaches less than 30 percent of the targeted population. This difference was in part a product of the active promotion of the policy

[64] Partisan alignments in these two provinces have been roughly constant since the left segment of the Peronist Party (*Frente para la Victoria)* won the presidency in 2003. For a description of the political trajectories in the selected provinces and municipalities, see chapter 3 on case selection.

by Mendoza and the hindering of the policy by San Luis. By 2013, Mendoza covered almost 90 percent of the targeted population and San Luis reached almost 70 percent – that is, the gap in coverage between the two provinces still existed but it had been reduced. As will also be clear in the analysis of Bolsa Família, subnational resistance to more universalistic policies is more effective during the initial years after implementation.[65] After some time, the subnational units can no longer bear the costs of resisting broadly targeted policies, and their efforts are less effective because the policy becomes widely known. The next section explains the mechanisms through which each subnational unit hinders or enhances the implementation of Asignación, including an analysis of these mechanisms at the provincial and municipal levels.

### *Partisan Alignments and Territorial Infrastructure*

*Province of San Luis*

The opposition province of San Luis hinders the implementation of Asignación with both bureaucratic obstacles and direct policy competition. To begin, the province refused to share lists of beneficiaries of provincial social policies. This imposes a challenge to the implementation of Asignación, since the national government determined that this policy is incompatible with the principal provincial workfare program, *Plan de Inclusión Social* (Social Inclusion Program, PIS; *El Diario de la República, San Luis* 2009). Given the incompatibility between the two policies, people living in the province of San Luis and recipients of Asignación have to deal with an extra formality: every six months they have to present a certificate of negativity, a proof signed by

[65] Following Pribble (2013), Asignación is coded as a moderate universal policy, given that eligibility criteria are broadly defined. There is no political manipulation in its implementation, and there is equality with the contributory system in the size of the transfer, but financing partly through the nationalized pension funds is unsustainable. See Appendix 3.1 for a description of coding criteria for the level of universalism in policies.

both Anses and the Provincial Department of Social Development,[66] located in the capital of the province, that shows they are not beneficiaries of the provincial workfare program. This means that every six months, Asignación is cancelled and it can only be re-activated after each recipient provides this piece of paper. The Coordinator of the provincial program explained this situation in a personal interview:

> It is ridiculous what the national government makes us do, I have two people working exclusively signing these certificates of negativity…The national government wanted us to share with them the databases of all the beneficiaries of provincial programs; and we will not give them that information…You never know what they [the national government] can do with that information (Interview Di Cristófano).

The decision to not share the databases, and therefore the need to present extra paperwork every six months imposes a challenge for every recipient of Asignación in the province of San Luis. These challenges are worse for those recipients who do not live in the capital city, where the provincial Department of Social Development is located. Recipients throughout the province have to travel to the capital city every six months to avoid the cancelation of their cash transfer. The representative of Anses in the City of Villa Mercedes remembered the difficulty that recipients faced to travel the 62 miles that separate Villa Mercedes from the City of San Luis: "For us it was even more difficult because the certificate of negativity was only handled in the City of San Luis. Therefore, these people who were unemployed, had to go all the way to the city" (Interview Medaglia). More than one year after Asignación was implemented, a representative of the provincial program started providing certificates also in Villa Mercedes, but not in other municipalities.

[66] For clarity purposes, I call Department of Social Development to the institution in charge of providing social assistance at the provincial, state, or municipal levels. However, this institution is called differently throughout each particular subnational unit.

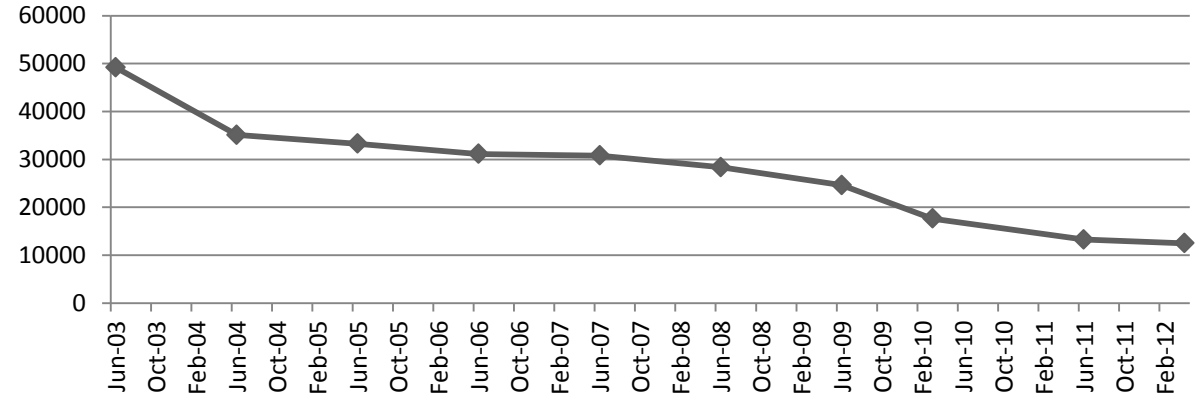
Besides from not sharing the databases of recipients, the principal way San Luis hinders the implementation of Asignación is by providing direct policy competition through the provincial workfare program, Plan de Inclusión Social, which has existed since 2003. Recipients of this program work six hours per day, five days a week, in exchange for a monthly stipend of US$142 (in 2012). The majority of beneficiaries work planting trees by the road, in public safety activities, in health centers, schools, or municipalities. This policy is fully designed and funded by the province, representing 20 percent of the provincial budget in 2003, and around three percent in 2012 (Interview Rodriguez Saá).

From the 22 recipients of this workfare program whom I asked whether they would change to the national Asignación, none of them answered positively.[67] One of the justifications for this answer was that, after comparing the two programs they realized they would lose money. In the words of a woman who had been a recipient of the provincial workfare program since 2003, "It is not in my best interest to change. Here [with the provincial program] I earn 855 pesos and there [with the national program] I would earn 200 pesos" (Interview Argentina #44). Other interviewed recipients answered that they did not have enough information about the national program to make an informed decision, and other recipients responded that either they did not qualify for the national policy because their children were older than 18, or they actually enjoyed participating in the workfare program, in part because there was the promise of a potential permanent position.

The following figure shows total levels of coverage of the provincial workfare program from 2003 to 2012. From covering almost 50,000 people in 2003, the policy has been drastically reduced to cover only around 12,500 in 2012, as figure 5.2 shows.

[67] In addition, when I asked them who was responsible for this policy, 20 (out of 22) referred to the provincial government, most of them directly referring to the former governor and creator of this policy, Alberto Rodriguez Saá.

**Figure 5.2: Total coverage of Plan de In**




**clusión Social (2003-2012).**

Source: Ministerio de Inclusión Social, San Luis (2012)

The rapid peak of 50,000 recipients soon after the policy was implemented in 2003 reflects the fact that the province of San Luis has almost monopolistic control of its territory. The province does not coordinate with any other institution to implement the provincial policy – neither municipalities, NGOs, nor community leaders (Interviews Alberto Rodríguez Saá, Russo, Di Cristófano, Tula-Barale, Nieto). A former governor's principal advisor on the program, remembered: "We reach the entire province; the whole territory of the province…without any help…the province goes directly and individually to each person" (Interview Bailac). This direct territorial control is strengthened every month at the moment of payment, when all high-ranking provincial officials are in charge of personally handing out the checks in different locations of the province. In the words of the same advisor: "If the person who had to receive the check was sick and could not attend, I went to the hospital to pay her…we generated a solidarity network, town by town, district by district…Each of us paid to around 300-400 people…and the day that you received your check, nobody worked and they went home" (Interview Bailac).

As a non-pluralistic political regime (Giraudy 2009; Gervasoni 2010b) embedded in a system that empowers provinces (Gibson 2012, 75), authority is centralized in the province. The

province of San Luis is therefore the main actor when it comes to hindering the implementation of national policies. Municipalities and civil society organizations are overall irrelevant when it comes to the implementation of national policies, in part because they are weakened by the province.[68] In particular, municipal social development departments are poorly funded and have a marginal role. With that caveat in mind, municipalities are part of the story in the implementation of Asignación, since the national government implements the policy in San Luis through representative Anses offices, located in major municipalities. When comparing municipalities, the functioning of Anses in the aligned city of San Luis is more active than in the opposition city of Villa Mercedes.[69] While Anses in San Luis City has had an active territorial strategy, the Villa Mercedes office has a more passive role (Interviews Témoli, Medaglia).

In San Luis City, the branch of Anses attempts to articulate with churches, NGOs, members of the community, and the municipal government to take Anses to the poorest neighborhoods every week. These activities are promoted on Facebook, Twitter, and local radio stations not affiliated with the provincial government. Nevertheless, these organizations are weak and such coordination attempts are less than successful. In particular, the overwhelming control of the provincial government throughout the territory, including newspapers and radio stations, makes it challenging to reach the population (Interviews Témoli, Di Chiacchio). In addition, when this branch of Anses tries to reach the population outside of the municipalities aligned with the national government, the job is even more challenging. In the words of the

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[68] Stepan (2001) studied the ways in which authoritarianism weakened the organized working class during bureaucratic authoritarian regimes in Argentina, Brazil, Chile, and Uruguay.

[69] There are two branches of Anses in the province of San Luis - one in Villa Mercedes (in charge of four departments) and one in the City of San Luis (in charge of five departments), and they divide the area of the province between these two offices. Unfortunately, there are no available data on levels of coverage of Asignación at the municipal level in the province of San Luis. Nevertheless, the overall result is that the provincial obstacles are too strong to overcome them through the federal presence through Anses.

Director of Anses in the City of San Luis: "We are not present in those municipalities, because most mayors are aligned with the province" (Interview Témoli).

Unlike the case of the San Luis City, where the mayor is aligned with the national government and in opposition to the provincial government, in the municipality of Villa Mercedes there is no real possibility for an opposition to the governor's party to win. Villa Mercedes is a longstanding bastion of the governor. Therefore, the role of Anses in Villa Mercedes is very limited. As a result, while Anses promoted the initial signing up to Asignación in 2009 through diffusion campaigns, it stopped engaging in an active promotion strategy after that. In particular, the branch of Anses in Villa Mercedes cannot develop cooperative relationships with the local government. In the words of the Director of Anses in Villa Mercedes: "We [Anses] have no relationship with the municipality; they ignore us to the point that we are not even included in the protocol lists… [The municipal government] has no role in Asignación because it provides no political payoff; they are constantly trying to keep the national government from interfering in the province" (Interview Medaglia). In an interview the current mayor of the city confirmed that the municipality had no role in the implementation of Asignación; and explained that the national government does not have access to this opposition municipality. "The federal government has not reached this territory…It is a political issue… They want to jump over the province…But the federal government needs to respect the province" (Interview Merlo).

*Province of Mendoza*

The province of Mendoza has been aligned with the national government since 2006, when governor Julio Cobos was part of the *Radicales-K* ("K" from Kirchner), the Radicals who supported the national government. In 2007, Cobos ran for vice president with Cristina

Kirchner, and a Peronist aligned with the federal government was elected as governor. In the words of a current Sub-Secretary of Social Development in the province of Mendoza: "We not only support the national model, we *are* the model" (Interview Alfonso). In addition to being closely aligned with the national government, another major difference separating Mendoza from San Luis is that Mendoza is among the most democratic provinces in the country (Gervasoni 2010b; Giraudy 2009). Therefore, authority is not concentrated in the province, and municipalities and organized civil society are central for understanding different levels of coverage in Asignación. This section analyzes the role of the province and municipalities, in coordination with organized civil society organizations, to explain the success in the implementation of Asignación.

Unlike San Luis, the province of Mendoza signed the original agreement in which the province shares the list of recipients of provincial programs with the national government. In this way, the national government can determine incompatibilities between Asignación and other provincial programs without imposing extra bureaucratic steps on recipients, and the federal government also gathers a list of potential recipients for the national policy. Besides signing basic agreements, the province went a step further: it adapted its provincial program to complement Asignación.

Before Asignación was enacted, the province of Mendoza had been developing a program of scholarships of US$17 per month for low income children who attended school. It was called *De la Esquina a la Escuela* (From the Corner to School). When Asignación was implemented, the province decided to provide this scholarship (which was defined by the national government as incompatible with Asignación) only to those not eligible for Asignación. The province further complements the national policy by providing tutors for children who were going back to school thanks to the national policy (Goldar 2012). In addition, the province of

Mendoza also contributes to the national policy by making sure that the population has access to national IDs needed to receive the cash transfer.[70]

Finally, the province and some of its municipalities coordinate with non-governmental organizations to shape the successful implementation of the national policy. Most NGOs that work with issues related to children in the province are organized around an umbrella organization called *Federación de Entidades No Gubernamentales de Niñez y Adolescencia* (Federation of NGOs for Children and Adolescents, Fedem). This group of organizations works to ensure that the transfers are not discretionally interrupted. For example, in 2012 Fedem, in coordination with the provincial government, realized that the cash transfer was sometimes interrupted when the adult recipient was a parent who did not live with the family, and it could only be reactivated after providing a judge with proof of residence with the child recipient. The success of this collaboration led to a change in the national legislation: there could be a change of the adult recipient without the need to go through judicial channels to prove who lived in the house with the child recipient (Interviews Manoni, Spoliansky; Goldar 2012, 109).

In the opposition province of San Luis, we saw a difference also at the municipal level, although the role of the local level was more limited in that authoritarian province. Here, in the aligned and democratic province of Mendoza, municipal governments can make a difference in the implementation of Asignación. In Mendoza, the municipal governments have a real impact in expanding coverage of the national policy (Interviews Alfonso, Miranda, Rafael Moyano, Ulises Moyano, Serú). Therefore, the next paragraphs focus on municipal variation between the two selected municipalities, Godoy Cruz and Las Heras.

[70] The aligned province of Buenos Aires has also adapted or cancelled provincial programs, and promoted the distribution of national IDs to enhance the implementation of Asignación (Mazzola 2012, 121–23)

Table 5.1 shows the level of coverage of Asignación among young people (0 to 17 years old) across municipalities in Mendoza. Las Heras scores higher than Godoy Cruz in terms of coverage of Asignación as a percentage of the young population, in part due to differences in partisan alignments. While Las Heras is aligned with the provincial and national governments, Godoy Cruz is in opposition to both. The level of coverage as a percentage of young population is a valid measure for the successful implementation of Asignación in these two municipalities, since socio-economic characteristics are comparable. The proportion of the population younger than 17 years is roughly similar across departments in Mendoza. In addition, the percentage of illiteracy among the population older than 10 years old is around one percent in both cases. In addition, five percent of the households do not have access to public sanitation in Godoy Cruz, compared to a bit more than 10 percent in Las Heras (Instituto Nacional de Estadísticas y Censos 2010).[71]

[71] The 2010 census data on the number of people living with unsatisfied basic needs by department was not publicly available as of January 2014.

**Table 5.1: Total coverage of Asignación Universal por Hijo in 0-17 years old population and as a percentage of 0-17 years old population.**

| Department | Coverage- 0-17 years old with AUH | % 0-17 years old with AUH |
|---|---|---|
| Malargue | 1037 | 9 |
| **Godoy Cruz** | **8504** | **14** |
| Rivadavia | 2893 | 15 |
| Tunuyán | 2978 | 16 |
| San Carlos | 2086 | 17 |
| San Martin | 9651 | 24 |
| Maipú | 15335 | 25 |
| Tupungato | 3588 | 26 |
| Guaymellén | 26109 | 27 |
| General Alvear | 4529 | 29 |
| **Las Heras** | **21835** | **29** |
| Luján | 13831 | 30 |
| San Rafael | 19628 | 30 |
| Capital | 8917 | 31 |
| Lavalle | 4733 | 31 |
| Junin | 5493 | 42 |
| Santa Rosa | 2642 | 42 |
| La Paz | 2225 | 57 |
| **Total** | **156014** | **26%** |

Source: Goldar (2012)

Las Heras is the only case in my analysis of Argentina in which the three levels of government are aligned. This triple alignment enhances the implementation of national social policies. Clearly, as a former governor of Mendoza and former vice-president of Argentina put it, "social programs function much better when the national, provincial, and municipal governments are all of the same political color" (Interview Cobos). In Las Heras, when Asignación first appeared in December 2009, the municipality engaged in a full-scale diffusion campaign that included promoting the policy in the community centers, and through *delegados territoriales* (territorial delegates, Interviews Serú, Quintana). The role of the municipal government was central to informing the population about this new policy, its eligibility

requirements and the documentation needed to sign-up. At present, the municipality acts as the entry point of social demands, and therefore provides accurate information to those who might have been excluded from the policy and are potential recipients. In the words of the Secretary of Social Development in Las Heras:

> When the program [Asignación] started, we needed to sign-up the community, make sure that they met the eligibility criteria to access that universal allowance right. We coordinated with Anses, we provided the territorial structure here in Las Heras…everybody participated, municipality employees, territorial delegates… and we started explaining what the policy was all about. At the beginning it was not easy like now, that you go to Anses and sign-up. At the beginning we needed to inform the majority of the people…So we organized two weeks of sign-up campaigns in different parts of the municipality, with neighborhood organizations, pensioners' organizations, centers of social and cultural development, sports clubs… in two weeks we went neighborhood by neighborhood informing everybody (Interview Serú).

The municipality combines the political will to inform citizens about Asignación and the territorial infrastructure to do so. The territorial infrastructure includes both municipal institutions (territorial delegates and community centers) and a number of allied non-governmental organizations. There are ten territorial delegates representing the mayor in each of the ten districts. The delegates are generally appointed by the mayor and are municipal agents. Their main focus is public sanitation, but they also develop social activities in the community and distribute information. A current territorial delegate explained his role in Asignación: "We went home to home to let people know the date and place when Anses would come to sign-up for Asignación, and we had a list of paperwork they had to bring that day" (Interview Quintana). The same delegate remembered that many people said they did not have national IDs, and so they worked with provincial and national institutions to distribute national IDs, a pre-requisite for receiving Asignación. These territorial delegates exist in other Peronist municipalities in Mendoza. In the words of the Sub-Secretary of Social Development in the province and former Secretary of Social Development in the Peronist municipality of Guaymallén: "The national

government reaches the territory through the provinces. Provinces through the municipalities and municipalities through delegates. They are the ones who know Pedro and Juan…and they need to be known by the community …that person is a common fellow" (Interview Rafael Moyano).

*Centros de intergración comunitaria* (Community Centers, CIC) are also part of the infrastructure in the municipality that contributes to the implementation of Asignación. Community centers are built with funds from the national government and staffed with personnel paid by the municipality. Their aim is to promote community participation in a place that combines a health center, day-care and all-purpose rooms. The current mayor of Las Heras described the CIC in the following terms: "Before the CIC, people thought that the health center had nothing to do with the day care, with a place for recreation and culture, or with a place for community debate and participation…Those who want to, can participate in the CIC…and we promote that" (Interview Miranda). There are three CICs in Las Heras alone (in the neighborhoods of Plumerillo, Algarrobal and Borbollón) and there are plans to build three more in the following years (Interviews Serú, Martínez). From the four municipal cases studied in Argentina (two in Mendoza and two in San Luis), only Las Heras has functioning CICs.

The CICs include *mesas de gestión y desarrollo local* (similar to an open community forum), where the community discusses needs and projects. Both individuals and groups participate in these roundtable discussions, including neighborhood organizations, churches, social leaders, and municipal officials, among others. These community meetings facilitate the role of the municipality both for designing local projects and for disseminating information. Among non-governmental institutions, the municipality coordinates with sport-clubs, cultural and social centers, pensioner's organization, and neighborhood organizations (Interview Serú).

In contrast to the municipality of Las Heras, the process of implementation of Asignación in the opposition municipality of Godoy Cruz can be described as indifference. High ranking officials in the municipality confirmed that Godoy Cruz does not have an active role in the implementation of Asignación, since the implementation is purely the responsibility of the national government through Anses (Interviews Cornejo, Fernandez, Salomón). In the words of the mayor of Godoy Cruz: "the municipal government has no role in Asignación. It does not have a specific role; the national government has not given us a specific role. It is a direct relationship between the beneficiaries and Anses" (Interview Cornejo). In practice, then, the municipal government in Godoy Cruz did not engage in any diffusion campaign to promote the policy, and it is not currently involved in finding new recipients for the policy. It should nevertheless be noted that Godoy Cruz, and most municipalities throughout the country, could not provide policy competition the way that the opposition province of San Luis does. This is because municipalities, as might be expected, are weaker than provinces throughout Argentina, both in terms of formal authority and actual access to resources (Gibson 2012; Hooghe et al. Forthcoming).

The lack of a desire to enhance Asignación in Godoy Cruz that stems from partisan opposition is combined with a weaker territorial infrastructure in the municipality, compared to that of Las Heras. First, the position of a territorial delegate does not exist in this municipality. In the words of a former mayor of Godoy Cruz when asked about territorial delegates: "We [Mendoza] have 18 departments, and 18 Mayors, and that's it" (Interview Biffi). Second, there are no functioning CICs in the municipality, mainly due to local resistance to this federal

initiative (Interviews Berrios, Cornejo, Lecaro, Salomon).[72] Finally, the articulation with neighborhood organizations is not effective.

The municipal government engages in some minor social assistance activities such as distributing food and clothes through what is called *efectores* (providers); that is NGOs located in the poorest areas of the municipality, where the municipal government is not present. The Secretary of Social Development in Godoy Cruz expressed her dissatisfaction with these providers in a personal interview: "the model with providers does not give me hope… I would like to conduct direct intervention in these places…because we [the municipal government] are not reaching those who need it the most" (Interview Fernandez). Interviews with leaders of these NGO providers and with high-ranking municipal authorities (Interviews Cornejo, Fernandez, Reales), confirmed the lack of significant support from the municipality to these institutions. The Co-Director of the main NGO in the municipality of Godoy Cruz, Coloba, explained that the institution is located where there is a complete absence of the state: the municipality is not present in the territory and Coloba does not articulate permanently with the municipality (Interview Reales). Such institutions do not receive significant funds from the municipality and they do not report to the mayor in any respect (Interviews Bautista, Cornejo, Reales,).

### *Policy Legacies*

Overall, partisan alignments and territorial infrastructure at the provincial and municipal levels shape the successful implementation of Asignación. The role of positive policy legacies is more limited because previous national policies were narrowly targeted and did not develop the institutional capacity to ensure compliance with requirements related to health and education

[72] The only CIC in the municipality is located inside a hospital and was not functioning in 2012.

conditionalities. In addition, provincial programs were either very narrowly targeted in Mendoza or were in direct opposition to Asignación in San Luis, thus providing a negative legacy in the latter.

A number of previous national social assistance programs were the precursors of Asignación, and transferred most of their recipients to the new policy. Most notably, 40 percent of Asignación coverage in 2009 came from direct transfers from *Jefes y Jefas de Hogar Desocupados* (Unemployed Heads of Households, PJJHD or Jefes) and *Famílias por la Inclusión Social* (Families for Social Inclusion or Familias). These two programs provided a basic coverage (Basualdo 2010, 8–9; Bertranou and Maurizio 2012, 3; Bertranou 2010, 19; Mazzola 2012, 114).[73] Jefes was a workfare program implemented in 2002 and targeted to unemployed heads of households, prioritizing households with children, handicapped people, and pregnant women, as well as unemployed young people with no children, and seniors over 60. Since 2004, recipients of Jefes who qualified as "unemployable" (poor women with children and pregnant women) could choose to transfer to Familias. Those recipients of Jefes considered "employable" could choose to transfer to a training program called *Seguro de Capacitación y Empleo* (Employment and Training Insurance, SCyE) (Campos, Faur, and Pautassi 2007; Cogliandro 2010).[74]

Nevertheless, these previous policies were narrowly and ineffectively targeted, and therefore their effect on Asignación was limited. In 2009, in the province of Mendoza, less than five percent of people living with unsatisfied basic needs were recipients of the national Jefes,

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[73] Plan Jefes y Jefas de Hogar Desocupados was preceded by *Programa Trabajar, Servicios Comunitarios,* and *Programa de Emergencia Laboral* in the 1990s (Chiara and Di Virgilio 2005, 133–35; Andrenacci et al. 2005, 186). Compared to all previous policies, Asignación increases the level of coverage and the amount of cash transfer (Basualdo 2010).

[74] Campos, Faur, and Pautassi (2007) evaluate Plan Familias under the light of (the lack of) social rights standards.

and around 16 percent in San Luis (Argentina 2011a).[75] In addition to these two previous cash transfers, the program *Vale Más* incorporated the use of ATM cards for cash transfers to buy food, but its effect was limited. In Mendoza, for example, it only covered around 11 percent of those living with unsatisfied basic needs and the transfer was not enough to cover the basic food basket (Ruggeri 2012, 68).

Legacies in terms of complying with conditionalities were also weak. Although Familias did have health and education conditionalities, they were not effectively monitored. Therefore, there were limited previous capacities developed at schools, health centers, or social assistance institutions to control for the compliance with conditionalities. This is in part the reason why the conditions required by Asignación have been poorly monitored. In addition, municipal institutions in charge of social development mostly conduct social assistance activities, handing out goods such as mattresses, blankets, food, clothes, and plastic to cover holes in houses, particularly after heavy rainfall.[76]

Finally, previous provincial programs leave legacies for the implementation of Asignación. In Mendoza, provincial programs covered 24 percent of the population living with unsatisfied basic needs (Dirección de Estadísticas e Investigaciones Económicas de Mendoza 2011), although these programs varied widely in type and sustainability, as explained above, the scholarship program (De las Esquina a la Escuela) complemented Asignación, but it covered only 528 children throughout the province in 2011 and the transfer was of only US$17 per

[75] The data for unsatisfied basic needs is taken from the Census (Instituto Nacional de Estadísticas y Censos 2010). There was also variation at the local level, for which there is no systematic information. In the municipality of Las Heras in Mendoza, for instance, more than 22 percent of the population living below the poverty line received a national social program (Ruggeri 2012, 60).

[76] Municipal social assistance institutions are also in charge of enrolling people for the national program of non-contributory pensions. The final decision on who receives these pensions lies with the national government.

month (Ministerio de Desarrollo Humano, Familia y Comunidad de Mendoza 2011b). Although more than half the population of San Luis living with unsatisfied basic needs was covered by the provincial workfare program (Plan de Inclusión Social) in 2009, this policy was in direct competition with Asignación (Ministerio de Inclusión Social, San Luis 2012).

Policy legacies have also been central in the expansion of Brazil's Bolsa Família, particularly through the automatic incorporation of policy recipients. In addition, territorial infrastructure through social assistance centers and councils also enhanced the implementation of this national policy. Finally, partisan alignments are central in the implementation of Bolsa Família given that recipients can identify the responsible of the policy as the national government. The next section analyzes the implementation of Brazils' main cash transfer across aligned and opposition states and municipalities.

**Bolsa Família - Changes in Attributability**

Bolsa Família is a conditional cash transfer enacted in 2003 targeted at all Brazilian families with a monthly per capita income of less than half a minimum salary (US$70) and included in a master database called *Cadastro Único* (Single Registry).[77] The transfer is conditioned upon school enrollment and minimum school attendance of 75 to 85 percent (depending on the age of the child), completion of required vaccinations, regular health check-ups (for children and pregnant women), and updating the Single Registry every two years. By early 2014, families in extreme poverty received a fixed monthly transfer of US$35; those with young children and pregnant women received a variable transfer of US$16 per child (up to five children); and families with

[77] Exchange rate US$1=R$2, as of January 24, 2013. All conversions are taken at this rate. Monthly income per capita is calculated by the sum of each family member's income divided by the total number of family members. According to 10836 law, "family is a nuclear unit, eventually expanded by other individuals connected by parentage or affinity links, forming a domestic group living under the same roof and sustained by the contribution of its members" (Brasil. Presidência da República, Casa Civil 2004, Art. 2).

teenagers (16-17 years old) received US$19 up to two children.[78] This means that the transfer varies between US$35 and US$150.[79] For these characteristics, Bolsa Família is considered as an advanced universal policy; eligibility criteria are broadly defined, there is no political manipulation in its implementation, financing is stable, and the transfer is higher than the contributory family allowance thus reducing segmentation.[80]

As a non-contributory social policy, Bolsa Família has been part of the legislation of the *Sistema Único de Assistência Social* (Unified Social Assistance System, SUAS) since 2005, by which all levels of government (national, state, and municipal) are responsible for social provision.[81] The general administration of the policy is in the hands of the *Secretaria Nacional de Renda de Cidadania* (National Secretary of Income and Citizenship, SENARC) within the *Ministério do Desenvolvimento Social e Combate à Fome* (Ministry of Social Development and the Fight against Hunger, MDS). The federal government is in charge of administering and funding Bolsa Família. In particular, it determines eligibility, sets targets, pays recipients through an ATM card, and

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[78] Ministéro do Desenvolvimento: http://www.mds.gov.br/bolsafamilia/beneficios, Accessed January 4, 2014. Since 2011, the increase in Bolsa Família transfers, its focus on children and teenagers, and the active search of new recipients is pursued within a strategy called *Brasil Sem Miséria* (Brazil with no Extreme Poverty )http://www.brasilsemmiseria.gov.br/apresentacao Accessed January 6, 2014.

[79] In 2011, the average transfer was US$60 (Baddini Curralero 2012, 19). Bolsa Família has received an investment of less than 0.4 percent of the GDP (Soares and Sátyro 2010, 33).

[80] See appendix 3.1 for a description of coding criteria for the level of universalism in policies.

[81] Previous legislation set the context for launching Bolsa Família. The 1988 Constitution raised social assistance to the same status as health, education, and pensions. The Organic Law of Social Assistance (LOAS, 1993) and the National Policy of Social Assistance (PNAS, 2003) also contributed toward the construction of a legal framework for the creation of Bolsa Família. Since 1985 Brazil's social assistance has been funded by the *Fundo Nacional de Assistência Social* (National Fund of Social Assistance, FNAS), as well as mandatory contributions from states and municipalities (Brasil. Congreso Nacional, Arts. 27-28). In addition, three previous experiences of conditional cash transfers were developed in Campinas, Distrito Federal, and Riberão Preto in 1995 and then replicated throughout the country (Bandeira Coêlho 2012, 62–66; Borges Sugiyama 2007, 94–103; Soares and Sátyro 2010, 28–30).

monitors states and municipalities through the transfer of federal funds with strings attached to them.

The federal government transfers to municipalities US$1.25 per month per Bolsa Família family to support administrative efforts, and the municipality receives a double transfer for the first 200 families that the municipality signs-up. This value is currently multiplied by the *Índice* de *Gestão Descentralizada* (Index of Decentralized Management, IGD), which varies from 0 to 1) and measures the quality of management (Brasil. Congreso Nacional, 12A; Soares and Sátyro 2010, 40).[82] The resources transferred through Bolsa Família are increasingly important for municipalities, especially for the poorer ones. In 2006, for example, Bolsa Família transfers to municipalities equaled 15 percent of all federal transfers and up to 23.5 percent in some municipalities (Da Silva e Silva and Santos de Almada Lima 2010, 86). Some of these transfers are used to strengthen municipal institutions in charge of implementing Bolsa Família, especially the Reference Centers of Social Assistance (*Centro de Referência da Assistência Social,* CRAS). This institution has been created in 80 percent of all municipalities, with the task of identifying potential recipients, of supervising the fulfillment of conditionalities, and of keeping an updated registry of poor families in the Single Registry (Amaral Rizzotti, Almeida, and Albuquerque 2010, 142; Baddini Curralero et al. 2010, 147; Baddini Curralero et al. 2010, 157). All families with monthly income per capita below half a minimum salary should be included in this registry. In

[82] The IGD takes into consideration the following indicators: quality of the Single Registry data, registry update, and information on education and health conditionalities. Only the municipalities with IGD higher than 0.5 receive federal resources in a given month, and these can be used toward the management of conditionalities, the monitoring of recipients, signing-up new families, and implementing complementary programs (Brasil no year).

this way, the registry keeps track of potential recipients of national social policies, one of which is Bolsa Família.[83]

While municipalities are central actors in the implementation of Bolsa Família, the role of states is somewhat unclear. The legislation declares that states are in charge of coordinating and training municipalities, thus giving them a secondary role, but they also have the authority to design and implement their own social policies (Brasil. Congreso Nacional, Arts. 27-28). As a result, cooperation from states is important for complementing Bolsa Família. Whether to do so is a state-level decision and is influenced by partisan alignments.

As a conditional cash transfer, attribution of responsibility is clear in Bolsa Família. The Brazilian Electoral Panel Study project conducted 4,611 interviews with 2,669 voting-age Brazilians throughout 2010, an election year. It found that six months before the presidential election 76 percent of respondents identified the federal government as responsible for the program. By the time of the election this number had risen to 84 percent (Ames et al. 2010, 37; Zucco 2013, 814). In addition, previous analyses have shown that Bolsa Família benefits incumbent presidents by increasing the performance of their party in presidential elections (Hunter and Power 2007; Zucco 2008; Zucco 2013).[84] The assumption of all these studies is that attribution of responsibility is clear. In other words: the electorate can reward presidents for Bolsa Família only because they are able to identify the national government as the main responsible for this policy.[85]

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[83] Another role of municipalities is monitoring the federal transfers through a local council. Since 2005, municipalities have been required to develop local councils, composed of government and civil society members, for monitoring the use of federal funds (Baddini Curralero 2012, 117).

[84] The electoral effect of Bolsa Família on the success of the presidential incumbent has been shown to be non-clientelistic (Sugiyama and Hunter 2013).

[85] An editorial of the local newspaper in Goiás announced Bolsa Família in the following terms: "Government programs have names and logotypes that have been carefully studied by marketing teams

Such clear attribution of responsibility partly explains why opposition subnational governments have hindered the implementation of Bolsa Família. Figure 5.3 shows levels of coverage of Bolsa Família as a percentage of the targeted population, as measured by the 2010 Census. Coverage has been lower than the Brazilian mean in the opposition state of Goiás. In this state, elected governors have belonged to the opposition parties PSDB and PP, at least since the PT won the presidency in 2003.[86] The currently aligned state of Rio Grande do Sul (with a PT governor) has scored better than the Brazilian mean and better than the opposition state of Goiás.[87]

Aside from the below-average performance of Goiás and the better performance of Rio Grande do Sul, figure 5.3 also shows a tendency toward convergence around the mean in both cases by 2008. Such convergence is caused by three sources. First, as in the case of Asignación in Argentina, the effect of the obstacles put forward by opposition subnational units diminishes through time in universalistic policies such as Bolsa Família. Subnational units do not have the resources to successfully resist national policies for a long period of time. Second, conditionalities have the effect of blurring the policy provider and therefore the potential electoral gains. Since recipients have to keep up with health check-ups, school attendance and updating of the registry, the municipal as well as the state and federal levels have some participation in Bolsa Família and can claim some credit. Last, but certainly not least, I argue that

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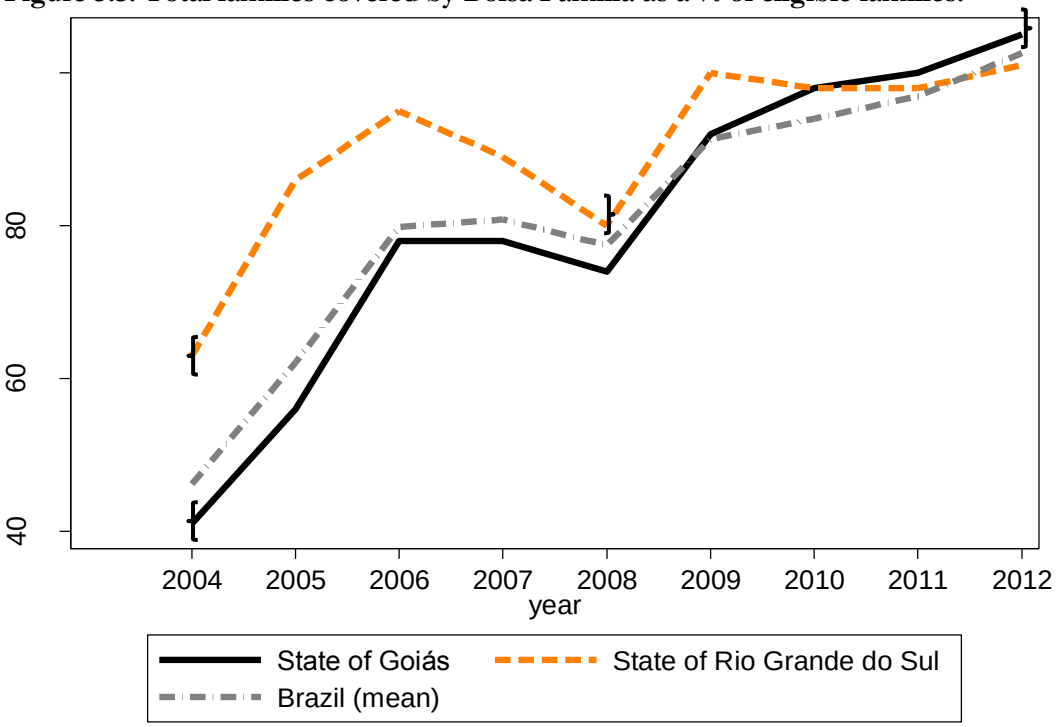
advising the government. This happens during elections at the local, state and, most importantly, federal levels. With the arrival of Lula, this sequence is repeated…The government is trying to put its own stamp on social assistance by announcing yet another program, Bolsa Família" (Weinberg 2003).

[86] The PSDB headed a coalition that included 11 parties in 2010 elections, when it competed against an alliance headed by the PMDB and the PT. The confrontation between these two coalitions at the state level has remained stable at least since 2003 (Interview Rezende Machado).

[87] The governors of Rio Grande do Sul have belonged to the PMDB (2002-2006), PSDB (2006-2010), and PT (2010-2014). Therefore, we should expect that changes in alignments affects changes in responses to Bolsa Família across time.

this convergence in coverage across states is also the result of an active strategy by the federal government to share responsibility.

**Figure 5.3: Total families covered by Bolsa Família as a % of eligible families.**[88]




Sources: Census 2010 and *Secretaria de Avaliação e Gestão da Informação* do *Ministério do Desenvolvimento Social e Combate* à *Fome*. Periods in between brackets {} represent subnational governments in opposition to national governments.

By 2011 the federal government actively asked states to develop programs or use existing programs to complement Bolsa Família, in exchange for which the logo of the state would be placed on the ATM card that recipients use every month to withdraw the funds.[89] Figure 5.4 shows an example of such ATM cards for the state of Rio de Janeiro. In addition to adding the state logo, the federal government also proposed to provide a document to each beneficiary family, where the separate contributions from the federal and state governments would be

[88] In 2009, the national targeted population was expanded from 11.1 million families (2003-2008) to 12.9 million (Baddini Curralero 2012, 92). This partly explains the increase in coverage at the national level since 2009.

[89] This very recent policy (and its effect on the diminished role of partisan alignments) is only now appearing in some of the case studies for which I conducted field research in 2012. Therefore, it does not show up in the statistical analysis of chapter 4 that covers until 2012.

shown. Although these pacts have not been completely successful, in terms of durability and scope, more states are slowly signing up (Interview Mariz de Medeiros). In 2010, only two states (both with PT governors) were part of these agreements, Acre and Distrito Federal. By mid-2012, a total of eleven states decided to sign such agreements, and some of these states were opposition states (Brasil 2012c; Brasil 2011).[90] By expanding attribution of responsibility, the federal government enhances the implementation of Bolsa Família. In the words of the National Secretary for Citizen Income:

> States have the prerogative to develop their own programs…the federal government is now offering state governments…more visibility…The problem was the identity of Bolsa Família is very strong, so now we try to divide the identity by including the state, so that their participation becomes stronger; and integration is actually increasing up to nine state pacts…We knew we had to give visibility to state governments for a joint effort, so dividing the ATM card is good because it gives more space to the partner state, making it clear that the benefit is being divided…That contributed to the fact that states led by the opposition would agree to participate (Interview Silva de Paiva).

**Figure 5.4: ATM card of Bolsa Família (front and back) with the logo of the state program in Rio de Janeiro.**


Source: Brasil (2012d)

[90] By August 2012, the following states had joined the federal government's proposal of complementing Bolsa Família with the state programs (in parenthesis): Acre (*Programa Adjunto da Solidariedade*), Amapá (*Programa Família Cidadã*), Distrito Federal *(DF Sem Miséria*), Espírito Santo (*Programa Bolsa Capixaba)*, Goiás (*Renda Cidadã*), Mato Grosso *(Programa Panela Cheia*), Rio de Janeiro (*Programa Renda Melhor)*, Rio Grande do Sul (*Programa RS Mais Igual*), Rondônia *(Programa Bolsa Futuro*), Santa Catarina (*Santa Renda*), and São Paulo (*Programa Renda Cidadã*) (Brasil 2012d).

In my own qualitative interviews with Bolsa Família recipients throughout the second half of 2012, this change in attributability has slowly started to appear in numbers. When asked about where Bolsa Família came from and who funded it, 63 percent (24 out of 38) of the respondents answered that they did not know or had the wrong answer. Inaccurate answers included: "I don't know," "from the government…I don't know which one," "from the municipality," "from the governor, "from the state government of Rio Grande do Sul," or "from the government of Iris Rezende and then Marconi Pirillo [former governors in the state of Goiás]." As attribution of responsibility progressively fades away and opens up the possibility of sharing credit, the effect of partisan alignments on the implementation of Bolsa Família is also starting to disappear. As the Coordinator of Bolsa Família in the municipality of Porto Alegre commented,

> The partisan issue does not weigh in Bolsa Família any longer, because all other parties know how to make political use of this cash transfer…Today, there is much less identification with a particular government… At the beginning, the partisan issue was important because it was directly associated with Lula's government…But in 2012, that is not the case (Interview Lúcia Souza).

The following section analyzes this transition, from a strong to a weaker effect of partisan alignments on the implementation of Bolsa Família, in the opposition state of Goiás. In the beginning the state used its state cash transfer for open competition with Bolsa Família, but in 2012 it agreed to sign a collaboration agreement with the federal government.

### ***Partisan Alignments***

*State of Goiás*

The state of Goiás has been in opposition to the federal government since the Worker's Party candidate won the presidency in 2003. The state's former and current governors have belonged to the PSDB (and PP), and to coalitions that were in opposition to the national PT. As a

consequence, Goiás originally hindered the implementation of Bolsa Família by presenting direct policy competition through its own cash transfer program called Renda Cidadã (Citizen Income) and through refusing to share the list of recipients of this state policy with the federal government. Nevertheless, as attribution of responsibility for Bolsa Família became less clear, competition gave way to cooperation. In 2012 the state signed an agreement with the federal government to collaborate with the implementation of Bolsa Família by which Renda Cidadã started complementing the national cash transfer.

That summary omits many details. To begin, when Bolsa Família was launched in 2003, the state of Goiás already had had its own non-contributory cash transfer since 2000, Renda Cidadã, which was designed, implemented, and fully funded by the state. From the beginning Renda Cidadã has been the centerpiece strategy of the state for the provision of social assistance and it has had high approval rates from the electorate.[91] It is targeted to poor families and entails a cash transfer of US$40 (raised from US$23 to US$30) paid through an ATM card, shown in figure 5.5. The funds can only be used for buying a particular list of items, including bread, milk, flower, beans, soap, medicine, and propane tanks (Faria 2005, 53; *O Popular* 2000; *O Popular* 2000; Vieira 2005, 83).

[91] The policy was announced a few months after the new PSDB governor, Marconi Pirillo, began his term in 1998. It was a way to differentiate himself from the previous opposition PMDB governorship, which had implemented a program providing baskets of food (*O Popular* 1999; *O Popular* 1999; *O Popular* 1999; *O Popular* 1999). Renda Cidadã had an approval rate of 73 percent in 2001. Therefore, in 2002 governor elections, the PMDB contender assured in the campaign he would keep the transfer (Chuahy 05-17-2002).

**Figure 5.5: ATM card of Renda Cidadã in the state of Goiás in 2008.**


Source: Estado de Goiás, Secretaria de Fazenda (2008)

Municipalities have a supervisor in charge of ensuring that the transfer is only used for buying items in the list.[92] The supervisor is appointed by the governor, generally with the approval of the mayor and the federal and state deputies from that municipality (Interviews Arantes, Lobo). This person represents the governor in the neighborhoods, and is the main channel through which the policy is implemented, thus avoiding the need to coordinate implementation with opposition groups (Interviews Abreu, Ribeiro Guimaraes).[93] In the past, the supervisor was also in charge of mobilizing recipients for political rallies in support of the governor. For its clientelistic characteristics, Goiás' Renda Cidadã is similar to Argentina's San Luis Plan de Inclusión Social, analyzed earlier in this chapter.[94]

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[92] "Five days after the transfer of funds, the family needs to present receipts, showing that they bought food and not alcohol or cigarettes" (Botão 12-25-2002). The policy also includes health and education conditionalities, which were given priority in 2009, but overall only the type of goods bought are monitored and can cause exclusion from the program (Interviews Renda Cidadã Recipients Brazil #30, 32, 55; Faria 2005, 58; Vieira 2005, 83). In addition to the cash transfer, the state provides subsidies for water and electricity bills.

[93] The state does not coordinate with municipalities for the implementation of this and other state cash transfers, particularly when municipalities are in the opposition (Interviews Accorsi, Arantes, Bezerra, De Nacimento, Edson, Lobo, Ribeiro Guimaraes). In the words of a former mayor of Goiânia: "Renda Cidadã is extremely paternalistic…they [state-level officials] go directly to the population, jumping over the municipality" (Interview Accorsi).

[94] Aside from the mobilization for rallies, Renda Cidadã's original transfer (45 reais) coincided with the ballot number of the party of the governor, and coverage was expanded during election years, and cancelled for many people in non-election years. Of the 12 interviewed Renda Cidadã recipients, 8 said that the transfer had been suspended for them at least one time. Local newspaper articles and academic

As in the Argentine opposition province of San Luis, Goiás refused to provide the federal government with the list of people included in Renda Cidadã, and banned these recipients from receiving any federal policy. To receive the state cash transfer, people could not be included in the Single Registry, a fact that excluded them from any policy that came from the federal government such as Bolsa Família. The state determined that potential beneficiaries of Renda Cidadã had to receive written proof from their municipal government stating that they were not recipients of Bolsa Família. This added a burden to municipal governments, which were dealing with the initial signing-up for Bolsa Família. Obviously, not sharing databases also excluded the national government from accessing a list of potential recipients for Bolsa Família and of fully assessing the extent of social exclusion in Goiás. The Coordinators of Bolsa Família in the municipality of Goiânia (first) and the state of Goiás (second) remembered this time of competition:

> It was very difficult because there was rivalry between programs. For the federal government, if the person was in a vulnerable situation, he or she could receive Bolsa Família. But for the state government, it asked families to not be included in Bolsa Família to receive Renda Cidadã. So, to receive Renda Cidadã, we had to give families a declaration from the municipality saying that they were not included in Bolsa Família's registry… Bolsa Família tried to have a registry of vulnerable families, but we had a large number of families that were excluded from the registry because they chose Renda Cidadã (Interview Artiaga).

> If you had Bolsa Família you could not receive Renda Cidadã … Those who had Renda Cidadã were excluded from the Single Registry…and if a person is excluded from the Single Registry it means they will be excluded from every other federal program…this was a complete des-information…it completely disoriented people (Interview Barra de Azevedo).

In order to convince people to stay in the state program, Goiás offered a higher cash transfer than Bolsa Família. In 2007, for example, Bolsa Família recipients received from US$7

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sources also document the discretionary suspension of benefits and cuts in spending (C. Borges 2007; Lettry 11-27-2009; *O Popular* 2005; *O Popular* 2011; Vieira 2005, 85).

to US$47, while Renda Cidadã offered around US$40 (*O Popular* 2007; Oliveira 2008). The state program reached a maximum of 160,000 families in 2004-2005 or roughly half of all families living with less than one minimum salary in 2002 (Estado de Goiás 2010; Faria 2005, 85; Rodriguez da Cunha 2005). Today, Bolsa Família is the preferred policy; it not only offers a higher transfer for families with children, but it also appears to be more stable in the minds of recipients. Of the 36 Bolsa Família interviewed recipients 60 percent said they thought the cash transfer would not end in the future.. For Renda Cidadã, eight of 11 recipients who were asked the same question said they thought this policy would be cancelled in the future.

Since July 2012, competition has given way to the first steps of cooperation between Renda Cidadã and Bolsa Família, although the state government is still in the hands of politicians opposed to the national government. Renda Cidadã now complements the transfer of Bolsa Família recipients to reach at least US$35. In addition, the state cash transfer covers those excluded from Bolsa Família: people above extreme poverty with no children, and particularly populations excluded from the labor market such as the elderly and the handicapped. Some say the goal in the long run is for Renda Cidadã to cease to exist (Interviews Arantes, Ribeiro Guimaraes; Silva 2012).

This transition from competition to collaboration with the implementation of Bolsa Família appears to reflect a move toward less clear attribution of responsibility, or a lesser degree to which the PT at the federal level claims credit for this policy. As explained above, this weaker attribution of responsibility is in part a result of an active strategy by the federal government (such as sharing logos in the ATM card), but also the effect of conditionalities and of the passing of time. The Planning Director at the Secretary of Social Development in Goiás expressed this shift in the following terms:

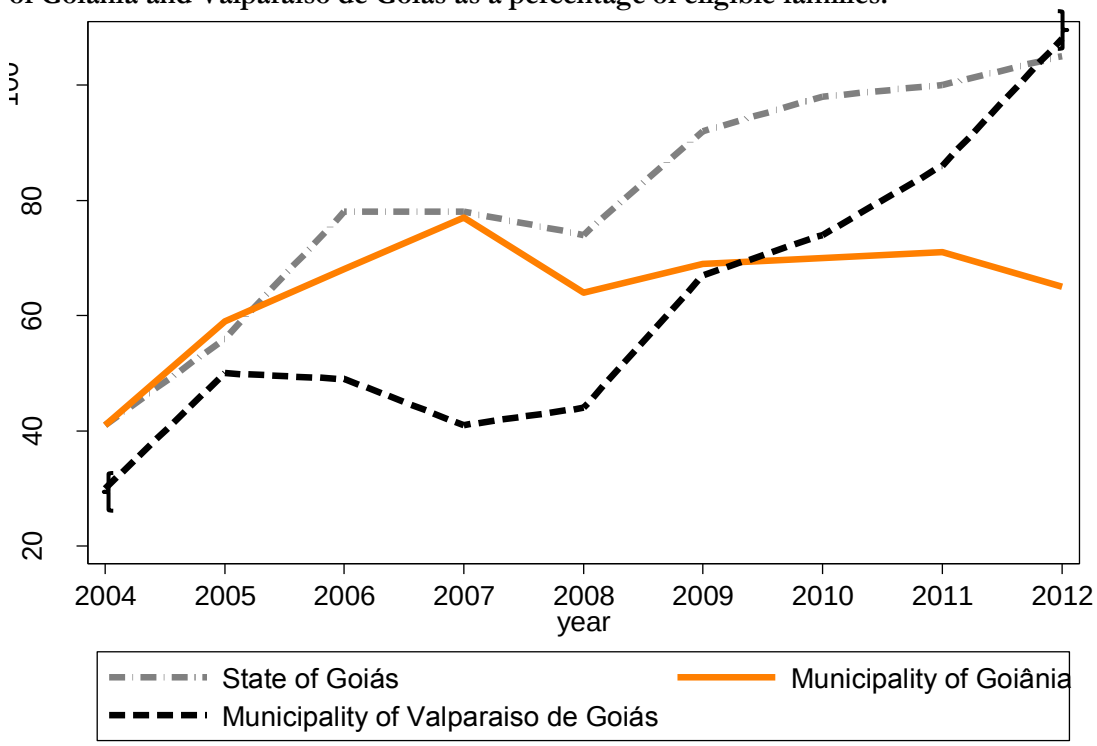
> We are now in a process of unifying both programs…which did not exist before because it was not technically or politically propitious…In Goiás, Bolsa Família has lost its

> exclusive personality as a federal program.. Nobody says that it is from Dilma [Rousseff, the current President], or from Lula [Da Silva, the former President]…it has lost that attribute…Cash transfers before were used for political gain because they were new; now it brings less political dividends than what they used to ten years ago (Interview Lobo).

This change in attribution of responsibility has also weakened the effect of partisan alignments on the successful implementation of Bolsa Família across municipalities. The municipality of Goiânia has been aligned with the federal government since 2003, and the municipality of Valparaíso de Goiás has been in opposition to the federal government and aligned with the state government. Figure 5.6 shows how the opposition municipality of Valparaíso de Goiás has consistently scored lower in the percentage of eligible people covered by Bolsa Familia than the average for the state of Goiás, and lower than the federal-government-aligned Goiânia.[95] As with the state level, this tendency starts to reverse around 2008-2009 when attribution of responsibility weakens.

[95] Given that Valparaíso de Goiás is significantly smaller (in area and population) than Goiânia, its volatility is also higher.

**Figure 5.6: Total families covered by Bolsa Família in the state of Goiás and the municipalities of Goiânia and Valparaíso de Goiás as a percentage of eligible families.**




Sources: Census 2010 and *Secretaria de Avaliação e Gestão da Informação* do *Ministério do Desenvolvimento Social e Combate à Fome*. Periods in between brackets {} represent subnational governments in opposition to national governments.

As in the case in Argentina, while states may have the resources to temporarily compete with the federal government through their own subnational policies, municipalities generally do not have this option. Opposition municipalities can hinder the implementation of national policies more by omission than by action. This figure also shows that both municipalities score lower than the average for the state, which responds to the relatively weak territorial infrastructure and negative policy legacies in both cases, which will be analyzed below.

The municipality of Goiânia has been mostly aligned with the federal government since 2003. It was led by a PT governor from 2001 to 2004 and also since 2010, and by a PMDB governor during 2005-2009 (in coalition with PT since 2008). This close partisan connection to the federal government has made Bolsa Família a priority for the local government. Goiânia was one of the few subnational governments to sign an agreement with the federal government in

2004 to help co-fund the policy through local initiatives (Licio 2012, 189). In 2006, the municipality received an award from the federal government for the implementation of Bolsa Família, called *Prêmio Práticas Inovadoras na Gestão do Programa Bolsa Família* (Innovative Practices in the Administration of Bolsa Família). The award recognizes the successful implementation of a local program that aimed to develop cooperatives among actual and potential Bolsa Família recipients; highlighting this particular experience as a possible way of incorporating these recipients to the labor market (Brasil 2006b, 92–97).

Valparaíso de Goiás has changed its political alignments since its creation as an independent municipality in 1995, but has mostly been in opposition to the national government and aligned with the state government (Interview Arimateia). As such, Bolsa Família has not been a priority for the local government until very recently. Although there are two Reference Centers of Social Assistance (CRAS) in the municipality, they have remained inactive for the implementation of Bolsa Família, which is centralized in the Secretary of Social Assistance (Interview Tabosa). This clearly has limited further expansion of Bolsa Família.[96] Figure 5.6 shows a stark increase in Bolsa Família coverage, particularly in the last year (2011-2012), but since 2008-2009. Around the time when Bolsa Família started losing its clear attribution of responsibility and the state government signed an agreement with the national government, this municipality started having a more active commitment to this policy. Every 15 days, the Secretary of Social Development moves her activities from her central office to a highly populated neighborhood (called *Santa Rita*) to cover those who were unable to come to the central office. In addition, the Secretary developed a campaign using the local television network

[96] The lack of decentralization of Bolsa Família implementation to CRAS is not necessarily negative. This municipality has almost 150,000 inhabitants, compared to Goiânia, which has more than 1.3 million. Still, the ratio of population to social assistance institutions is significantly lower in Valparaíso de Goiás.

to promote Bolsa Família (Interview Machado Freitas). The Secretary of Social Development in the municipality referred to this higher commitment:

> We increased the number of people directly working with recipients, we bought a car specifically for Bolsa Família with money from the federal government…We started making weekly visits to families…So we basically increased the service…and because service was better people started coming more…We also started disseminating more information to mothers about courses offered through Bolsa Família, so they had more incentives to sign up (Interview Tabosa).

*State of Rio Grande do Sul*

While the state of Goiás represents uninterrupted partisan opposition to the federal government, Rio Grande do Sul's alignment with the federal government has changed since the candidate of the Worker's Party won the presidency in 2003. The governor of Rio Grande do Sul had been mostly in opposition to the federal government, from then until 2010 when a PT governor was elected. Therefore, we should expect a change of commitment of the state government towards Bolsa Família since 2010. Compared to both Goiás and the national mean, the state of Rio Grande do Sul shows higher levels of coverage in Bolsa Família for most of the period. This responds in part to a strong territorial infrastructure, built upon robust civil society organizations throughout the state.

While previous governments had been mostly indifferent to Bolsa Família in Rio Grande do Sul, the commitment toward this policy became stronger since a PT governor was elected. When Bolsa Família was launched, the state was led by an opposition PMDB-PSDB coalition (2002-2006). This opposition government eliminated its cash transfer program targeted at poor families (called *Família Cidadã*, Citizen Family) that had been implemented by the previous PT governor since 1998 (Interview Nunes; Dualibi 2009).[97] Therefore, when the federal policy was

[97] Família Cidadã entailed a transfer of around US$100 and reached 100,000 families in January 2002 (Cidades do Brasil 2002).

launched, the state government remained indifferent: it neither complemented the federal policy nor provided policy competition. When an aligned PT governor was elected in 2009, one of the first measures was to create a new policy that would directly complement Bolsa Família, called *RS Mais Renda Mais Igual* (Rio Grande do Sul More and Better Income). The program targets Bolsa Família families with children in high school, and complements their transfer. Recipients of Bolsa Família who qualify for this extra transfer receive a card with the state's logo.

This complementarity began to have increases in coverage since 2013, as depicted in figure 5.3. The high level of commitment from the state in designing and fully funding this program is explained by the director of the program:

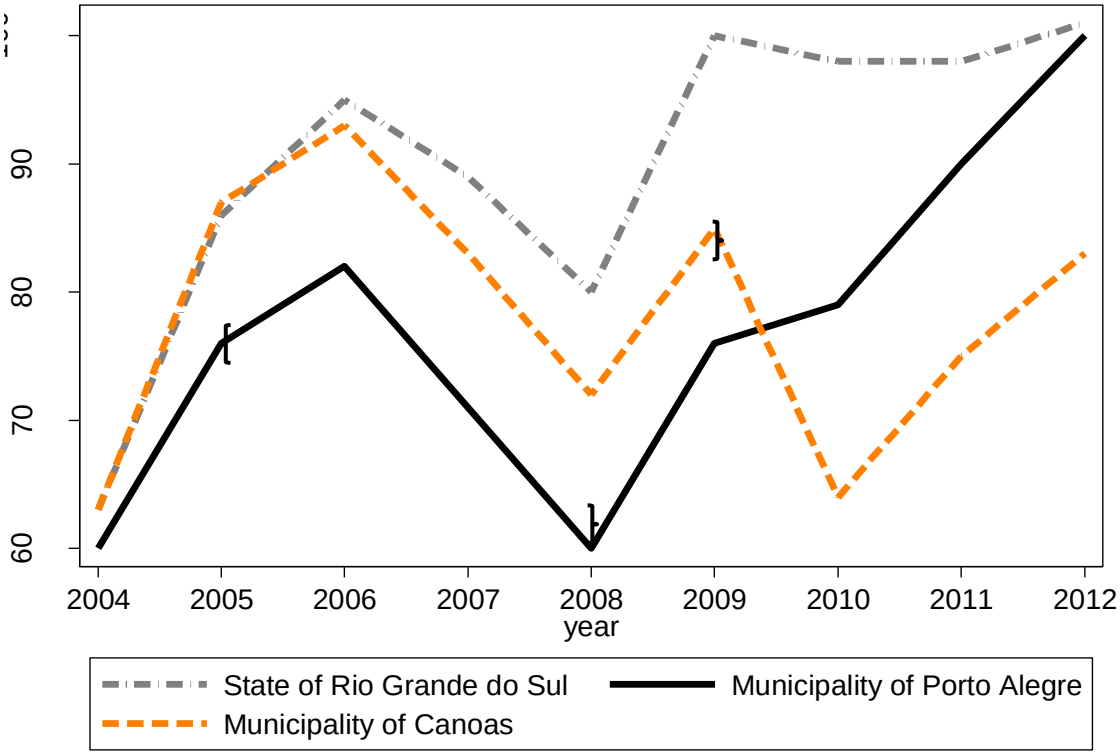
> Policies such as Mais Renda were induced by the federal government so that states could start to complement Bolsa Família. That is what we are doing here…While some states followed the federal government's suggestion, others did not…We were one of the first ones with Tarço's government [Rio Grande do Sul's PT governor]…We feel very close to the federal government, and that is why we work for the improvement of Bolsa Família…The main characteristic of the state government is our complete alignment to the federal government (Interview Bauer).

Echoing the role of partisan alignments in the implementation of federal policies, the implementation of this state program also encountered resistance in opposition municipalities and support in aligned municipalities. While the PT municipality of Canoas fully implemented the state program by informing eligible families and adding them to the Single Registry, the opposition government of Porto Alegre, the capital of Rio Grande do Sul, resisted it (Interviews Boniatti, Lúcia Souza, Mardemattos, Seadi). This is somewhat complicated by the fact the government of the City of Porto Alegre was currently in opposition to the PT at the state level but part of the PT coalition at the federal level. As a result, this local government refused to sign agreements with the state for the implementation of RS Mais Renda Mais Igual, but fully implemented Bolsa Família. According to high-level bureaucrats at the local and state levels, such resistance to the state cash transfer reflected partisan opposition, particularly throughout

the electoral year of 2012. The municipality opposed the idea of adding the state logo to the Bolsa Família ATM card, arguing that it would confuse recipients (Interviews Bauer, Lúcia Souza). A concrete effect of not signing the agreement with the state government is that those who theoretically would be in charge of signing up potential recipients for the state policy in Porto Alegre are unaware of the state program (Interviews J. Mallmann, J. Ribeiro, Velloso).

Municipalities in the state of Rio Grande do Sul are also crucial actors in the implementation of the national cash transfer. Figure 5.7 shows the levels of coverage of Bolsa Família in the municipalities of Porto Alegre and Canoas. Compared with the state and the selected municipalities within Goiás, partisan alignments across Canoas and Porto Alegre vary throughout the analyzed period. Therefore, periods of opposition to the federal government are in between brackets in the figure. Canoas was in opposition to the national government until a PT governor was elected in 2009. This is reflected in the levels of coverage, which see a significant recovery since 2010. Conversely, Porto Alegre had PT governors until 2005, when the levels of coverage were initially increasing. Since 2006, an opposition alliance between PPS (*Partido Popular Socialista*) and PMDB was elected at the local level. These changes in alignments led to a significant decrease in the levels of coverage, which jumped again in 2008, first, and 2010 with an aligned PDT (*Partido Democrático Trabalhista*) mayor. In Porto Alegre, aside from the relevance of partisan alignments, the role of organized civil society is central to explaining the increasingly strong performance of this city.

**Figure 5.7: Total Families covered by Bolsa Família in the state of Rio Grande do Sul and the municipalities of Porto Alegre and Canoas as a percentage of potential families covered.**




Sources: Census 2010 and *Secretaria de Avaliação e Gestão da Informação* do *Ministério do Desenvolvimento Social e Combate* à *Fome*. Note: Periods in between brackets {} represent subnational governments in opposition to national governments.

The municipality of Canoas switched from a weak commitment to Bolsa Família to an active participation when a PT mayor was elected in 2009. The previous opposition government did not comply with the obligation to update the Single Registry and therefore the new government did not receive federal transfers in their first year in office. In the words of the Coordinator of Social Protection in Canoas: "We did not receive transfers from the federal government in 2009 because the registry was not updated, only since 2010 have we started to reverse that situation" (Interview Mardemattos). In addition, the previous opposition government underspent the budget by around US$1,000, which was provided by the federal government for human capital development and institutional building to expand Bolsa Família (Interview Mardemattos). The previous opposition government agreed to build one CRAS in 2007, as a response to pressures from civil society groups. Nevertheless, it did not provide any

public space for building this CRAS. Therefore, the CRAS was built within a church-associated NGO called *Grupo da Ação Social Nossa Senhora Aparecida* and located in one of the poorest neighborhoods in the municipality (Interviews Pisonique, Mardemattos). The Secretary of Social Development in Canoas at the time recalled that "Bolsa Família was never a priority" for the PSDB mayor (Interview Pisonique).

Since the PT government was elected, the municipality of Canoas has shown a more active involvement with Bolsa Família along the lines proposed by the federal government (Da Silva 2011, 36). One of the ways in which this commitment can be seen is the expansion of the number of CRAS from one to five, and closing down the one located within the NGO because it did not comply with the minimum requirements for a CRAS as defined by the federal government. The CRAS in Canoas have also expanded their activities by developing an active search of new recipients, by following-up on those who were not fulfilling conditionalities, by increasing business hours, by installing internet access, and by hiring additional personnel. The new government hired professionals through a public competition, and incorporated a coordinator, two social assistants, one psychologist, and four administrators. In addition, the PT government made efforts to keep the Single Registry updated, and the transfer of funds was routinized. Finally, the new aligned government also implemented a "mobile unit," a van that could register people who live far from the CRAS, thus lowering barriers for access (Interview Mardemattos; Canoas Secretaria Municipal de Desenvolvimento Social 2009; Vieira Ferrarini, Deitos Giongo, and Silva Silveira 2010). For these improvements, since 2010 Canoas expanded coverage as shown in figure 5.7, and received a national award.[98]

[98] *Colegiado Nacional de Gestores Municipais de Assistência Social* (National Association of Municipal Social Assistance Administrations) (Da Silva 2011, 48).

The process of implementation of Bolsa Família has been different in Porto Alegre. When Bolsa Família was launched the PT municipal government modified its local cash transfer to complement the national policy, to reach a maximum total of US$100 per household. For doing so, in 2004 Porto Alegre (as Goiânia above) signed an agreement with the federal government to co-fund the policy through local initiatives (Licio 2012, 189). The local program was called *Núcleo de Apoio á Estrategia De Saúde da Família* (Support for the Health of the Family, NASF). It had been created in the late 1990s and was targeted to families in risk of domestic violence or drug addiction. Since the transfer was never updated, the program slowly disappeared. The years between 2005 and 2008, under and opposition government, were characterized by poor performance, as shown in figure 5.7. This PMDB opposition mayor had an approach of non-confrontation and of keeping only the good ideas from the PT and changing the bad ones. It did not engage in any open opposition to the federal policy (Interviews Olegario, Verle). Since 2010, the aligned PDT governor has been fully committed to the expansion of Bolsa Família by further developing the active search for potential recipients and by following-up on the fulfillment of conditionalities. This has been enhanced by the strong infrastructure across the territory.

### *Territorial Infrastructure*

Partisan alignments coupled with territorial infrastructure to explain the successful implementation of Bolsa Família. Territorial infrastructure is conceptualized in chapter 2 as government institutions along with civil society organizations in the territory, and the relationship between the two. Municipalities are in charge of implementing Bolsa Família and, therefore, the strength of social assistance institutions and civil society organizations at the local level are particularly important. While infrastructure in the state of Rio Grande do Sul is comparatively stronger than in Goiás, there is significant variation across municipalities. Within

Rio Grande do Sul, the municipality of Porto Alegre is an example of strong civil society organizations in a context of a highly inclusive local government. This results in a fruitful collaboration between government and non-government institutions for the implementation of Bolsa Família. The neighboring municipality of Canoas lags behind due to the combination of weak municipal social assistance institutions, and a weak collaboration with civil society organizations. Local variation is also present in the weakly-pluralistic state of Goiás, where the relationship between state and civil society organizations is fragile. The municipality of Goiânia has lagged behind in the development of social assistance institutions, in part due to a previous local infrastructure that only partly implemented Bolsa Família, and in part as a result of weak linkages with civil society organizations. Finally, Valparaíso de Goiás is a relatively new municipality that lacks significant development of either social assistance institutions or civil society organizations.

The above average performance of Rio Grande do Sul in the implementation of Bolsa Família represented in figure 5.3 is partly due to the fact that territorial infrastructure is comparatively stronger in this state. As a highly pluralistic state (A. Borges 2007; Montero 2007), it decentralizes social provision to municipalities, thus strengthening them, and it promotes the participation of civil society. Throughout Rio Grande do Sul, organized civil society is vital for controlling the use of Bolsa Família funds.[99] Such control is conducted through state and municipal councils, as well as agreements (*convenios*) between civil society organizations, the state, and municipalities. This high level of decentralization makes civil society organizations and municipalities central actors in the successful implementation of Bolsa Família. The city of Porto

[99] Such strong organized civil society structure is seen in the development of participatory budgeting at the state level. Almost five percent of the electorate, and more than 16,000 delegates representing different organizations, participated in 2002 meetings (Feres Faria 2005, 174).

Alegre is an example of successful collaboration between civil society organizations and strong government institutions.

The provision of social assistance in Porto Alegre through the government *Fundação de Assistência Social e Cidadanía* (Social Assistance and Citizen Foundation, FASC) has a lengthy history, and is supported by strong material and human resources.[100] Today, Porto Alegre decentralizes the implementation of Bolsa Família in 22 CRAS divided into nine regions and staffed by professionals who have passed public service exams. The work of CRAS is monitored and enhanced by an active participation of civil society.[101] Such participation is favorable for monitoring the use of federal funds and the quality of the service, for reaching recipients who are not complying with conditionalities, and for finding new recipients. In particular, grassroots organizations currently have a role in monitoring the fulfillment of conditionalities for Bolsa Família. CRAS directors assign NGOs a number of families that are not complying with conditionalities and who live in the area where the NGO works. The NGO, who knows the territory, also can best conduct an active search of recipients (Interview Marli Medeiros). The Secretary of Social Development in Porto Alegre summarized the monitoring role of organized civil society:

> Every single thing is discussed mainly with civil society…clause by clause…you open up the discussion and therefore you take longer, but it is more democratic…They work towards accountability…We are held accountable every week throughout the year...Every week I have to go to the CMAS [Municipal Council of Social Assistance] before implementing any change in the street…They are partners, they make a good debate (Interview Seadi).

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[100] Despite the name, FASC is a fully-funded government institution.

[101] The Municipal Council of Social Assistance produces yearly reports on the work of each CRAS (Conselho Municipal de Assistência Social de Porto Alegre 2011). This active participation of organized civil society in Porto Alegre is the legacy of 16 years of the PT in the municipality. The party developed a number of mechanisms for direct participation, such as participatory budgeting and the enhancement of councils (Interviews Dutra, Schmidt).

Since its creation in 1994, the Municipal Council of Social Assistance has been composed of 44 members, half of which represent civil society and the rest represent the municipal government. The Council meets every other week while its special commissions (including a Bolsa Família Commission) meet weekly. Porto Alegre is the only of the four Brazilian municipal cases included in this dissertation that subdivides the Municipal Council of Social Assistance in 16 regions that follow the participatory budgeting regions. The *Conselho Regional de Assistência Social* (Regional Councils of Social Assistance, CORAS) take the discussions to a smaller scale. These regional councils are then present in the municipal council. The Municipal and Regional Councils have a central role in Bolsa Família. For example, they were active in the definition of the location of the new CRAS and CREAS in the territory, and they receive complaints from users of social assistance if they feel their rights have been violated (Interview Lúcia Souza). In these cases, councilors visit the involved institution (generally the CRAS) and take the complaint to the Council (Interview Dariva).

Compared to Porto Alegre, the neighboring municipality of Canoas has a fragile government and civil society infrastructure. CRAS buildings are not adequate in that they do not provide comfort for populations with special needs, such as a private space for people in need or a bathroom for children and handicapped people. In addition, three quarters of these buildings are rented, which is a problem because the municipality does not invest on improvements and there is always the risk of moving to another location, a fact that can challenge the sustained work in a given neighborhood. Moreover, the specific neighborhoods for which each CRAS is responsible for is not clear, which is a major challenge for monitoring the fulfillment of conditionalities. In terms of activities conducted by the CRAS, only since July 2012 has the CRAS been able to update the registry directly without the approval of the Department of Social Development. Nevertheless, the families that are not complying with Bolsa Família

conditionalities do not receive a visit to their house, as is the case in Porto Alegre, but receive a letter from the CRAS informing them that they need to come to the CRAS in a certain date and at a certain time to explain the situation. Many families never show-up to their appointment. Finally, human resources in the CRAS are not enough and some CRAS workers are still not familiar with the families they assist. Overall, the CRAS is not yet a recognized institution in the territory and thus it has not yet become the entry port of social assistance (Interviews Boniatti, Mardemattos; Vieira Ferrarini, Deitos Giongo, and Silva Silveira 2010).

Another source of territorial weakness in the municipal administration of Canoas, which also differentiates it from Porto Alegre, is the weakness of grassroots organizations (Interviews Dutra, Fagundes, Gilmar Rosa, Mardemattos). Organizations in the society are not partners of the municipality in the implementation of Bolsa Família. They do not help the CRAS in the supervision of conditionalities or in finding potential recipients (Interview Mardemattos). Although a Municipal Council has existed in Canoas since 1997, the level of participation is low (and lower than in Porto Alegre). There are 18 councilors, nine representing organized civil society and nine representing the municipal government. There are no regional councils to raise concerns from the neighborhoods. Additionally, the institutional weakness of the CRAS undermines the legitimacy of the Council, since CRAS members barely participate in Council meetings. As the director of a CRAS in Canoas acknowledged: "The truth of the matter is that the CRAS is not very much involved in the Council, we participate only if they call us…we know it would be important to participate but we do not have the time to do so" (Interview Boniatti). Until 2009, there was very little dialogue with the Department of Social Development, and the Council lacked professionals in social assistance, a situation it has been trying to revert since the new PT governor was elected (Interview Gilmar Rosa).

Compared with the state of Rio Grande do Sul and its major municipalities, the state of Goiás faces the challenge of a relatively weak state territorial infrastructure, coupled with fragile linkages to civil society organizations. Goias' weak pluralistic regime (A. Borges 2007; Krause 2008; Montero 2007) does not promote the development of independent civil society organizations that can effectively monitor the use of Bolsa Familia funds. There is a state council composed of members representing the state government (50 percent) and members representing organized civil society (50 percent). Nevertheless, the council does not meet regularly (Interview Arantes);[102] and since it was created in 1995, most of the Council's Presidents have been representatives of the government (Interview de Jesus). The following three quotes represent the limited role of civil society in Goiás, two of them comparing it with Rio Grande do Sul and Porto Alegre. The first quote is from the President of the Municipal Council of Social Assistance in Goiânia, the second from the President of the Worker's Party in Goiás, and the third from the current Mayor of Goiânia.

> The state council was implemented very politically, and institutions never had real presence…they never had much participation…Participation is really minimal, councilors were always very few…the Presidency of the council has always been appointed by the governor (Interview de Moraes).
>
> Participation here [in Goiás] is lower than in Porto Alegre or Rio Grande do Sul… social participation here is not as strong as in other places…civil society is just not organized, it is not strong enough (Interview Bezerra).
>
> Porto Alegre is an example of participation in Brazil…our [Goiás'] society is more conservative, more rural, the large landlords are still very powerful here (Interview Paulo García).

In the municipality of Goiânia, weak territorial infrastructure has hindered a further expansion of Bolsa Família. Goiânia implements Bolsa Família through 15 CRAS and to a lesser

[102] In fact, during my two months living in this state, I was not able to participate in any of the meetings because their schedule was uncertain.

extent through 15 *Unidades Municipais de Assistência Social* (Municipal Units for Social Asistance, UMAS) that have existed since the late 1990s. UMAS only exist in Goiânia, they are a legacy of a previous policy in the municipality called *Cidadão 2000* (Citizen 2000), and therefore this institution does not receive any transfer from the federal government. Given the strong legacy of UMAS, which will be analyzed in the next section on legacies, the CRAS structure has only been in place since 2009 and remains very weak. There is a lack of professional personnel working at the Department of Social Development, and the CRAS do not have the human and material resources (such as a car in larger territories) necessary to conduct an active search of Bolsa Família recipients (Interviews de Moraes, de Nacimento, de Oliveira, Edson).

The deficient territorial infrastructure also reflects the fact that the participation of organized civil society in Goiânia is weak and does not actively engage with the local government, which is seen as unwelcoming to civic participation (Interviews Barra de Azevedo, Paulo García, De Nacimento, Accorsi). The Municipal Council of Social Assistance faces a number of challenges, such as being viewed as irrelevant by the municipal government, as being unable to monitor the use of federal transfers for social assistance, and as lacking infrastructure and human resources (Pio de Santana, Dilma 2007, 210). As a consequence, the Council does not have the capacity to monitor the Department of Social Development and its CRAS in the implementation of Bolsa Família (Interview De Nacimento). The current President of the Goiânia Council of Social Assistance explained it in the following terms:

> There does not exist monitoring or evaluation of Bolsa Família, there are processes that should be working but are not working…there exists a systematic way of monitoring but this Council is not carrying it out…we just don't have a functioning evaluation system…the evaluation process of the program is not working…only few councilors are involved in the daily activities, because most of them prioritize their own institutions, so it is difficult for the council to make demands, to complain (Interview Regina de Moraes).

Valparaíso de Goiás is challenged by an even weaker territorial infrastructure. The few CRAS in the territory and the centralization of the implementation of Bolsa Família in the Department of Social Development means that potential and actual recipients of Bolsa Família in this municipality have to travel to the neighborhood where the Department of Social Development is located, imposing an extra barrier to access. At the same time, and similar to Goiânia, the role of organized civil society is also limited in Valparaíso de Goiás. The council does not regularly meet and is not very active in Bolsa Família (Interviews Machado Freitas, Baddini Curralero).

Besides the role of partisan alignments and territorial infrastructure for the successful implementation of Bolsa Família, policy legacies are also central for understanding differences in performance. Some policy legacies have been general and have affected all subnational units (such as the unification of previous national cash transfers), while others have been specific for each subnational case study. The next section is devoted to analyzing the ways in which policy legacies have affected the implementation of Bolsa Família.

### *Policy Legacies*

Brazil's previous non-contributory social policies have had a significant effect on the implementation of Bolsa Família. The main legacies from previous policies were the incorporation of recipients from other programs to the Single Registry, institutional learning (including the practices of schools and health-centers in working with conditionalities), and recipients' use of ATM cards in previous cash transfers. Table 5.2 presents a description of previous policies and their legacies for the implementation of Bolsa Família.[103]

[103] Bither-Terry (2013) argues that it is precisely this building on legacies from previous policies what made Bolsa Família such a successful social policy.

**Table 5.2: Previous social policies and their legacies for the implementation of Bolsa Família.**

| Policy | Description | Legacy for Bolsa Família Implementation |
|---|---|---|
| Programa de Erradicação do Trabalho Infantil –Peti (1996) | • *Target*: families with children under 16 currently working or in risk of child labor<br>• *Transfer*: roughly US$30 (rural) and US$45 (urban)<br>• *Conditionality*: 85 percent school attendance<br>• *Responsible*: MDS | • Registered recipients: 1,000<br>• Schools started working with conditionalities |
| Bolsa Escola Federal (2001) | • *Target*: families with income per capita below US$45 with children between 7 and 15 years old<br>• *Transfer*: roughly US$7.5 per child and a maximum of US$23 (three children)<br>• *Conditionality*: 85 percent school attendance<br>• *Responsible*: Ministry of Education | • Registered recipients: 3.6 million<br>• Schools continued working with conditionalities<br>• Municipalities in charge of implementation |
| Bolsa Alimentação (2001) | • *Target*: families with income per capita below US$45 and with children between 0 and 6 years old or pregnant women<br>• *Transfer*: roughly US$7.5 per child and a maximum of US$23 (three children)<br>• *Conditionality*: health controls for pregnant women and children<br>• *Responsible*: Ministry of Health | • Registered recipients: 300,000<br>• Health centers and hospitals started working with conditionalities |
| Cartão Alimentação (2003) | • *Target*: families with per capita income below half minimum salary<br>• *Transfer*: roughly US$25 per family that could only be used for buying food<br>• *Conditionality*: funds can only be used for food<br>• *Responsible*: Extraordinary Ministry of Food Safety | • Registered recipients: 350,000<br>• Recipients start using ATM cards |
| Auxílio-Gás/ Vale-Gás | • *Target*: families with per capita income lower than half a minimum salary per capita and beneficiaries of Bolsa Escola or Bolsa Alimentação<br>• *Transfer*: US$4 per month, every two months<br>• *Conditionality*: fulfill conditionalities from Bolsa Escola and Bolsa Alimentação<br>• *Responsible*: Mines and Energy Ministry | • Registered recipients: 9.7 million |
| Estrategia Saúde da Família | • *Target:* Brazilian population<br>• *Service:* Provision of primary healthcare<br>• *Conditionality:* no<br>• *Responsible:* Ministry of Health | • Active search of potential recipients through health agents<br>• Health conditionalities |

Sources: Based on Baddini Curralero (2012); Brasil (2008); Da Silva e Silva and Santos de Almada Lima (2010); Soares and Sátyro (2010); Sposati (2010).

The novelty of Bolsa Família was to unify programs that were not coordinated and registries that were incomplete. It unified previous conditional cash transfers that were created since 2001 (Bolsa Escola, Cartão Alimentação, Auxílio-Gás, and Bolsa Alimentação) as well as it incorporated programs from the 1990s (Peti). This means that the implementation of Bolsa Família did not start from scratch, there already were 4.2 million families receiving other programs, such as Bolsa Escola (3,601,217), Bolsa Alimentação (327,321), Cartão Alimentação (346,300), and Peti (1,000) (Soares and Sátyro 2010, 43). Many of these families were to be incorporated to Bolsa Família.

The transfer of recipients from previous programs to Bolsa Família was particularly important when the program was launched. In personal interviews with CRAS directors across the states of Goiás and Rio Grande do Sul, they acknowledge that the first recipients included in the registry were those who already received another program, such as subsidies for gas, milk and food (Auxílio-Gás, Vale Leite, and Cesa Básica), and cash transfers targeted to families with child labor, children with malnutrition, or children in school (Peti, Bolsa Alimentação, Bolsa Escola). Some of these programs had a registry that dated from the 1990s and were incorporated (after arduous work updating and adapting information) to the Single Registry (Interviews Baddini Curralero, Bartholo, Boniatti, Camara Pinto, Lucia Souza, Mallmann, Silva de Paiva, Teixeira; Cotta and Paiva 2010, 61; Modesto and Abrahão de Castro 2010, 15). The Single Registry was launched in July 2001 in the context of Bolsa Escola, and the unification of registries started in October 2003 (after Bolsa Família was implemented), and ended in 2011 (Interviews Baddini Curralero, Teixeira). As the National Secretary for Citizen Income put it:

> The existence of previous programs assisted Bolsa Família to get started on a database…but it was a very arduous process…the large majority of people who were receiving these previous benefits, also qualified for Bolsa Família, so it was simply a matter of unifying it, of paying a single benefit for all families…that allowed Bolsa Família to reach 11 million people in 2006…It would have very difficult to start from scratch (Interview Silva de Paiva).

Previous policies did not only leave a paved road for the unification of registries and transferring of recipients, they also encouraged institutional learning, particularly for the implementation of conditionalities. These previous policies were present in the great majority of the municipalities (Da Silva e Silva and Santos de Almada Lima 2010, 113). Therefore, many of these municipalities had already developed institutions for the provision of welfare (through Departments of Social Development, for example) that enhanced Bolsa Família when it was launched. In addition, Peti and Bolsa Escola already had school attendance, and Bolsa Alimentação had health check-up conditionalities. Therefore, Bolsa Família's conditionalities were not a complete novelty for schools and municipal officials. In 2004, critics of the lack of control over the fulfillment of conditionalities in Bolsa Família, compared it with the success of Bolsa Escola at registering school attendance. As a consequence, the government started exercising a stricter control over the compliance with conditionalities (Cotta and Paiva 2010, 61).

The primary health policy analyzed in the next chapter, *Estrategia Saúde da Família* (Family Health Strategy, ESF), also paved the road for the implementation of Bolsa Família. Since 1994, the former policy has organized teams of primary care physicians, nurses, and health agents, who are in charge of the health of no more than 4,000 people in an assigned area. This policy is also characterized by an active search to find and register patients, an activity for which the health agent in the community is responsible. Since Bolsa Família was launched in 2004, the work of these teams, and particularly of health agents, has been important for expanding coverage through distributing information about the cash transfer, such as where to go to seek information and what to bring to sign-up. The Ministry of Health published a recent document explaining how these teams aid the expansion of Bolsa Família to more than 800,000 families (particularly reaching families with young children) and enhance health check-ups (Souza 2012).

Both policies complement one another nicely since health check-ups in the patients' house or in the health unit fulfill Bolsa Família health conditionalities.

Legacies from previous policies were also specific to each state and municipality. The state of Rio Grande do Sul had designed and implemented conditional cash transfer programs before Bolsa Família. These were Pia 2000 (1996-2000) and Citizen Family (*Família Cidadã*, 1998-2003). These programs were cash transfers to poor families under the condition of school assistance and health check-ups. When Bolsa Família was implemented, Rio Grande do Sul's health centers and schools had developed practices that made the implementation of conditionalities a smoother process. In the words of a former Secretary of Social Development in the state of Rio Grande do Sul:

> We had already developed linkages with Família Cidadã and Pia 2000…In the case of Pia 2000, for example, other state agencies had to work towards the provision of national i.d's…The banks had to learn to include this new population…All this already existed at the level of the state since 1997…The work with health and education ministries, who had to check school attendance and vaccination, already existed here…When Bolsa Família was launched we already had a process underway (Interview Nunes).

Within the state of Rio Grande do Sul, policy legacies were not as positive in the city of Porto Alegre. Its below-average success in implementing Bolsa Família, depicted in figure 5.7, is partly related to the legacy of a previous system for social provision. This previous structure took some time to be converted to the standards defined by the national government through the Unified System, namely that signing up for Bolsa Família had to be conducted at CRAS or at social development departments. The city had developed a network of nine social assistance centers, some of which were slowly transformed to CRAS and CREAS until reaching 22 CRAS and nine CREAS in 2012. Nevertheless, this transformation is still being completed (Interviews Brito, Lúcia Souza, Timmen).

Social assistance legacies in Canoas, also in the State of Rio Grande do Sul, contrasts with those in Porto Alegre. Until 2001, social assistance did not have the status of Department; it had been a sub-department within the Department of Health since 1970 and therefore developed the activities that the Health Department mandated, such as distributing prosthesis and coordinating ambulances. Between 1995 and 2000, this sub-department started training personnel and developed closer links to social assistance NGOs for the distribution of "benefits that were only received by those who took a personal initiative" (Interview Pisonique). In 2001, social assistance was upgraded to Department status and separated from Health. Due to the historic secondary position that social development had in Canoas, the Department lacked human resources when Bolsa Família was launched; the first CRAS was opened in 2005 in a space that had to be borrowed from an NGO (in the neighborhood of Guajuviras). The rest of the CRAS were built after the PT mayor assumed in 2009 (Da Silva 2011, 33–50).

In the state of Goiás, the initial meager performance of Bolsa Familia's implementation reflects in part the direct competition through the state cash transfer and the refusal to share databases of state programs with the federal government, explained above. Within the state of Goiás, Goiânia and Valparaíso de Goiás represent negative and weak legacies, respectively.

In Goiânia, social assistance was run by an NGO, the *Fundação Municipal de Desenvolvimento Comunitário* (Municipal Foundation for Community Development, FUNDEC) and directed by the wife of the mayor. This foundation had provided social assistance between the 1970s and 2009. Therefore, until very recently, social assistance in Goiânia was linked to the first lady (*primero damismo*), and had a charitable and philanthropic characteristic. As the Executive Secretary of the Municipal Council of Social Assistance put it: "changing that philanthropic and first lady characteristic is not a simple thing…you don't change that easily…but at least we have a Department now…whereas before we did not have almost any

psychologists or social assistants" (Interveiw Edson). In the municipality of Valparaíso de Goiás, institutional legacies are weak, and that hinders further provision of social development. As a new municipality (it was founded in 1995), the Department of Social Development dates back to 1997. Although the question of spouses as heads of social assistance was never an issue, there has not been strong institutional investment in terms of human and material resources (Interview Tabosa). As a result, the implementation of Bolsa Família is done in a somewhat void context.

**Conclusions**

In Argentina and Brazil partisan alignments affect the successful implementation of social policies when attribution of responsibility is clear. When recipients can identify the responsible government level or political party, there is a potential electoral gain and therefore opposition subnational units have incentives to hinder the implementation of national social policies. The aligned province of Mendoza and state of Rio Grande do Sul complement Asignación and Bolsa Família with their own programs. Conversely, the opposition province of San Luis and state of Goiás hindered the implementation of Asignación and Bolsa Família by providing direct policy competition and by refusing to share the list of recipients of state policies. Nevertheless, while San Luis was still obstructing the implementation of Asignación by 2012 in Argentina, Goiás had signed an agreement with the federal government to collaborate with Bolsa Família for the first time. This reflects the fact that attribution of responsibility is more blurred in Bolsa Família both by the passing of time and because of an active effort by the federal government to share credit. The federal government proposes to incorporate the state logo into the ATM card in exchange for cooperation. When comparing Brazil and Argentina, the effect of partisan alignments is

stronger in the latter because alignments are clearer, policies have a stronger attribution of responsibility, and they have existed for a shorter period of time.

In terms of territorial infrastructure, the two countries also show differences in their forms, though not necessarily in their results. In Argentina the institutions that provide social protection vary throughout the territory, including municipal territorial delegates and community centers in some municipalities, and centralizing social protection in the province in others. Conversely, Brazil has engaged in a process of homogenization of the territory – the Unified System of Social Assistance provides clear guidelines for how the territory should be organized, and on the specific roles of the national, state, and local governments. Such territorial organization is relatively new and builds from the *Sistema Único de Saúde* (Unified System of Health, SUS), which will be analyzed in the next chapter.

Territorial infrastructure includes government institutions and civil society organizations, as well as the interactions between the two. While the municipality of Porto Alegre in Brazil is an example of strong municipal institutions and active civil society participating in the monitoring of Bolsa Família, all the other cases lag behind. This is in part because civic organizations are weaker in these other cases than in Porto Alegre, but also because municipal agencies are less receptive to their joint participation.

Besides partisan alignments and territorial infrastructure, policy legacies are also central for explaining the successful implementation of Asignación and Bolsa Família. Policy legacies are both common throughout the territory and at the same time specific to each locale. States, provinces, and municipalities had previous policies that competed with or complemented Asignación and Bolsa Família when it was launched. At the same time, the national cash transfer benefitted from previous social policies, but the implementation of these previous policies was uneven throughout the territory. Among these policies, we find health policies Estrategia Saúde

da Família (Family Health Strategy) in Brazil and Plan Nacer (Birth Plan) in Argentina, which aided the national cash transfers through informing the population and through the fulfillment of health conditionalities.

Chapter 6 studies health policies in Argentina and Brazil, policies for which attribution of responsibility is not clear and therefore partisan alignments are an insignificant predictor of successful implementation. Territorial infrastructure and policy legacies are the main variables shaping the performance of these policies.

# CHAPTER 6: BLURRED ATTRIBUTION OF RESPONSIBILITY IN HEALTHCARE POLICIES IN ARGENTINA AND BRAZIL.

Chapter 5 analyzed the role of partisan alignments when policies have clear attributability. In those cases, resistance from opposition subnational governments hindered the implementation of national cash transfers. This chapter presents the opposite case – when attribution of responsibility is not clear, partisan alignments are irrelevant for shaping the successful implementation of national social policies. This is the case of the selected health policies in Brazil (*Estratégia Saúde da Família*, Family Health Strategy, ESF) and Argentina (*Plan Nacer,* Birth Plan, PN). For each country, I first analyze the sources of blurred attribution of responsibility and, as a consequence, the irrelevance of partisan alignments.

Second, I focus on the role of policy legacies within each national health policy. Entrenched interests from a previous primary healthcare strategy and from high complexity health provision are crucial for understanding the challenges in the implementation of ESF in Brazil. The states and municipalities that had a more developed health structure before the implementation of ESF will present the highest resistance to this policy. In Argentina, Plan Nacer is implemented in posts that provide both preventive and curative healthcare (including high complexity hospitals) and therefore the policy does not generate a conflict between the different strategies for the provision of healthcare. Therefore, there are no negative legacies for the implementation of Plan Nacer.

Finally, territorial infrastructure is crucial for understanding the successful implementation of national health policies. Given that the case selection strategy controls by GDP per capita and population density, there are no wide disparities in state capacity across the

selected states and municipalities.[104] However, there are differences in the administration of healthcare across countries and within countries across states, provinces, and municipalities. In Brazil, municipalities alone are in charge of implementing primary healthcare, and states are more or less present in coordinating health provision. In Argentina, mostly provinces provide healthcare but some municipalities in some provinces have also taken on health responsibilities.

**Estrategia Saúde da Família in Brazil**

Brazil's health system is called *Sistema Único de Saúde* (Unified System of Health, SUS) and is two-tiered – it includes a public tier financed by general taxes and a private tier financed by individuals.[105] Decentralization of the public tier since the 1980s has given states and municipalities room for innovation while leaving the definition of broad parameters to the federal government (Chapman Osterkatz 2013). These national health policies are enforced through conditional transfers to subnational governments. Subnational governments also partly co-fund healthcare, as well as participate in designing the system though commissions and health councils.[106] In terms of health administration, the federal government is in charge of high complexity healthcare, states deal with medium complexity procedures, and municipalities administer primary healthcare. In practice, big cities and some states have taken on high complexity health administration.

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[104] See chapter 3 for a description of case selection.

[105] For a description of health reforms in Brazil, see Niedzwiecki (2014).

[106] In terms of funding, in 2008 44 percent of health spending came from the federal government, 28 percent from the states, and 29 percent from municipalities. In theory 30 percent of the national, state, and municipal social security income should be invested on healthcare, as well as a percentage of the income from taxes at the state (15 percent) and municipal (12 percent) levels. The federal government has to increase health spending at the same rate as GDP increases. These percentage are rarely respected (Levi and Scatena 2011, 82, 88). In terms of the design of health policies, health commission incorporate the federal and the state levels (C*omissõe Intergestores Bipartite*) as well as the three levels of government (*Comissõe Intergestores Tripartite*) (Vieira Machado et al. 2011).

Within the Unified Health System, Estrategia Saúde da Família or ESF is the main primary health policy.[107] The national government launched the policy in 1994 to decrease health spending while overcoming the lack of de facto access to healthcare of large sectors of the population despite the constitutional mandate of universal coverage.[108] The aim of this policy is to substitute the curative and more expensive health strategy for universal and good quality preventive healthcare.[109] This is done by increasing immunization, nutritional controls, and basic medical and dental assistance for children; prenatal, cancer of the womb, and dental controls for women; and health check-ups for populations in risk such as people with high blood pressure, diabetes, or tuberculosis. It is expected that good quality preventive healthcare decreases illnesses that require high complexity and expensive services. In this way, the policy aims at reorganizing the provision of healthcare around preventive healthcare, and thus decreasing public health spending.

The federal government is in charge of setting minimum standards by legislating and monitoring ESF implementation, which is guaranteed through the transfer of funds called *Piso de*

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[107] Primary healthcare is defined in Brazil as "a set of actions in health that comprehend the promotion, prevention, diagnosis and care (treatment and rehabilitation) developed through democratic and participative management and sanitation procedures, guided by a multiple discipline approach, carried out by work groups and oriented to well-defined population territories (territory-process), for which they take full responsibility, through the use of highly complex low-density technology, which should be able to attend to the population's health issues (the most frequent and relevant ones), preferably within the health system and oriented by the principles of universality, accessibility, continuity, wholeness, responsibility, humanization, vinculum, equity and social participation" (Brasil 2005b, 21). Medium and high complexity healthcare include specialized services that are generally conducted in hospitals.

[108] Although this policy was initiated by the national government there are records of local experiences before that (Borges Sugiyama 2013; Chapman Osterkatz 2013). In 1987, the *Programa Agentes Comunitarios* (Community Agents Program, PACS) was implemented in the state of Ceará as a precursor of ESF. It entailed the delivery of a restricted package of services through health agents.

[109] As it is analyzed below, resource constraints force actual coverage to be targeted to the poor.

*Atenção Básica* (Primary Care Baseline, PAB).[110] PAB transfers include a fixed portion based on population and a variable portion to promote the implementation of ESF, among other national health policies. States also monitor the implementation of ESF and provide training, and municipalities are in charge of implementation. A team of professionals at the municipal level is responsible for the health of no more than 4,000 people in a defined territory located at a *Unidade Saúde da Família* (Family Health Post, USF).[111] According to an official document, "[t]his organization favors the establishment of bonds of responsibility and trust between professionals and families and enables a better comprehension of the health/disease process and the necessary interventions" (Brasil 2005a, 15). At a minimum, the multi professional team includes a primary care physician, a nurse, a nurse assistant, and four health agents (*Agente Comunitário de Saúde*).[112] This team is in charge of offering health assistance, registering the population, formulating a local health plan, monitoring diseases, developing educational activities, engaging with community organizations, boosting health councils, and getting to know each family (Brasil 2005a, 21). ESF is characterized by the "active search" (*busca ativa*) to find and register patients as well as visit them in their house, an activity for which the health agent is mainly responsible.

Health agents are crucial actors in the implementation of ESF. They are the link between the families and the health post, and they decrease barriers of access to the health system. Of the 44 users of ESF who I asked whether they had received house visits from health agents, 65

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[110] Increases in federal transfers since 1999 have correlated with increases in coverage (Brasil and Fundação Oswaldo Cruz 2005, 17). In addition, the National Program for Access and *Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica* (Quality Improvement of Primary Care, PMAQ) since 2011 is targeted to enhancing the quality of the service (Brasil 2012a).

[111] Each USF can host one or more teams, depending on the concentration of the population in that territory.

[112] Since 2000, some teams also include a dental team (*Equipe de Saúde Bucal*). According to local needs and possibilities, a psychologist, nutritionist, social assistant, and physical therapist can be incorporated to the team.

percent (29 people) answered positively and 35 percent (15 people) answered negatively. [113] Of the ones who answered positively, almost 70 percent said that health agents visited their house at least once a month. Users of the system summarized the role of health agents in the following way: "Health agents come very often to my house, sometimes even twice a week. They let us know if it is time for the vaccines or weight controls for Bolsa Família" (Interview Brazil #10); "Sometimes I call them [health agents] and sometimes they come directly. They know me already" (Interview Brazil #23); "[health agents come] once a month now; they came more often when my children were newborns" (Interview Brazil #54); "They [health agents] came more often before, because my mother had HIV, but now I go directly to the health post for pregnancy controls" (Interview Brazil #19).

Users of this primary health system participate through health councils, which are mandatory for the implementation of ESF. There are health councils at many ESF units, and at the municipal and state levels. In fact, almost 40 percent of ESF units throughout the country participated in local or municipal health councils in 2002 (Brasil 2004, 21). The composition of the health councils at the state and municipal levels follows specific guidelines – 50 percent of its members should be users of the system (organized in neighborhood associations or other NGOs), 25 percent should be government representatives, and 25 percent should represent health workers.

Of all the policies included in this study, ESF is the only pure universal policy.[114] To begin, financing is stable through the Primary Care Baseline from the *Fundo Nacional da Saúde* (National Health Fund). In addition, ESF is an automatic right with no political manipulation. In

[113] All interviews were conducted from August to December 2012, mostly in Family Health Posts while patients were waiting for assistance, and also in their house together with health agents who were carrying out their regular visits.

[114] See Appendix 3.1 for a description on the coding of the level of universalism in policies.

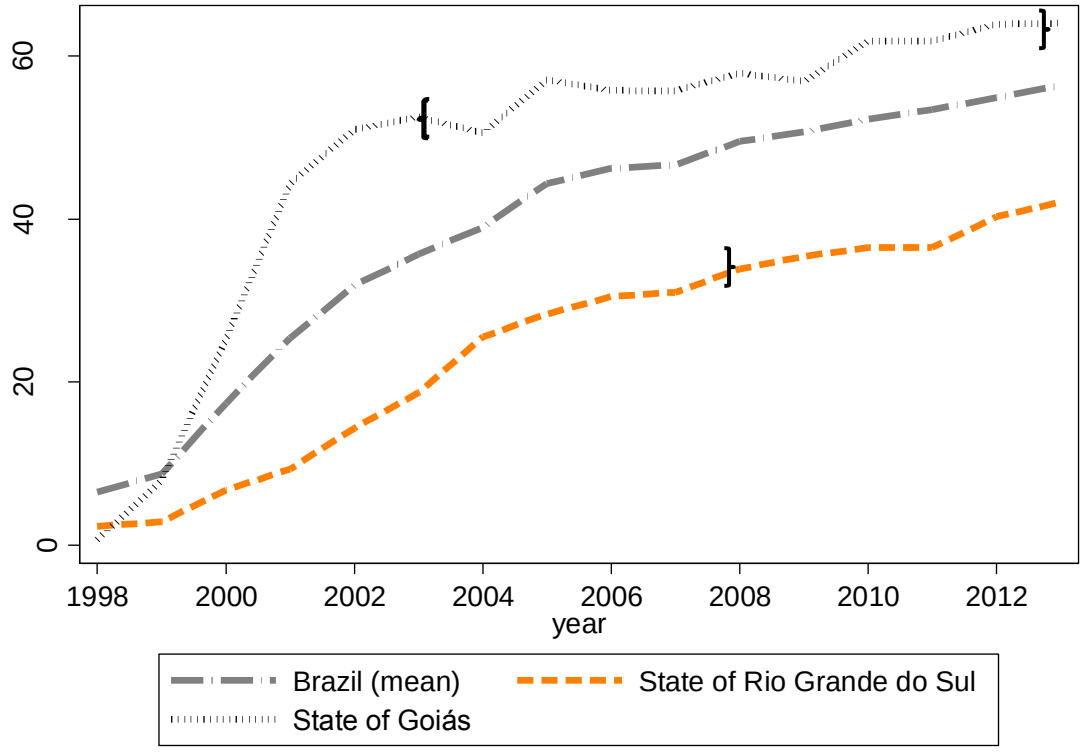
fact, if health services do not reach adequate standards (for example, if the doctor of the health post is generally absent or the health post is in poor conditions) users of the system can complain at the health councils or through a free hotline. ESF also helps narrowing the gap between the service provided in the public and private systems, through increasing pregnancy and child check-ups, and thus decreasing maternal and infant mortality. Finally, all Brazilian citizens are eligible for this policy, independently of their income levels. Although this policy is universal in ideals, its actual coverage is still much lower than universalism and the users of ESF are mostly poor people. As a result, the policy is commonly referred to as "poor medicine for poor people" (*medicina pobre para pobre*). The Coordinator of Health in the *Instituto de Pêsquisa Econômica Aplicada* (IPEA) in Brasilia explained this idea:

> The organization of the public health system in which preventive healthcare is an entry port is only used by poor people. The middle class and rich people are not users of the SUS for primary healthcare; they have private coverage for primary healthcare…And they use the SUS for high complexity procedures (Interview Servo).

Figure 6.1 shows the levels of ESF coverage as a percentage of the total population in Brazil and in the states of Rio Grande do Sul and Goiás. The levels of coverage consistently increase in Brazil until 2013. Different to Bolsa Família where there was a convergence in high levels of coverage (analyzed in chapter 5), states increase their coverage at different pace in ESF. This is in part because ESF requires higher levels of commitment from professionals, as it will be analyzed in the policy legacies section, a fact that hinders convergence in levels of coverage. In addition, while Rio Grande do Sul scores below the national average, Goiás scores above the national average. This is noteworthy since Goiás has been in opposition to the national government throughout most of the period. This lack of correlation between partisan alignments and ESF coverage is also true at the local level. Figures 6.2 and 6.3 show levels of coverage within Goiás' and Rio Grande do Sul's selected municipalities. Figure 6.2 shows that Vaparaíso de Goiás scores consistently higher than Goiânia and even higher than the state average since

2008. Conversely, Goiânia scores below both. At the same time, Goiânia has been generally aligned to the national government and Valparaiso de Goiás has been in opposition. Figure 6.3 shows that both Canoas and Porto Alegre are below the state average, and the brackets in the figure show that changes in coverage are not directly correlated with changes in partisan alignments.[115]

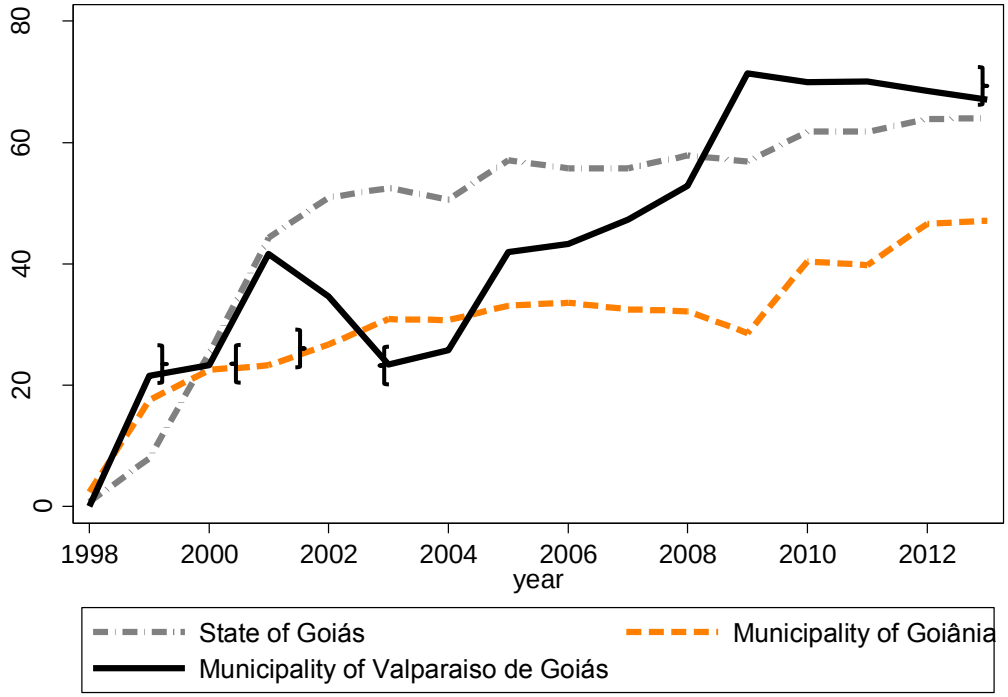
**Figure 6.1: Coverage of Estratégia Saúde da Família as a percentage of total population.**




Source: Brasil (2014). Periods in between brackets {} represent subnational governments in opposition to national governments.

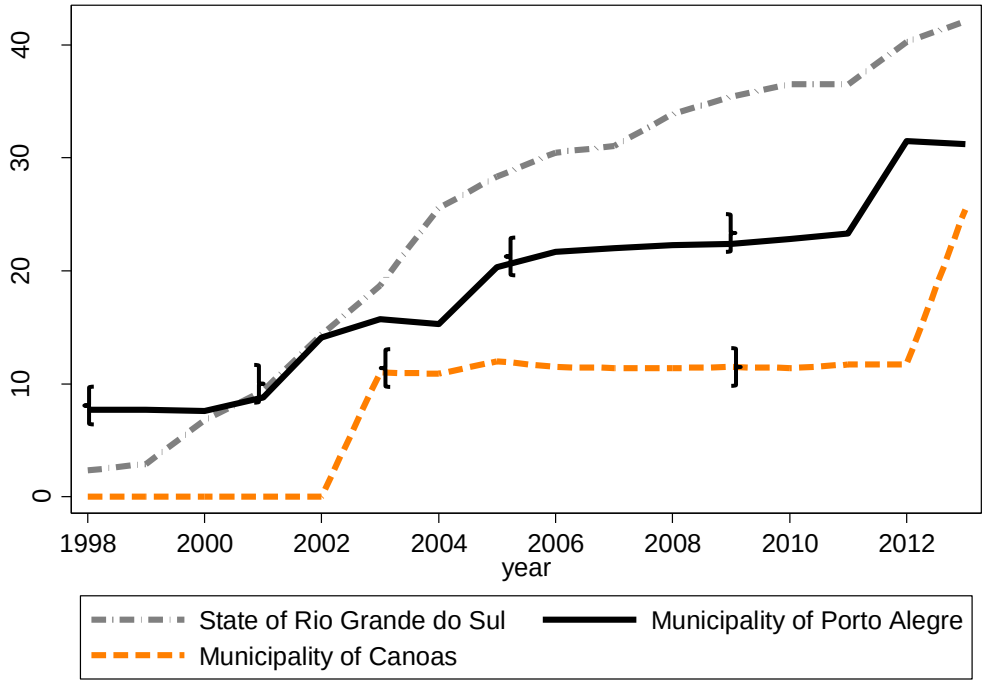
[115] For a description of partisan alignments across states and municipalities, see chapter 3.

**Figure 6.2: Coverage of ESF as a percentage of total population in the state of Goiás and the municipalities of Goiânia and Vaparaíso de Goiás.**




Source: Brasil (2014). Periods in between brackets {} represent subnational governments in opposition to national governments.

**Figure 6.3: Coverage of ESF as a percentage of total population in the state of Rio Grande do Sul and the municipalities of Porto Alegre and Canoas.**




Source: Brasil (2014). Periods in between brackets {} represent subnational governments in opposition to national governments.

***Blurred Attributability and Irrelevance of Partisan Alignments***

As a health policy, attribution of responsibility is expected to be less clear in ESF than in the cash transfers analyzed in chapter 5. Although the policy is mostly funded and designed by the federal government, a great majority of the users of the system do not attribute this policy to this government level. Of the 45 people who I asked where ESF came from, only one answered that it came from the national government – 78 percent answered they did not know where the policy came from, 15 percent thought the municipal government was the main responsible, five percent identified the state government as the main responsible, and only two percent identified the national government as the main provider. Along similar lines, in interviews with medium and high level bureaucrats at the local, state, and national levels, many expressed the idea that ESF does not belong to any particular government (Interview J. Pinto) or that any government could self-attribute it (Interview Rousselet de Alencar). These ideas show the same underlying fact – attribution of responsibility is fuzzy in this health policy and it can therefore belong to no government or to any government. A permanent member of the Health Council in the city of Porto Alegre put it in the following terms:

> People think that the mayor or council person gives Estrategia Saúde da Famíia, and not the national government…And that is what the SUS wants, that people identify the municipality as the entry port…no matter where most of the resources come from (Interview Rousselet de Alencar).

This lack of clear attributability is a quality of the policy – as a service (compared to a cash transfer) the direct recipients of federal transfers are health posts and not patients. As a result, patients do not identify receiving any particular policy. In fact, 86 percent (out of a total of 44) users of ESF answered they did not know which services the policy provided.[116] In addition, the fact that the policy has been implemented for almost 20 years means that it has

[116] The 14 percent who answered they knew the services provided by ESF, identified the policy only with house visits from health agents.

survived changes in national, state, and municipal administrations. ESF was implemented in the mist of economic adjustment policies in 1994, for which reason some initially miss-categorized it as a neoliberal policy (Interview Fagundes). The policy was then strengthened by the left-leaning PT government since 2003 (Chapman Osterkatz 2013, 248). These changes in government administration across time and territorial levels further contribute to blurring attributability. Finally, the decentralized implementation of ESF also opens the possibility for self-attribution at different levels of government. The face of the policy is the municipality, although the main source of funding is the federal government. As a result, governments at the three levels have self-attributed responsibility of this policy.

The main outcome of this blurred attribution of responsibility in ESF is that partisan alignments are irrelevant for predicting the successful implementation of this policy. This idea was confirmed by politicians at the local, intermediate, and national levels (Interviews Alencar, Alvarenga, Bosio, Britzke, Castilhos Gomes, De Camargo, Dhein, Frantz, Rassi, Rodrigues, Sant'ana de Lima, Tura Toazza). The Secretary of Health in the Municipality of Porto Alegre explained the continuity of ESF implementation, regardless the party of the mayor:

> There are not that many changes in ESF because federal guidelines are implemented across all states and all municipalities; that is why there are not that many changes in ESF when the municipal government changes (Interview Bosio).

While partisan alignments are irrelevant predictors of policy performance, the two other variables analyzed in this study are relevant for explaining the successful implementation of ESF across subnational units – policy legacies and territorial infrastructure.

### *Policy Legacies*

The implementation of ESF faces strong resistance from supporters of the previous primary health strategy and of high complexity healthcare. The SUS did not always organize the provision of primary healthcare through ESF; it was previously organized through *Unidades*

*Basicas Tradicionais* (Traditional Basic Health Units, UBS).[117] This previous model was comparatively more expensive than ESF and had limited coverage. In particular, UBS did not include health agents for active search, a central characteristic of ESF that increases access to healthcare for those patients who cannot access the health post for different reasons. These patients would not have received healthcare through the previous system. The UBS system was centered on access to health assistance (as opposed to prevention) and incorporated more specialized doctors, including pediatrician, gynecologist, and clinical doctor. This means that generations of doctors were trained for this previous system and did not change their training to become less specialized to adapt to ESF. Instead, some of these doctors became even more specialized to work in the hospital system. Partly for this reason, it has been a challenge for ESF to find doctors trained in family medicine (Brasil and Fundação Oswaldo Cruz 2005, 18). It has also been challenging to convince patients of the old system to adapt to the new one. A previous user of UBS system who moved to a neighborhood that had ESF expressed this idea: "I was used to the other health unit where there were more doctors…I would still choose that other one because I felt more accompanied" (Interview Brazil #12).

In 2009, almost half of the municipalities that implemented ESF did so in combination with the UBS system (Brasil 2009a, 27). The most successful cases of ESF implementation were those that could replace the old UBS system with the new ESF system, taking advantage of the previous infrastructure and resources (Giovanella et al. 2009). At the same time, the places that had the highest density of UBS found it hardest to transition to the new system than the places that did not have any system before. A government report (first) and the National Director of

[117] The term UBS throughout this chapter refers to these health units aimed at providing primary healthcare through the traditional system.

the Basic Health System (second) evaluate the challenges of implementing ESF in the presence of strong UBS legacies:

> In municipalities with more structured health systems and preventive health provision the resistance to the implementation of ESF was higher, compared to cases where there was no previous health provision. In other words, changing the existent model, by substituting already existent traditional basic units, generates more resistance than creating new family health posts in areas without coverage (Brasil and Fundação Oswaldo Cruz 2005, 54).

> There are places where Estrategia Saúde da Família coexists with the basic unit of the traditional system… Today we have a third of basic health provision under the traditional system…In the 90s, we had the idea of complete replacement of the previous system, but decades go by and that is still missing…Of course, we still keep pushing for Estratégia Saúde da Família (Interview H. Pinto).

Doctors and patients interested in keeping the old system can use health councils to organize and voice their demands. As a result, health councils that are crucial for monitoring the implementation of ESF, as it will be analyzed in the next section, can also hinder the expansion of ESF. Nevertheless, some municipalities also used the health councils to raise awareness on the benefits of the new policy compared to the traditional system (Brasil and Fundação Oswaldo Cruz 2005, 53–54). The role of health councils for hindering or enhancing ESF varies across municipalities and within municipalities across their regular meetings but is shaped by the strength of the previous UBS and high complexity systems.

High complexity health provision is another structure that challenges ESF implementation, particularly with regard to the struggle for material and human resources. The more a health system is structured around curative and high complexity healthcare, the more challenging it is to convince that municipal government to invest on basic healthcare of any kind. Municipalities have autonomy in deciding how to spend their own resources, and investment in hospitals is generally a smart electoral strategy since it is very visible (Interview Santos Servo). In addition, federal transfers for health reinforce medium and high complexity health structures. In 2008, almost 50 percent of the national health transfers was for medium

and high complexity healthcare, and less than 20 percent was for primary healthcare (Brasil). Finally, high complexity health provision holds back the expansion of ESF though offering higher salaries to general practitioners, and therefore making it difficult for the primary health system to compete for human resources. Health professionals can receive a higher salary by working part-time in hospitals, and particularly in private ones, than by working exclusively in ESF. Given these salary differences, many medicine students choose not to follow preventive health training, and specialize in curative healthcare.

In general, UBS and high complexity health systems are more developed in larger cities compared to smaller places. As a result, smaller municipalities have implemented ESF faster and with better results than larger ones. In 2002, small municipalities had more than doubled the coverage of large municipalities (Brasil 2006a, 18; Brasil and Fundação Oswaldo Cruz 2005, 20).[118] To overcome this gap, since 2002 the federal government developed a program called *Programa de Expansão e Consolidação da Saúde da Família* (Expansion and Consolidation of Family Health, PROESF). This program seeks to expand ESF coverage in cities with more than 100,000 inhabitants with the aim to transform the UBS system to ESF, train human resources on family medicine, and promote monitoring mechanisms (Brasil 2005a, 21; Viana et al. 2009, 17; Do Nascimento and Da Costa 2009, 75). In addition, the fixed portion of the federal transfers for the provision of primary healthcare is calculated based on population, a fact that benefits municipalities with large populations (Ferla et al. 2002, 16).

Besides the negative legacies that stem from the health system, ESF also faces a challenging legacy from the period of neoliberal reforms –The Fiscal Responsibility Law (*Lei de Responsabilidade Fiscal*). Since 2000, this law determined that no more than 60 percent of net fiscal

[118] It should also be mentioned that reaching higher percentage coverage requires less effort in a small municipality, compared to a larger one. The smaller the municipality, less family health teams are needed to reach higher coverage percentages.

revenues of states and municipalities could be spent on personnel (Brasil 2000, Art. 19).[119] This affects every sector of the public bureaucracy but particularly those that are human resource intensive, such as health and education. To not exceed the 60 percent limit, municipalities are forced to find alternatives to hiring ESF teams. In 2006, 60 percent of municipalities outsourced hiring to non-profit private organizations. In addition, 80 percent of municipalities hired doctors through precarious contracts, and 70 percent of doctors and more than half of nurses had a temporary contract (Brasil 2009a, 5). Such precarious contracts contributed to the high turnover rate of doctors in ESF – almost 80 percent of all doctors and dentists stay for less than one year (Brasil 2004, 18).

*State of Rio Grande do Sul*

The state of Rio Grande do Sul had a legacy of strong development of UBS and high complexity units before ESF was implemented. Today, roughly 70 percent of primary healthcare is provided through UBS and only 30 percent through ESF (Interview Castilhos Gomes). In addition, the state had already developed a strong hospital infrastructure by the time ESF was launched, most of which was non-public.[120] Therefore, a considerable amount of the population in this state receives healthcare through other than ESF systems, and thus the implementation of ESF has not been a priority. As a result, figure 6.1 shows that the state scores lower than the national average. A former Director of a conglomerate of health institutions in Rio Grande do Sul

[119] The law also sets specific minimums for each branch of government. At the municipal level, no more than 54 percent of revenues can be spent on personnel in the executive branch and no more than six percent on personnel in the legislative branch. Violation of these rules is subject to criminal penalties, fines, and even jail (Liu and Webb 2011, 39).

[120] In 2001, only seven percent of hospital beds in Rio Grande do Sul were public. The rest were philanthropic (55 percent), university (21 percent), and private (17 percent) (Ferla et al. 2002, 19).

explained the reasons why the struggle for resources has generally benefitted the high complexity system at the extent of preventive healthcare:

> There is a constant political pressure from hospital administrators to receive the resources they want…No health secretary has ever had the courage to…allocate more resources to ESF and reduce the resources to hospitals…Medical entities in Rio Grande do Sul are also very strong, and they constantly criticize primary care…They generate an impossible pressure…While the hospitals organize banquets in *Plaza San Rafael* [expensive hotel in Porto Alegre], primary care organizes a picnic in the *Parque da Rendenção* [public park in Porto Alegre] (Interview Sanzi Souza).

Popular participation in Rio Grande do Sul is vibrant across many municipalities and takes place through health councils and forums. Every time there is a proposal to transform an UBS to an ESF unit, that proposal needs to be first approved by the local UBS council, then by the district council, and finally by the municipal council. While popular participation enhances the quality of health provision, as it will be analyzed in the next section, it can also hold back ESF implementation. These three instances of debate are also veto points that can push the proposal back. The municipality of Porto Alegre, with its high levels of popular participation (Baiocchi 2005), is the best representative of the benefits of health councils for improving the service of ESF and the costs of health councils for providing a platform for those willing to maintain the old UBS system.[121]

Porto Alegre had developed a strong UBS and high complexity hospital infrastructure before the implementation of ESF. The first hospital was founded in 1954, and in 1990 there were already 12 UBS in the city (Goulart 2002).[122] As a result, when ESF was implemented in

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[121] On September 4, 2012, I participated in a meeting from the District Council in the East Region in Porto Alegre (Bom Fim). The proposal to change a particular UBS to an ESF unit was approved by majority vote. Most of the debate was around the strategy for mobilizing the local population to exercise pressure at the Municipal Health Council, where other groups would present open opposition to the proposal.

[122] The city had been pioneer of primary healthcare training (through *Centro de Saúde Escola de Murialdo* and *Grupo Hospitalar Conceição*) since the mid-1970s (Goulart 2002).

Porto Alegre it had to coexist parallel to the UBS system, and always occupying a secondary role. The first 24 ESF teams in 1996 were located in a space that had to be borrowed from neighborhood associations, which were also in charge of hiring ESF professionals (Woltmann 2012, 45). Figure 6.3 shows that Porto Alegre has had an overall poor performance compared to the state levels, with an increase in coverage in 2011.[123] In addition, changes in coverage have been slow as result of these previous health systems that are challenging to modify.

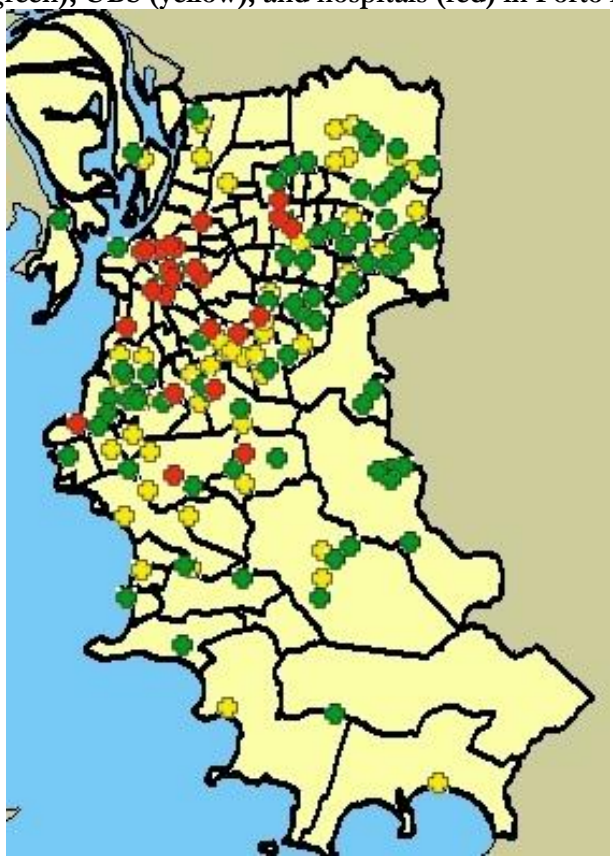
Figure 6.4 shows the distribution of ESF units, UBS, and hospitals in 2011. Although there is a higher quantity of ESF units than UBS, the latter covers a larger number of people – around 30,000 people are covered by each UBS compared to no more than 4,000 by each ESF unit. In 2013, there were 54 UBS, each covering between 5,300 and 116,000 people (Prefeitura Municipal de Porto Alegre, Secretaría Municipal de Saúde 2013, 145). Therefore, in Porto Alegre the mainstream primary health strategy is still UBS.[124] The Secretary of Health in Porto Alegre expressed the challenges of implementing ESF in the presence of these strong negative legacies:

> After that health structure was in place, we tried to implement Estrategia Saúde da Família. In other municipalities, you did not have that structure before the implementation of ESF…And that initial moment defined the outcome, because it was too late; you already had too many resources in another health structure and it was hard to change those resources…The big structures will remain…When we started implementing Estratégia Saúde da Família, we wanted to make a complete replacement; that is, make all UBS disappear. But as time went by we realized that could not be the way…The system will remain mixed (Interview Bosio).

[123] Since 2011, the national coordination of ESF has started to relax the requirements of Family Health Posts to allow for the incorporation of UBS (Interview A. Pinto). In addition, the municipality has improved the working conditions of ESF professionals, a fact that will be analyzed in the next section. In part due to these changes, the municipality of Porto Alegre had a spike in 2011. However, these changes did not seem to continue the positive trend in 2013.

[124] The municipal government, in agreement with the municipal health council, plans to make ESF the primary strategy by opening only ESF units in the future (Prefeitura Municipal de Porto Alegre, Secretaría Municipal de Saúde 2013, 148).

**Figure 6.4: ESF units (green), UBS (yellow), and hospitals (red) in Porto Alegre.**



Source: Prefeitura Municipal de Porto Alegre (2011)

Besides the struggle with the UBS system, ESF competes for resources against the high complexity system. In 2013, there were 13 high complexity hospitals, between the public and private systems in Porto Alegre (Prefeitura Municipal de Porto Alegre, Secretaría Municipal de Saúde 2013, 241). Given that hospitals are more expensive to maintain and that they have organized a stronger lobby, they receive a larger amount of resources than primary healthcare strategies. These budget priorities have proven challenging to modify. A former Secretary of Health in Porto Alegre expressed this struggle over resources between the different health strategies:

> Porto Alegre always had a health structure that highly valued emergency care, and that received most of the financial resources…When healthcare was municipalized in 1991-1992, Porto Alegre responded with emergency units…and that is a very expensive system…Only later Porto Alegre focused on primary healthcare…but only through

> unidades basicas tradicionais in the late 1990s…Since 2000s the municipality started working towards the implementation of ESF, but the municipality was already financially strangled (Interview Fagundes).

Primary healthcare also competes against the high complexity system over human resources. Salaries for family doctors are lower than salaries for specialized doctors, and it is therefore difficult to convince students of medicine to choose that career path. This couples with the fact that the Fiscal Responsibility Law promotes precarious contracting of ESF professionals. Most doctors who participate in ESF have an unstable contract renewable every year and their contracting is outsourced. As a result, of the 189 ESF teams in 2013, 45 of them are incomplete, mostly lacking general practitioners (Prefeitura Municipal de Porto Alegre, Secretaría Municipal de Saúde 2013, 149). To improve these conditions, since 2011 ESF professionals in Porto Alegre now have a contract that follows the *Consolidação das Leis do Trabalho* (Consolidation Labor Law*,* CLT) that is the same legal framework that regulates all hires in the private sector, a fact that improves labor conditions of ESF workers. However, contracting is still outsourced, meaning that they are not municipal workers. The institution in charge of hiring ESF doctors is a publicly owned foundation governed by private law (*Fundaçõe Pública de Direito Privado*) that reports to the municipality of Porto Alegre.[125] The initial result of this more stable labor contract has been an increase in professionals interested in ESF, and a subsequent increase in ESF coverage in 2011, shown in figure 6.3.

[125] ESF personnel was hired by neighborhood associations from 1996 to 2000, by the public State University from 2000 to 2007 (*Fundação de Apoio da Universidade Federal do Rio Grande do Sul*), and by a public interest non-governmental organization (*Organização da Sociedade Civil de Interesse Público*) from 2007 to 2010. Serious corruption accusations form the media and local councils against this organization (called *Sollus*) forced the municipality to change the outsourcing entity in 2010 to the private Cardiology University Foundation (*Fundação Universitaria de Cardiologia*) until it changed again in 2011 to the current outsourcing entity – a publicly owned foundation governed by private law. Throughout this period, all ESF employees continued to be outsourced, with the exception of health agents, who had to be hired by open bid since the 2006 Constitutional Amendment 51 (Woltmann 2012).

The bordering municipality of Canoas in the state of Rio Grande do Sul also exhibits obstacles in the implementation of ESF. This policy was not implemented until 2002 and its coverage levels are lower than the state and Porto Alegre averages (figure 6.3). Previous UBS structure and a developed hospital infrastructure, as well as precarious contracts for ESF professionals, explain this poor performance. Canoas had developed a strong infrastructure of 20 UBS when ESF was implemented. The last UBS was built in 2000 and 13 are still used today for the provision of traditional primary healthcare. The remaining seven of the original 20 UBS were transformed into ESF units. However, all new ESF units have been exclusively built in poor neighborhoods where the previous system had never been implemented. As a result, ESF in Canoas is accepted as medicine for poor people (Interviews Camargo, F. Santos, L. Santos).[126]

The main resistance against ESF comes from doctors. Doctors who work in UBS earn a higher salary than ESF professionals and have a more stable contract. In addition, they do not have to work 40 hours a week (as in ESF) and therefore they can choose to work 20 hours a week at the UBS and the rest of the time at another place, such as an emergency room. While ESF doctors earn US$25 per hour, a doctor in the emergency room earns more than US$35 (Interview Camargo).[127] In addition, contracts in ESF are precarious. To respect the Fiscal Responsibility Law, Canoas outsources the hiring of health professionals to a cooperative since 2003, and their contracts are yearly renewable and vacations are not included. As a result, "recently graduated doctors may start working at Estrategia Saúde da Família, but only until they find something better" (Interview F. Santos).

[126] New UBS are built in middle class neighborhoods or when there are no health agents available (Interview F. Santos).

[127] Exchange rate US$1=R$2, as of January 24, 2013. All conversions are taken at this rate.

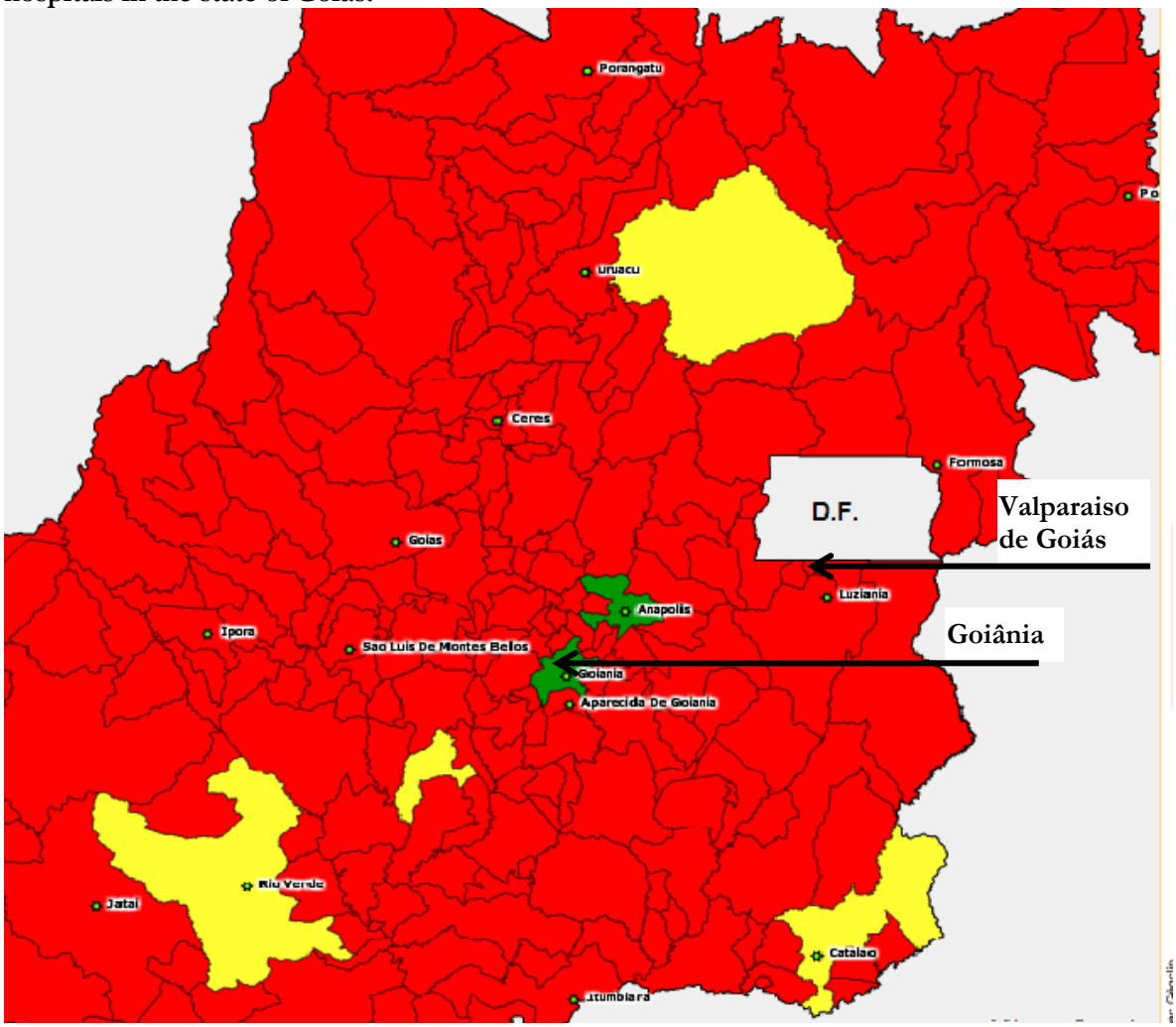
The developed hospital system gives doctors a more attractive alternative to ESF since struggle for resources generally benefit the high complexity system (Interview L. Santos). Moreover, the hospital infrastructure includes the private sector, which is also highly developed in Canoas – around 30 percent of the population in Canoas has private insurance. Following the idea that ESF should be targeted to poor neighborhoods, in neighborhoods where many people have private insurance, the municipal government has decided not to expand ESF (Interview L. Santos).

*State of Goiás*

The state of Goiás also presents health systems that compete against ESF, including UBS and hospitals. However, both competing systems are less developed than in Rio Grande do Sul, and therefore Goiás exhibits higher levels of ESF coverage, as depicted in figure 6.1. On one hand, the coverage of UBS is lower than in Rio Grande do Sul because primary healthcare was never a priority in this state. On the other hand, the development of high complexity public and private hospitals is also more limited. Figure 6.5 shows the perception of municipal health secretaries regarding the development of high complexity health units in that municipality. With the exception of the largest cities in the state, most health secretaries perceived the development of the hospital network as low, represented with the color red in the figure.[128]

[128] I am using this measure for the lack of comparable data on the development of high complexity and UBS systems in the State of Goiás.

**Figure 6.5: High (green), medium (yellow), and low (red) perception of high complexity hospitals in the state of Goiás.**




Source: Governo de Goiás, Secretaria de Estado da Saúde (2011)

As is the case in Rio Grande do Sul, health councils both strengthen the infrastructure for the implementation of ESF and provide a platform for those against the expansion of ESF, be it for sustaining the previous UBS system or for pushing for the high complexity strategy. The Coordinator of ESF in Goiânia explained:

> There are neighborhoods in which the local health council goes against Estrategia Saúde da Família…I remember a particular case in which the population resisted because they wanted to keep the old system…And we have to respect the discussions at the councils (Interview Belem).

Within Goiás, the municipality of Vaparaíso de Goiás is among the most successful in implementing ESF, reaching almost 70 percent of coverage since 2009. The municipality was founded in 1995 and therefore it lacked the development of a strong previous UBS and hospital infrastructure when ESF was launched nationally.[129] This explains the above average performance in the implementation of ESF, as shown in figure 6.2. There are only six UBS (none of which could be transformed into ESF units) and only one medium complexity hospital that was recently inaugurated.[130] These weak negative legacies allow for re-structuring health provision around primary healthcare – it is mandatory to see a general practitioner before being transferred to a specialized doctor. Such administration strengthens the primary health system, and ESF in particular, since it increases the actual take-up rate. The Coordinator of Basic Healthcare in Vaparaiso de Goiás explained the successful performance of ESF in the following terms:

> Saúde da Família is the base of the system; it is the entry port to the health system...We have had a hospital for one year, but it is embryonic, it has very few specializations. Serious health cases are transferred to Brasilia (Interview Chaveiro).

In spite of the absence of negative legacies in terms of hospitals and UBS development, Vaparaiso de Goiás cannot escape the requirements of the Fiscal Responsibility Law. As a consequence, professionals are not municipal employees and they have unstable contracts that need to be renewed every year. As in Rio Grande do Sul's municipalities, the precariousness of contracts and the low salaries produces a high turnover rate of ESF doctors. This volatility

[129] This lack of strong development of previous health infrastructure makes Valparaiso de Goiás comparable to low income municipalities and states that also lacked these structures when ESF was implemented.

[130] The perception of health secretaries is that Valparaiso de Goiás has a low hospital infrastructure (figure 6.5).

damages the implementation of this policy in the sense that "the community is most affected because they lose the linkage with the ESF unit" (Interview Chaveiro).

In contrast to Vaparaiso de Goiás, Goiânia shows low levels of ESF coverage in figure 6.2. The development of a previous UBS system together with the presence of a strong (mostly private) hospital infrastructure explains this poor performance. The municipality has always implemented ESF parallel to the UBS system, and never had the plan to completely substitute it. It originally implemented a modified version of ESF – from 1998 to 2001 Goiânia had mobile teams (without family health posts) that went house by house to reach the population that the other systems could not reach. These efforts proved ineffective and since 2001 all future ESF teams were based at health posts, some of which were shared with the UBS system (Brasil and Fundação Oswaldo Cruz 2005, 76). Since 2011, the municipal Secretary of Health has tried to modify ESF to look a bit more like the UBS strategy that was widely accepted in the city. In particular, some ESF units agreed to extend the opening hours from 5 to 7 pm and to open on Saturdays. The aim in the long run was to convince those excluded from the ESF post schedule (Monday to Friday 9 to 5), particularly full-time workers, that ESF was a better alternative to the UBS system. The results of this new strategy have slowly started to affect the numbers since 2011.

Besides the previous UBS system, the existence of a strong previous hospital infrastructure marked in figure 6.5, further accounts for the poor performance of ESF coverage. The private sector is particularly strong in this municipality – more than 80 percent of hospital beds belong to the private system (Brasil and Fundação Oswaldo Cruz 2005, 45). The strong presence of private providers hinders the expansion of ESF because "rich people who have private insurance will never choose ESF" (Interview Batista). The Secretary of Health in Goiânia expressed this idea in different terms:

> In Goiânia there is a primacy of the private sector, and the primary health strategy cannot be implemented outside of that context…It is possible to expand ESF coverage but not much more than we have now…the private system imposes a limit because public provision is of worse quality…And in a city with such a strong private system, people buy services in the private sector (Interview Rassi).

This hospital, UBS, and private infrastructure also produce a competition for human resources. In general, doctors choose to specialize in disciplines other than family medicine in part because most ESF workers have an unstable contract – of the 181 doctors who were part of ESF teams in 2012, only 22 had a stable contract, the other 159 had a contract that was renewable every year (Interview Belem). A former Director of ESF in Goiânia expressed the difficulty of finding and maintaining ESF doctors:

> We find difficulty in trying to maintain doctors for Saúde da Família…It is difficult because family medicine is not as valued as…hospital medicine…General practitioners earn much less than specialized doctors…Some doctors start with ESF but they then migrate somewhere else…In some previous UBS we had issues because, for instance, the gynecologist did not want to change to family medicine; that person had to be transferred, he could not stay in ESF (Interview Batista).

### *Territorial Infrastructure*

Estrategia Saúde da Família is implemented through teams located at family health posts or USF. The key to a good quality implementation of the policy is partly the quality of the USF and the team that participates in that health post.[131] This has to do with the training that these professionals receive, which is partly in charge of states, as well as with the quality of their contract and salary, which are responsibilities of municipalities. In 2009, the average monthly salary for ESF doctors was US$3,150, US$1,150 for nurses, and US$270 for health agents (Brasil 2009a, 95). However, these salaries are comparatively low and contracts tend to be precarious.

[131] Since 2012, the federal government has started implementing a program for assessing the quality of health units (Brasil 2010). The results of these evaluations will further contribute to strengthening the infrastructure for the implementation of primary healthcare.

To monitor the quality of the service, civil society organizations supervise ESF through health councils at the USF, and at the municipal and state levels.

*State of Rio Grande do Sul*

Following national legislation (Law 7058), the state of Rio Grande do Sul divides health administration into 30 regions, with the aim of enhancing the coordination of the different levels of complexity within the system. However, this geographical division is in its initial phase, it has only been implemented since 2011. To promote ESF, since 2003 the state provides a monetary incentive of US$1,000 for each ESF team conditioned upon health targets. This state program is called *Saúde para Todos* (Health for All) and it resulted in increases in ESF coverage (Sanzi Souza et al. 2003). The state also complements ESF through a policy called *Primera Infância Melhor* (Better Early Childhood), which trains municipal health agents on providing care to young children during house visits.[132] In addition, the state participates in meetings of the Health Council since its creation in 1994 to enhance the coordination among municipalities.[133] Nevertheless, the state is secondary in ESF; the central actors being the municipality for its implementation and the federal government for funding the policy. Health Coordinators at the state level explained the overall marginal role of the state of Rio Grande do Sul in ESF – the first quote corresponds to the Coordinator of Basic Healthcare and the second one to the Director of Monitoring Healthcare.

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[132] Porto Alegre implements this state program since 2004, adapting its name to *Primeira Infância Alegre* (Happy Early Childhood). Since 2010, this program was officially approved through municipal law. Nevertheless, the program is very small – in July 2013 it covered only 468 people (Prefeitura Municipal de Porto Alegre, Secretaría Municipal de Saúde 2013, 161).

[133] The health council in Rio Grande do Sul is among the most democratic forums throughout the country. The President of the health council has always been elected among its members and most of its members belong to civil society organizations (Pereira, Côrtes, and Barcelos 2009, 111–12).

> The state does not really have a direct link with the users of the system…the implementation is in the hands of the municipal administration…we [the state] can just provide institutional support (Interview Bagatini Teixeira).
>
> The main problem in ESF is the lack of professional training…And the state does not back the municipality in this process…The support of the state has always been fragile (Interview Lermen).

Given the secondary role of the state, adequate health infrastructure for ESF at the municipal level is key for understanding the successful implementation of this policy. Porto Alegre divides its territory into 17 health districts, with eight regional administrations that report to the municipal health secretariat. As it was explained above, the city enjoys a developed health infrastructure of previous UBS and hospitals, but this hinders ESF. In addition, this infrastructure and ESF posts are concentrated in the center and north parts of the city, as shown in figure 6.4, leaving vacuums of health provision in the south of the city. The unevenness of health provision in Porto Alegre couples with the fact that the professional teams in charge of ESF are poorly paid and their contracts are unstable, a fact that affects most cities in Brazil.

In spite of the low levels of coverage depicted in figure 6.3, the quality of health provision in Porto Alegre is high. The active participation of organized civil society through health councils is crucial for understanding the quality in the provision of ESF. Porto Alegre has been singled out for its vibrant civil society, and the health sector is not an exception (Baiocchi 2005). Most ESF posts have a health council, which aggregates demands into 19 district councils, which are then represented at the Municipal Council. The Municipal Council was created in 1992 from pressures from civil society organizations, and particularly from the sanitarista movement since the 1970s. Civil society organized around the health councils monitors the implementation of ESF. These groups make sure that funds are spent correctly and that the functioning of ESF posts is adequate. In particular, they notify the government if health professionals are late or absent, if they do not conduct house visits, if there is not enough

medicine in a particular health post, or if the health post is not in adequate conditions. Organized civil society also helps the government identify new places for setting-up new ESF posts. This takes place during debates over the participatory budgeting and at health councils' meetings (Interviews Bosio, Frantz, H. Pinto, Rousselet de Alencar, Toazza Tura, Vilar da Cunha).[134]

Compared to Porto Alegre, the municipal health council and participatory budgeting in the neighboring municipality of Canoas is not as vibrant. The origins of the Municipal Council date back to 1996 and respond to pressures from the national government by conditioning health transfers to the creation of such council (Interview Martins). All 28 council members are appointed as opposed to elected.[135] In addition to the municipal council, there are also local councils at some ESF posts, but there is no district council. The opening of new ESF units is always suggested by the municipal government, and not by the councils or the participatory budgeting process (Interview Dhein). Nevertheless, the inauguration of each new ESF unit has to be approved by the council. In addition council members meet regularly to voice demands for improvements on ESF implementation, and the SUS more generally (Interviews F. Santos, Camargo, Dhein).[136]

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134 Roughly half of all ESF units were proposed by the civil society in participatory budgeting processes (Interview Frantz).

135 From the 28 council members, 14 are users of the public system (generally NGOs and representatives of the local councils), seven are health professionals (including health workers' union), four are health providers (including representatives of hospitals and laboratories), and three are from the government (including a representative of the Health Department). During national and local elections, the council decreases its levels of participation (Interview Dhein).

136 In one of the meetings of the municipal health council of Canoas in which I participated in October 8, 2012, members of the council discussed two main issues. On one hand, the hospital *Nossa Senhora das Graças* was being held accountable on a particular spending. On the other hand, members of the council discussed that the hospital at the state university had a bad smell, and the Council had contacted the hospital but nobody had provided an answer. Representatives of that hospital were present in the meeting to answer the members of the council's concerns.

Besides the generalized problem of hiring and maintaining ESF professionals, Canoas faces a particular issue with regard to health agents. There are 42 health agents in the municipality, but many of them are not yet registered in the system because they do not have the necessary qualifications. This is because very few people sign-up to take the exam in Canoas. The problem is that without credited health agents the ESF team is incomplete and cannot receive the transfers from the federal government. This is partly the reason why ESF performance in Canoas is below average (Interviews F. Santos, L. Santos).

*State of Goiás*

As is the case in Rio Grande do Sul, the state of Goiás has a limited role in the administration of primary healthcare. While many states have started to divide the territory for better administration, Goiás has not done so yet. In addition, there are no state policies similar to those in Rio Grande do Sul to complement ESF. For the implementation of ESF, the states' role is only to provide training activities and to help co-fund it. The opinion on the extent to which the state complies with these activities is controversial. Such disagreement partly responds to the fact that the state funds poorer municipalities more than larger cities, assuming that larger cities have enough resources to face ESF implementation (Interview Batista). The former Director of ESF in Goiânia (first) and the current Director of Basic Healthcare in Valparaiso de Goiás (second) represent this disagreement:

> There is very little coming from the state in terms of training. For example, the introductory course on family health is a 40 hour course for people without background on family health but who are interested in joining ESF…the state performs poorly in providing this course. That is why universities need to step in (Interview Batista).

> The state is reference for us…The state conducts most training activities…Most funding comes from the federal government and the states co-funds 25 percent (Interview Chaveiro).

The state of Goiás also participates in meetings of the state health council for monitoring ESF implementation. However, the role of the council is more limited in Goiás compared to Rio Grande do Sul. In particular, the Goias' health council is less organized and has had periods in which it was closed or had limited influence (Interviews Alvarenga, De Jesús).[137] Health councils can improve the quality and coverage of ESF particularly in places where there are no strong negative legacies from UBS or hospitals. This is the case of the municipality of Valparaiso de Goiás. In this municipality, the Secretary of Health sought input from the council and from civil society to determine the places where the first ESF posts would be located. The Coordinator of Basic Healthcare in Valparaiso de Goiás remembered the reaction from neighbors and organizations:

> The mayor organized one meeting in each community…The neighbors, the government, and the council participated in these meetings…this was particularly important in far-away areas where, for example, neighborhood associations participated…The community was interested because they had to walk long distances to the first health center…The ESF post is very important in these places…Before each meeting the mayor asked us to deliver brochures with information…The municipal government went to the neighborhoods rather than the neighbors to the municipality (Interview Chaveiro).

This initial high level of participation for the expansion of ESF faded away after the system was first launched. In 2012, none of the ESF posts had a local council, the municipal council did not meet regularly and most of their debates were exclusively centered on the salary of doctors. This topic of debate is relevant given that a serious issue in this municipality, as in all others, is the difficulty in finding doctors for ESF. Most ESF doctors in Valparaiso de Goiás are recent graduates who leave the job after a year, when they take their residency exam. A particular characteristic of this municipality is its closeness to Brasília (18 miles away), which provides a

[137] In a session of the State Health Council I attended on November 6, 2012, the council discussed the requirements for organizations that wanted to be part of the Council. 20 people attended this session and it was challenging to find volunteers to work on this topic. By the end of the session, there were no volunteers from the health workers.

bigger market for recent graduates. This makes it even more difficult to find ESF doctors for this municipality (Interview Rassi). To deal with this issue, Valparaiso de Goiás hires part-time ESF doctors that can complement their salary with their work at emergency rooms, a practice that is discouraged by the national government but seems to work for this municipality (Interview Chaveiro).

Compared to Valparaiso de Goiás, the municipality of Goiânia has a more structured health administration. The municipality divides health administration into seven health regions, each of which has a representative of the municipal government. These regions are in charge of monitoring the quality of the service, which is a priority for the local government. Higher quality is prioritized over expanding coverage (Interviews Belem, Rassi). The Department of Health in the municipality decides where to open ESF posts, and so far it has decided to open posts where there is a higher concentration of poverty, thus reinforcing the stereotype of ESF as "poor medicine for poor people."

Health councils in Goiânia do not participate in the decision of where to open ESF posts, but they contribute to guaranteeing adequate quality of the health service. At the local and municipal councils, people can raise concerns about the quality of the service, and there is a complaint commission that serves as the platform for such concerns (Interviews Belem, De Jesús, Lima, Rassi). Nevertheless, the level of participation at the municipal council is low (Brasil and Fundação Oswaldo Cruz 2005, 69–70). The Municipal Council exists since 1993, but there are no elected council members, they are all appointed by the government or by organizations. In addition, there are no regional councils between the local and municipal councils. There are between 60 and 130 local councils in Goiânia,[138] which are then represented at the municipal

[138] The number varies depending on the source. The President of the Municipal Council mentioned that there are 130 local councils, and the Director of ESF in the municipality counted 60 (Interviews Belem, De Jesús).

council. All councilors at the local councils are elected. The quality of local councils widely varies – while some are actively involved in every detail others are more passive.

The participation of civil society in the provision of healthcare through health councils is a particular characteristic of the Unified Health System in Brazil. Conversely, in Argentina civil society does not actively participate in healthcare. Another difference between Brazil and Argentina is that while in the former municipalities are in charge of primary healthcare, in the latter health administration is mostly under the realm of provinces. Similar to Brazil, though, policy legacies and territorial infrastructure shape the successful implementation of health policies, while partisan alignments are irrelevant. The next section analyzes a major health policy in Argentina, Plan Nacer, which had important implications for the provision of primary healthcare.

**Plan Nacer in Argentina**

Argentina's health system includes three components – social insurance funds financed by formal workers (*obras sociales*, administered by unions), a private sector, and a publicly-financed sector (administered by provinces and big municipalities).[139] Compared to Brazil, primary healthcare provided by the public system is less developed in Argentina. The main institution in charge of providing preventive healthcare is the *Centro de Atención Primaria* (Primary Health Center, CAPS). Fully-staffed CAPS include doctor, nurse, pharmacist, obstetrician, therapist, dentist, social worker, and health agents (*agentes sanitarios*). Health agents are defined as the nexus between the community and the health center, but they receive more limited training and resources compared to health agents in Brazil. In addition, primary healthcare administration is

[139] Around 40 percent of the population were exclusive users of the public system in 2009 (Cortez et al. 2012, 1). For a description of the health system in Argentina, see Niedzwiecki (2014).

not unified as in Brazil: the characteristics and quality of CAPS vary widely, and primary healthcare is generally administered by provinces but sometimes also by municipalities.

Plan Nacer directly intervenes in the provision of primary health since 2005, representing around 10 percent of the health public budget in 2009 and covering five million people in 2012 (Argentina 2012b; Cortez et al. 2012). It is targeted to all women up to 64 years old and children until 19 years old without health insurance.[140] The policy finances medical procedures at no costs for the patient. Most of these procedures fall in the realm of preventive healthcare, such as health check-ups, immunizations, sexual and reproductive health, and general health coverage. For the provision of these health procedures, Plan Nacer transfers funds from the federal government to all provinces and the municipalities in charge of administering healthcare, and these funds are then transferred to health providers – CAPS and hospitals. While 60 percent of the funds are transferred monthly after a subnational unit enters the program (and starts signing-up patients), the other 40 percent are conditioned on agreed-upon targets between the national government and each province. These health targets are called *trazadoras*, and there are ten of them.[141] The province or municipality then transfer the resources to health providers based on the quantity and type of medical services actually offered the previous month. The amount of transfer for each particular medical procedure is set by the province or municipality, based on an equation that cannot surpass the total amount of transfers from the federal government.

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[140] Plan Nacer expanded its targeted population in late 2012 (and changed its name to *Sumar* or Addition). Until 2012, it covered pregnant women and children up to six years old. Senior citizens in Argentina (65 and older) are covered through the *Programa de Atención Médica Integral* (Comprehensive Medical Attention Program, PAMI).

[141] The degree of compliance with each objective determines the percentage of funds transferred. If the province or municipality do not comply with the previously agreed minimum results for three consecutive months, a new agreements needs to be signed.

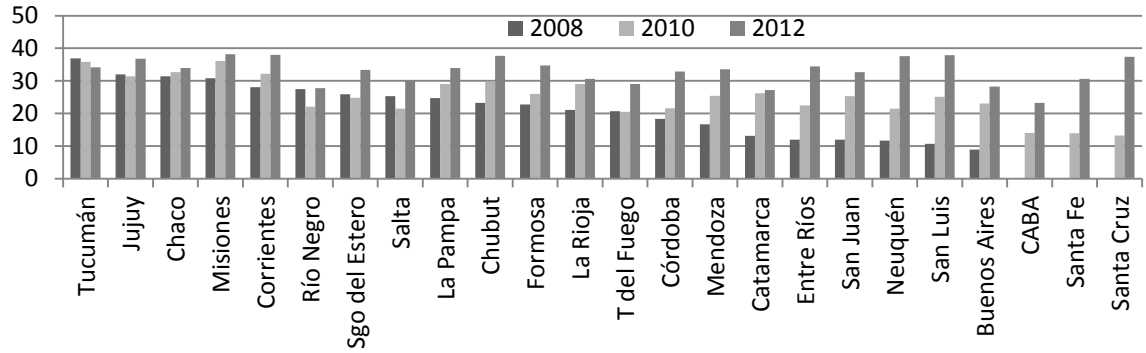
Plan Nacer is a moderate universal policy, as defined in chapter 3. Its targeted population is broad (uninsured children and women), the policy is distributed to all those who meet the eligibility criteria without political manipulation, and there is improvement in the quality of the public health system, thus narrowing the gap in quality compared to private providers. However, Plan Nacer is funded partly by a World Bank loan and partly by the federal government, and therefore at least one of its funding sources is not sustainable.[142] In the long term, the policy aims at strengthening the public provision of healthcare, thus narrowing the gap between the public and private systems (Auditoría General de la Nación 2008, 18). This is made possible because CAPS and public hospitals now have a monetary incentive for improving their facilities, filling out forms, and developing good quality medical histories of uninsured people, something that used to be a reality of insured patients only. The incentive to keep accurate records has to do with the fact that if the doctor does not fill-in the medical history of a given patient, then that medical procedure does not receive the transfer from Plan Nacer. As a former Secretary of Health of the province of Mendoza put it: "[Plan Nacer] pays us to do our job…We enhance the registry and the quality of medical procedures" (Interview Saracco). As a result of these changes, the experience of going to the health center is improved, and thus some patients who have low quality health insurance, although not eligible for Plan Nacer, sometimes prefer to go to the CAPS for treatment (Interviews Arce, Heguiabehere, Matta, Mercado, Musri, Nuñez, Reales, Varcalcel).

To implement Plan Nacer, the federal government signs an agreement (called *Convenio Marco* or umbrella agreement) with each province and the municipalities in charge of administering healthcare, and then that province or municipality signs an agreement with each

[142] Provinces have started to partially fund Plan Nacer since 2009, but their contribution has been overall marginal (Interviews Mercado, Miatello, Mussoto, Sabignoso). Having said that, provinces do fund most of the overall provision of healthcare.

public health provider (CAPS or hospital) called *Compromiso de Gestión* (management compromise). First, the umbrella agreement defines the responsibilities and health targets of each territorial level and is implemented through a contract that is renegotiated each year. Second, the management contract between the provinces and the health provider defines the providers' responsibilities, including signing-up recipients, providing medical services, billing the province or municipality for these services, and maintaining clinical and financial records. Finally, the World Bank and the Argentine Supreme Audit Institution (*Auditoría General de la Nación*) develop regular audits to hold the national government, subnational units, and health providers accountable; they ensure that funds are used according to the policy's guidelines, and contribute to building capacity for adequate health provision (Auditoría General de la Nación 2008; Cortez et al. 2012, 8).

**Figure 6.6: Degree of implementation of Plan Nacer measured through health targets (trazadoras).**




Source: Argentina (2013)

Figure 6.6 shows the successful implementation of Plan Nacer from 2008 to 2012, using the government's indicator. The Ministry of Health measures the degree of implementation as

the average of the percentages of coverage of different medical procedures.[143] The following ten percentages are averaged: pregnant women with the first prenatal checkup before the 20th week of gestation, sexual and reproductive counseling to puerperal women within 45 days after giving birth, new borns' health check-ups (Apgar score of six or higher five minutes after delivery), new born babies who are not underweight, vaccine coverage of pregnant women (including tetanus and test for sexually transmitted diseases), vaccine coverage in babies under 18 months (measles-mumps-rubella), health check-ups for children under age one, health check-ups for children under six years old, fully evaluated cases of maternal and child mortality, and personnel trained in indigenous medicine.[144] The first provinces in the figure (Tucumán, Jujuy, Chaco, Misiones, Corrientes, Santiago del Estero, Salta, and Formosa) are the places where the policy was implemented first (in 2005), for being the poorest provinces in the country, with the highest levels of maternal and child mortality. Therefore, their coverage starts higher in 2008 and then remains stable. The rest of the provinces were incorporated in 2007, after some of the original nine provinces had reached at least 25 percent of the target population, 20 percent of the World Bank loan had been disbursed, monitoring had been successful, and at least five new provinces were ready to join (Cortez et al. 2012, 3).[145]

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[143] The target levels vary by province, and are negotiated between the national and subnational governments. The medical procedures included here cover the original target population – pregnant women and children. This indicator was updated in 2013 after Plan Nacer expanded its target population.

[144] While the first eight objectives are services delivered to women or children, the ninth refers to the investigation of why a mother or child died with the aim of reducing preventable deaths in the future. The last indicator applies to indigenous populations, which comprise three percent of the total population in Argentina, and are traditionally poor and excluded; it aims at promoting culturally and linguistically equipped health providers for pregnancy, births, and child care procedures (Cortez et al. 2012, 15).

[145] The province of Santa Cruz implemented Plan Nacer last because salaries for the administration of this policy were lower than salaries paid by the province. Therefore, it took a longer time to reach an agreement. In the case of the province of Santa Fe, it considered that it was too costly to start signing-up children, and therefore focused almost entirely on providing good quality health coverage for pregnant women, and thus its low coverage (Interview Mercado).

A salient characteristic of this policy is that it is implemented in aligned and opposition provinces alike. As figure 6.6 shows, the opposition province of San Luis and the aligned province of Mendoza implement this policy at similar levels. While Mendoza starts at around 15 percent and San Luis at around 10 percent in 2008, in 2012 San Luis reaches almost 40 percent (being amongst the better performers) and Mendoza reaches around 35 percent. Disaggregating the indicator into the different health targets also positions San Luis and Mendoza at similar levels of implementation (Ministerio de Salud de la Provincia de San Luis 2011). In addition, there is no record of a province who has decided not to sign the agreement with the federal government. The opposition province of San Luis, for example, signed the agreement with the national government on January 1, 2007, and was among the first provinces to join the expansion of Plan Nacer in 2012 (Interview Mercado; Argentina 2012b). Finally, chapter 4 showed that partisan alignments were not a statistically significant predictor of successful implementation of Plan Nacer. I argue that partisan alignments are not correlated with Plan Nacer's implementation due to a lack of clear attribution of responsibility, the focus of the next section.

***Blurred Attributability and Irrelevance of Partisan Alignments***

Attribution of responsibility is not clear in Plan Nacer. Eligible patients do not generally recognize that they are actual or potential beneficiaries of this policy, and therefore it is not clear to them who they should reward for it (Interviews Calderón, Carrizo, Mattar, Sabignoso, Varcalcel). A survey conducted by the National Ministry of Health in 2007 among 5,159 eligible pregnant women belonging to native populations revealed that 60 percent of the sample did not know Plan Nacer at all (Argentina 2007). Along similar lines, of the 47 potential beneficiaries who I asked who provided Plan Nacer, 64 percent (30) answered they did not know and only 34

percent referred to the national government.[146] Different to the Argentine conditional cash transfer, analyzed in chapter 5, where beneficiaries directly identify the policy with the federal government, in Plan Nacer there is no clear attribution of responsibility, and therefore political credit is not assigned to any particular level of government.[147] In the words of a Regional Director of Primary Healthcare in the Province of San Luis:

> People are not aware that they have Plan Nacer, they do not know what benefit it gives them…They do not see that the benefit is for them. Some people even say 'I do not have anything, I have that thing called Plan Nacer, but I do not have anything'…[it works so well] because people do not identify where it is coming from (Interview Mattar).

As a service, compared to a cash transfer, it is expected that attribution of responsibility is less clear. In addition, the design of the policy contributes to further blurring attributability. First, there is no direct relationship between Plan Nacer and the patient. The monetary incentive is given to health centers and hospitals, and not to patients. The indirect benefit for patients is that they receive more medical controls (because the health unit receives money for each medical procedure) and that the conditions of the building improve (because the transfers from the federal government can be invested on enhancing the health unit). Nevertheless, the patient does not necessarily connect more health check-ups and better facilities with Plan Nacer.

Another characteristic in the design of this policy that blurs attributability is that at every level, ranging from the federal government to a small health-center, actors expressed the idea that each of them is autonomous and independent in the implementation of the policy (Interviews Cardello, Farjado, García, Mattar, Mercado, Miatello, Mussoto, Musri, Nuñez,

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[146] I define potential beneficiaries as women who are users of the public system. All interviews were conducted at CAPS or public hospitals.

[147] Interestingly, of the 13 people who identified Plan Nacer with a cash transfer (and possibly thought that Plan Nacer was the same thing as Asignación Universal por Hijo), eight identified the national government as the main responsible of the policy.

Rodriguez Assaf, Sabignoso, Saracco; Cortez et al. 2012, 36). This is true within reasonable boundaries: the national government and the World Bank set the general guidelines through establishing the list of health prescriptions and conducting monitoring activities, provincial governments give a monetary value to those prescriptions and monitor the use of transfers,[148] and health providers receive money for each medical service offered and can spend that money towards the enhancement of the health-center or hospital.[149] With this many levels of implementation, it is expected that attribution of responsibility is blurred. The Director of Primary Healthcare in the opposition province of San Luis (first) and the Director of Plan Nacer at the national level (second) expressed this idea in the following terms:

> We work very well with the national government in healthcare…Because one thing is to try to reach an agreement with the province and a different thing is to try to implement a pre-packaged (*enlatado*) program which will not work because we need to adapt them to our local reality…We consider Plan Nacer as our own child, our own child that we have to defend (Interview Fajardo).

> The program is very cooperative, particularly in the way we incorporate the province…And that has been favorable for the way it works…But the provinces will never take on 100 percent of the funding, because otherwise the national government would lose its leadership in the program…If we want to keep on maintaining the principles of the program, the national government needs to maintain that leadership (Interview Sabignoso).

Given that the primary beneficiaries are not the patients and that participation of multiple levels of government contributes to blurring attributability, national and subnational governments can in some cases share responsibility and in others dispute responsibility.

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[148] In assigning a monetary value to medical procedures, the province is also shaping the primary health strategy. For instance, while San Luis assigned one of the highest monetary values to early pregnancy check-ups (Interview Nuñez), Mendoza emphasized postpartum check-ups to babies and mothers (Interview Saracco).

[149] The transfers from Plan Nacer can be used towards the following expenditures: to improve the building, to buy medical and general supplies, and to pay bonuses or incentives for the staff (Argentina no year; Cortez et al. 2012, 19).

Provincial governments share responsibility in television advertisements, where they include the logos of both the national and subnational governments.[150] The same is true for sign-up, health targets, billing, and medical histories' forms, which generally include the logos of Plan Nacer, the national government, and the provincial government. At the same time, blurred attribution of responsibility also means that attributability can be disputed. For this reason, the national government develops print and television advertisements with the national logo only, trying to self-attribute responsibility for Plan Nacer.[151] Nevertheless, given the characteristics of the design of the policy described above, the efforts towards a clearer attribution of responsibility are not effective.

As a result of such blurred attribution of responsibility, opposition provinces and municipalities do not hold-back the implementation of Plan Nacer. For opposition subnational governments the implementation of Plan Nacer is a win-win situation –they receive the transfers from the policy at no electoral cost. Therefore, the opposition province of San Luis does not put obstacles for the implementation of this policy (Interviews Mercado, Mussoto, Nuñez). In fact, the software developed in San Luis for billing medical procedures and signing-up recipients for Plan Nacer was so advanced that the federal government invited the responsible developer to present it in Buenos Aires in 2010 with the aim to reproduce this methodology in other provinces. As a result, around fifteen provinces agreed to adopt a similar software by 2012

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[150] See for example advertisements of Plan Nacer in the provinces of Catamarca (http://www.youtube.com/watch?v=oriLLjBgwww&feature=related), Formosa (http://www.youtube.com/watch?v=bmVPEs8SJXA&feature=related), and La Rioja (http://www.youtube.com/watch?v=_sF81FsYuX8&feature=related). Last accessed on February 6, 2014.

[151] See for example advertisements from the national government (http://www.youtube.com/watch?v=52Ad_fNfsXU; http://www.youtube.com/watch?v=c6bgBVozHtw; http://vimeo.com/11175775), Last accessed February 6, 2014.

(Interview Nuñez; Argentina 2012a). Additionally, the province of San Luis considers the federal government a partner in the implementation of this policy (Interviews Mercado, Nuñez).

The lack of relevance of partisan alignments for the successful implementation of Plan Nacer finds a correlate at the municipal level. In the words of a former Health Secretary in the Province of Mendoza: "Every province and municipality accepts Plan Nacer; Why wouldn't you accept it if it gives you money…In fact, we sometimes implemented Plan Nacer better in opposition than in aligned municipalities" (Interview Saracco). High level health bureaucrats in opposition municipalities confirmed this lack of partisan alignment effect for the implementation of Plan Nacer (Interview Maccio, Martinez, Varcalcel). While partisan alignments do not shape the implementation of Plan Nacer, territorial infrastructure and policy legacies do impact the way in which this policy is implemented. The next two sections analyze these variables in each of the provinces and municipalities included in this study.

### *Territorial Infrastructure*

The infrastructure in the territory shapes the successful implementation of Plan Nacer, in particular the presence and characteristics of health centers and hospitals. The quantity of health units is not the only component of infrastructure; the geographical location and the quality of these institutions also matter. In other words, how evenly distributed in the territory these units are and how close to poor areas. In addition, it is important that the personnel (doctors, nurses, health agents, and assistants) are trained, and that they have the necessary medical devices. While civil society organizations are central actors in the implementation of Brazil's primary healthcare strategy, they are irrelevant in the implementation of Plan Nacer and in primary healthcare in Argentina more generally.

Both provincial cases, San Luis and Mendoza, had developed a robust primary health infrastructure through Primary Health Services (*Atención Primaria de la Salud*) since the Federal

Health Plan (*Plan Federal de Salud*) was implemented in 2004. Plan Nacer works directly through these health institutions, and particularly through CAPS, most of which are funded by provinces and big municipality. Within CAPS, health agents are crucial for signing-up uninsured women and children to Plan Nacer, as well as for identifying populations in risk, such as pregnant women, elderly people, and new-borns. Besides CAPS, hospitals also participate in Plan Nacer, both through the provision of primary healthcare and through more complex procedures such as assisting births. Overall, the provinces of San Luis and Mendoza implement Plan Nacer successfully because they can rely on a developed infrastructure of CAPS and hospitals. However, their strategies for administering the provision of healthcare (and therefore of Plan Nacer) is different. San Luis centralizes health provision in the province and Mendoza partly decentralizes primary healthcare to large municipalities.

*Province of San Luis*

In the case of San Luis, the province almost entirely administers the provision of healthcare. The province is responsible for all hospitals and CAPS; there are no municipal health providers.[152] The coordination of Plan Nacer is conducted from its offices in the Provincial Department of Health. The province transfers the funds to each health provider and is in charge of monitoring the use of such funds.[153] Therefore, successful implementation of Plan Nacer in San Luis is mostly reached by the efforts of the provincial Health Department, CAPS, and hospitals, all of which fall under provincial realm.

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[152] The only exception is one CAPS within a community center in the municipality of Merlo.

[153] The Systems Analysts of Plan Nacer in the province of San Luis provided an illuminating example of why centralizing the administration of healthcare in the province is a good strategy –if the province has planned to buy stretchers with its own funds and sees in the system that a health unit has budgeted to buy stretchers with money from Plan Nacer, the province suggests the health unit to wait until the stretches from the province arrive, and to use Plan Nacer money for something else (Interview Nuñez).

The province of San Luis has 131 CAPS, 28 medium-complexity hospitals (*centros de referencia*), and two high complexity hospitals (*hospitales de cabecera*).[154] Most of the CAPS (97) and all 30 hospitals have signed agreements with the provincial government to implement Plan Nacer by 2012 (Ministerio de Salud de la Provincia de San Luis 2012a). There is only one community health agent per 10,000 inhabitants, which is much lower than the target in Brazil. Health agents are required to have completed high school and are paid US$530 per month for 30 hours of work per week (Interview Leyes).[155] Doctors must be working at the CAPS with exclusivity, and their medical degree is blocked to make sure this is the case.[156] Although health professionals are well trained for their jobs, they expressed discontent with the basic salary for doctors of less than US$1,000 per month with almost any level of experience (Interview Arce; *El Diario de la República, San Luis* 2009).

The provision of healthcare in the province of San Luis is divided into six geographical areas for better administration; each geographical area includes a number of municipalities. The municipality of San Luis belongs to region V (Capital region) and Villa Mercedes belongs to region VI (Pedernera region). The province is responsible for the administration of each of these six areas. The province funds and designs health strategies, and trains medical and non-medical personnel for the implementation of Plan Nacer.[157] Table 6.1 presents data on the implementation of Plan Nacer in San Luis City and Villa Mercedes in 2012. The level of

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[154] The areas that are not covered by these health units receive either a health post with a nurse or community health worker, or a temporary team of doctors and nurses carrying vaccines and preventive health resources (Interview Fajardo).

[155] Official exchange rate US$1=$6, as of November 20, 2013. All conversions in Argentina are taken at this rate.

[156] Aside from the work at the CAPS, health professionals can teach at universities for a limited amount of hours.

[157] This includes, for instance, training in filling-in medical histories and billing of medical procedures.

implementation of this health policy across these two municipalities is almost identical, with the City of San Luis marginally surpassing Villa Mercedes in the level of coverage as a percentage of the targeted population, the level of training of personnel, and the percentage of the federal budget that has been already spent. The similarity in the implementation of this policy has to do in part with similar territorial infrastructure and the same provincial health administration.

**Table 6.1: Implementation of Plan Nacer in San Luis City and Villa Mercedes (Province of San Luis, 2012)**.[158]

| | Coverage as a % of targeted population | Agreements signed with health units as a % of eligible health units | Level of training of personnel (as a % of budgeted training) | Level of spending (as a % of funds transferred) |
|---|---|---|---|---|
| **San Luis City** | 119% | 100% | 78% | 58% |
| **Villa Mercedes** | 110% | 100% | 73% | 53% |

Source: Ministerio de Salud de la Provincia de San Luis (2012b)

Both municipalities have comparable health infrastructure. Figures 6.7 and 6.8 present a map of the municipalities of San Luis and Villa Mercedes, respectively, showing the geographical location of CAPS (in smaller font) and hospitals (in larger font). In the City of San Luis, there are 13 CAPS and four hospitals, one of which (Hospital San Luis) is a high complexity hospital. Comparatively, there are 12 CAPS and three hospitals in Villa Mercedes. Overall, health units are evenly distributed across the territory of both municipalities, and given that the province administers the whole territory, there is coordination among them. Finally, there are 22 health agents in the City of San Luis and 18 in Villa Mercedes, all of which are trained by the provincial Department of Health (Interview Leyes).

[158] The data includes the departments of capital (which includes San Luis City among other municipalities) and General Pedernera (which includes Villa Mercedes among other municipalities).

**Figure 6.7: Primary health centers and hospitals in San Luis City.**

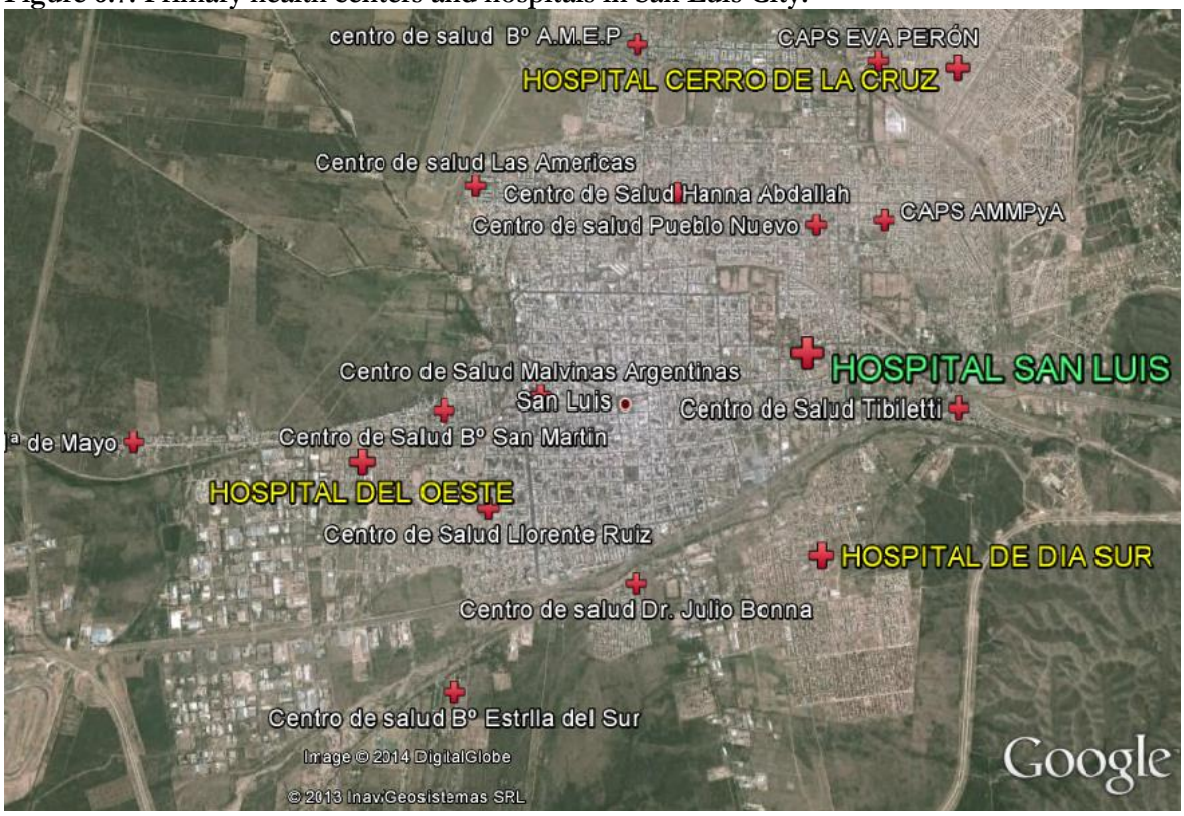


**Figure 6.8: Primary health centers and hospitals in Villa Mercedes.**

*Province of Mendoza*

As depicted in figure 6.6, the province of Mendoza is at least as successful as San Luis in the implementation of Plan Nacer. This is in part because both provinces have similarly adequate territorial infrastructure for the provision of healthcare. Nevertheless, their strategies for providing healthcare are different; San Luis concentrates the implementation of healthcare in the province, while in Mendoza the province and municipalities share the administration of health.[159] Within each of the 18 municipalities there is a Director of Health that represents the province, and some of the larger municipalities have a parallel health structure dependent on the municipal level. Ideally, the entry port should be the CAPS (administered by the province or large municipalities) distributed throughout the neighborhoods, the patient should be then directed to medium-complexity centers (one per municipality, administered by the province), and subsequently to one of the four high complexity hospitals across the province.[160] Three of these four hospitals are under the realm of the province and one of them is the responsibility of the federal government. There are 21 of the 22 hospitals implementing Plan Nacer, as well as around 219 CAPS (Potenza Dal Masetto 2011, 40).

Since both municipal and provincial levels of government are responsible for the administration of CAPS, both territorial levels have a role in the implementation of Plan Nacer. There are more than 300 CAPS located throughout the province, 80 percent of which are

[159] A particular characteristic of provincial health administration in Mendoza is that it is partly funded by gambling and casinos (*Instituto Provincial de Juegos y Casinos*). As a result, there is always a stable source of funding (Interview García).

[160] This path from lower to higher-complexity is not generally followed during emergencies, when patients choose to go directly to high complexity hospitals (Interview García).

administered by the province and the rest are administered by the municipalities.[161] In order to implement Plan Nacer, health centers need to have minimum infrastructure, such as the capacity to keep a registry of medical procedures and patients. The current Director of Maternal Health in the province of Mendoza (and former Director of Plan Nacer in the same province) expressed this idea in the following terms:

> Some health centers do not have an agreement with Plan Nacer because they do not have the capacity to administer this policy. This may seem like Plan Nacer excludes the most vulnerable centers, but the truth is that these places do not even have the capacity to bill their medical procedures, because they do not even have computers (Interview Cardello).

Given that most health providers are provincial, we should not expect significant differences across municipalities with similar levels of GDP per capita and population density. Table 6.2 presents the indicators for the implementation of Plan Nacer across two similar municipalities, Godoy Cruz and Las Heras. The first two columns compare the total spending of health units dependent on the province (first column) and on the municipality (second column) funded by Plan Nacer transfers. The third column shows the total quantity of recipients of Plan Nacer within the territory of the municipality. While Godoy Cruz has higher rates of spending, Las Heras is a better performer in terms of quantity of recipients. Overall, both municipalities end up being similarly successful at the implementation of Plan Nacer, but in different aspects.

**Table 6.2: Implementation of Plan Nacer in Godoy Cruz and Las Heras (Province of Mendoza)**

| | Total spending in provincial health units (accumulated 2007-2011) | Total spending in municipal health units (accumulated 2007-2011) | Total recipients of Plan Nacer (2010) |
|---|---|---|---|
| Las Heras | US$88,986 | US$19,128 | 10,350 |
| Godoy Cruz | US$175,196 | US$25,060 | 7,055 |

Sources: Plan Nacer Mendoza (2012); Goldar (2012)

[161] Provincial CAPS are fully funded and administered by the provincial government and municipal CAPS are fully funded and administered by the municipal government. However, there are a number of municipal CAPS that receive joint funding from the municipal and provincial governments.

In the municipality of Las Heras, there are three hospitals and 22 CAPS, 14 of which are provincial and eight are municipal. Figure 6.9 shows the distribution of these health units across the territory of the municipality.[162] Of the 22 CAPS, 21 are part of Plan Nacer.[163] However, some of these CAPS do not have the capacity to fill in forms and provide good quality healthcare, and that hinders the implementation of Plan Nacer. In particular, almost half of the provincial CAPS do not have the personnel to fill in patients' registries and bill medical procedures necessary to receive the transfers from Plan Nacer. As a result, these CAPS constantly received only 50 percent of the transfers from the policy, a situation that has been dealt with by the province through centralizing the filling of forms of those CAPS in the province (Interview Musri). Compared to Brazilian health units, CAPS in Argentina do not have an active strategy of looking for the community outside of the health unit. There are seven health agents that work in the 22 CAPS, but most of their activities are limited to work within the health center (Interviews Musri, Reales). The situation is different for the three municipal CAPS that lie within *centros de intergración comunitaria* (community centers, CICs), where the community meets in a single place for the provision of heath, early education, and social development (Interviews Berrios, Miranda, Musri). The CAPS within the community centers have been successful at reaching out the community outside of the CAPS and signing-up most eligible recipients of Plan Nacer. In addition, the quality of the service is adequate, since community centers are relatively new buildings and are informally monitored by the population who participate in their activities

[162] For presentation purposes, one CAPS and one hospital are not shown in the figure.

[163] The one health center excluded from Plan Nacer does not reach the minimum requirements (including a land line telephone) to access the policy (Interview Musri).

(Interviews Musri, Quintana). Overall, the municipality of Las Heras lacks the infrastructure to fill-in forms but is more successful than Godoy Cruz at reaching out to the population.[164]

The implementation of Plan Nacer in the municipality of Godoy Cruz surpasses that of Las Heras in the administration of spending but it is not as successful in overall coverage, as table 6.2 shows. Provincial and municipal CAPS in Godoy Cruz have overall more personnel for filling-in forms and keeping updated registries. The provincial administration of healthcare in this municipality, for instance, invested on a team exclusively in charge of administering the funds from Plan Nacer. This strategy has enhanced spending indicators. However, Godoy Cruz has more limited territorial infrastructure compared to Las Heras, as it was analyzed in chapter 5. For the provision of healthcare, there are 18 CAPS and two hospitals within this municipality, shown in figure 6.10, and only two of these CAPS are municipal.[165] Thirteen provincial and both municipal CAPS implement Plan Nacer. Nevertheless, one of these municipal CAPS is located in a middle class neighborhood (where most people are not users of the public system) and the other one is surrounded by provincial health services. For the latter, "there is superposition of supply between the province and the municipality because there is no coordination between the two levels" (Intreview Martinez). In addition, none of the CAPS are within community centers as in Las Heras, a model that is proving to be successful for the implementation of Plan Nacer. Finally, there are four health agents, and they have a limited role in the community.[166]

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[164] Las Heras' success at reaching the population was also evident in the implementation of the conditional cash transfer analyzed in chapter 5.

[165] There are also a number of municipal health posts that do not reach the minimum qualifications for accessing Plan Nacer.

[166] Health agents have to live in the neighborhood where they work and have to pass exams (Interviews Saralago, Zamora). However, municipal health agents only leave the CAPS once a week.

**Figure 6.9: Primary health centers and hospitals in Las Heras.**

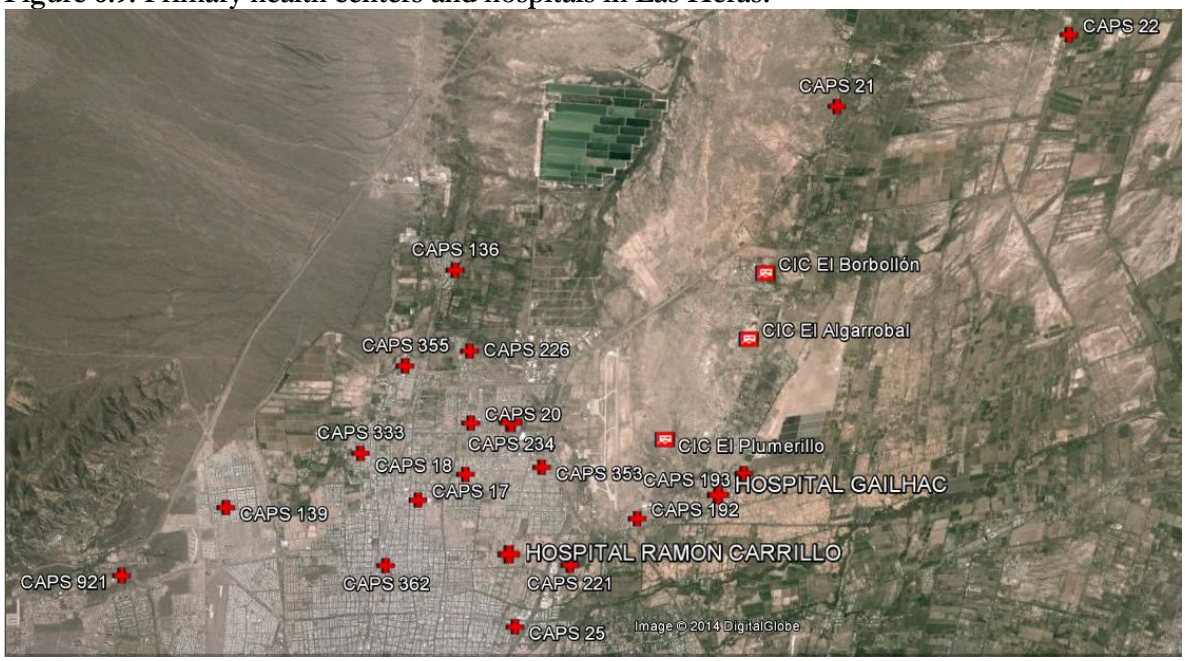
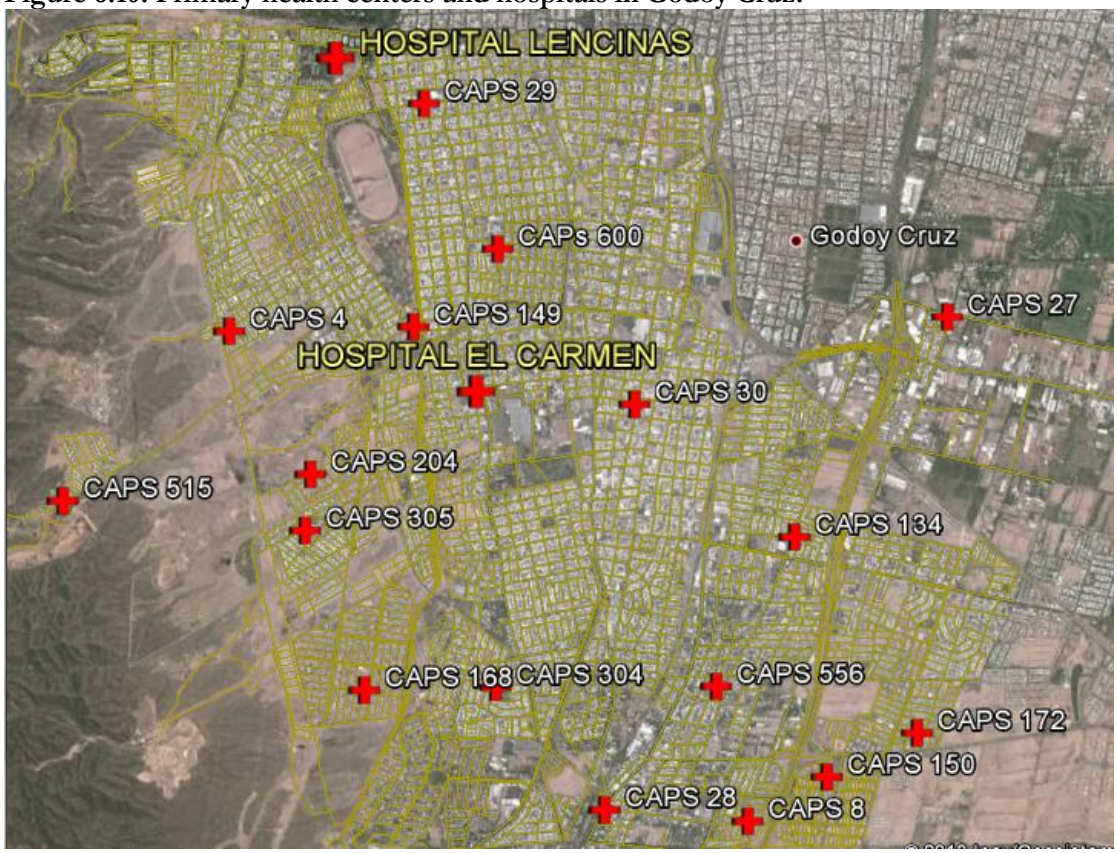



**Figure 6.10: Primary health centers and hospitals in Godoy Cruz.**



### *Positive Policy Legacies*

Plan Nacer does not affect any entrenched interests from previous policies, as Estrategia Saúde da Família in Brazil does, and actually benefits from the legacies of previous policies. As it is the case in Brazil, most health resources in Argentina correspond to hospitals' spending. Nevertheless, this does not affect Plan Nacer given that it transfers resources to both hospitals and CAPS. In this way, Plan Nacer avoids a conflict between the high complexity and primary strategies for the provision of healthcare. Having said that, the transfers of Plan Nacer represent a significantly higher percentage of the budget of CAPS than hospitals. Hospitals have such a high budget already, that the money from Plan Nacer is marginal. Conversely, for CAPS, Plan Nacer was "a blessing; if it wasn't for Plan Nacer, we would not have money even for the basic things" (Interview Musri).

The most direct positive policy legacy to Plan Nacer is the *Programa Materno Infantil y Nutrición* (Maternal and Child Nutrition Program, PROMIN), which was implemented since the mid-1990s. It was targeted to women and children younger than six years old who lived in areas where the poverty level was higher than 25 percent. In these places, CAPS and hospitals were in charge of implementing this policy that aimed at funding projects on infrastructure, training, communication, and buying medical supplies for health providers. This policy was also funded mostly by the World Bank and partly by the federal, provincial, and municipal governments (Auditoría General de la Nación 2008; Chiara and Di Virgilio 2005, 130–33). Although the program was narrowly targeted, it did develop initial capacities in health centers, hospital, provinces, and municipalities that Plan Nacer would benefit from.

Another national health policy that enhances the implementation of Plan Nacer is the Medicine Program *(Programa Remediar*). Since 2002, this policy comprises the delivery of a first aid kit from the central government to CAPS, to be then directly delivered to the population.

Both Plan Nacer and Remediar aim at strengthening the primary health network, by increasing the take-up rate of public primary health services – Remediar through providing medicine resources and Plan Nacer through transferring funds for the improvement of the service in the CAPS (Tobar 2004, 13). In addition, most CAPS where Plan Nacer is implemented also have Remediar, which allows for delivering free medicine to Plan Nacer recipients. In this way, the transfers from Plan Nacer do not generally need to be used for buying medicine.

Besides these national health policies, Plan Nacer is also enhanced by the conditional cash transfer Asignación Universal por Hijo, analyzed in chapter 5. Recipients of Asignación now visit the doctor more often to conduct health check-ups necessary for receiving 20 percent of the cash transfer. Therefore, demands for check-ups have consistently increased since the implementation of Asignación in 2009 (Interviews Arce, Cardello, Carrizo, Fajardo, García, Goldar, Mercado, Miatello, Nuñez, Reales, Saracco; Cortez et al. 2012, 25; Goldar 2012). In fact, since Asignación was implemented in 2009, there was an increase of three million new children signed-up for Plan Nacer, which means an increase of around 50 percent in Plan Nacer's national coverage (Argentina 2012c). In addition, the incorporation of pregnant women to Asignación, expanded Plan Nacer's coverage of pregnant women in 14 percent (Argentina 2012c, 10).[167] A former Secretary of Health in Mendoza remembered that when Asignación was first launched,

> health centers started being flooded with families seeking vaccination….CAPS started receiving more and more children. It was clear that Plan Nacer was under-utilized before Asignación…Both policies generate a positive feedback (Interview Saracco).

Not only national policies provide positive legacies for the implementation of Plan Nacer; provincial policies in San Luis and Mendoza also enhance Plan Nacer's implementation.

[167] Pregnant women receive 80 percent of the monthly transfer and the remaining is given at the end of the pregnancy (when the baby is born or the pregnancy is interrupted) and is conditioned upon health check-ups.

The main positive legacy for the implementation of Plan Nacer in the province of San Luis is the provincial workfare program (*Plan de Inclusión Social* or PIS) analyzed in chapter 5. The administration of Plan Nacer initially hired 27 PIS workers for signing-up patients and for data entry activities (Interview Mercado; *El Diario de la República, San Luis* 2007). In addition, most of the administrative and cleaning staff working at the CAPS is also funded by the provincial workfare program. These workers are very necessary for the normal functioning of the CAPS. For example, in a CAPS located in the City of San Luis, the two cleaning staff and four of the five administrative staffs are paid by the provincial program (Interview Arce).[168]

Plan Nacer in the province of Mendoza is marginally enhanced by a provincial program called *Comer Juntos en Familia* (Meals with Family). This provincial program has been implemented since 2009 and entails a basket of food handed out every other week.[169] It is implemented through civil society organizations and some municipalities (Interviews Martin, Massolo, Spoliansky). The provincial food program targets families under the poverty line (and who previously participated in soup kitchens)[170] and covered more than 1,000 families (5,500 people) in 2011 (Ministerio de Desarrollo Humano, Familia y Comunidad de Mendoza 2011a). The basket of goods is conditioned upon participation in training activities that include cooking courses as well as basic courses on preventive health and hygiene. In these courses, recipients are trained on the importance of health check-ups conducted by CAPS and covered by Plan Nacer.

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[168] The working conditions of these people are precarious since they do not enjoy access to the same salaries and the same benefits as workers included in the formal labor market who conduct similar activities (Interviews Bragagnolo, Carrizo, J. Gomez, Matta). As it was analyzed in chapter 5, beneficiaries of the provincial workfare program work for very low wages (US$140 per monh), with no pension contributions, and with no health insurance for their families. They work side by side and develop the same activities as workers hired by the formal labor market who earn around US$580 and enjoy full benefits (Interview Arce).

[169] The idea is to transition to an ATM card in the future.

[170] The policy aims at closing soup kitchens, arguing that they hinder beneficiaries' autonomy, and enhancing family meals at home (Interviews Massolo, Spoliansky).

In this way, the beneficiaries of the food program are encouraged to attend the local CAPS on a regular basis, thus marginally expanding Plan Nacer coverage.

**Conclusions**

This chapter analyzed the determinants of the successful implementation of national health policies in Brazil and Argentina. The most relevant finding for this study is that partisan alignments do not matter for the implementation of these policies because there is no clear attribution of responsibility. This is different from the conditional cash transfers analyzed in chapter 5, where recipients could identify who was responsible for these policies and could therefore potentially reward that party or government level in the elections. In those cases, the alignment between national and subnational levels of government shaped the performance of these policies. Conversely, these health policies do not carry clear attributability because recipients do not generally identify being direct beneficiaries of them. In addition, the decentralized implementation of health policies in Argentina and Brazil also contribute to blurring attributability.

This chapter has also highlighted the relevance of positive policy legacies and strong territorial infrastructure for successfully implementing national health policies. In the case of policy legacies, the presence of previous health systems that competed against the new system of primary healthcare in Brazil hindered the implementation of the policy. This is generally the case in middle to upper income subnational units where sectors of the population were previously covered by other health systems, be it the previous primary health structure, private insurance, or high complexity systems. Conversely, Plan Nacer did not face opposition from competing health strategies since it was originally funded by the World Bank and particularly since it transfers funds to both primary health centers and hospitals, thus avoiding conflict over resources. In addition, while the Brazilian health policy aimed at reorganizing the provision of

the entire health system, the Argentine health policy was just an incentive for enhancing the quality in the provision of public healthcare.

Besides the role of policy legacies, territorial infrastructure played a central role in the implementation of these health policies. Estrategia Saúde da Família was enhanced by good health administration and health councils monitoring the quality of the service. In Argentina, civil society did not participate in the provision of healthcare, and in Plan Nacer specifically. The different participation of civil society in the provision of healthcare in Argentina and Brazil responds to both normative and historical factors. On one hand, primary healthcare in Brazil requires by law the development of health councils that incorporate the state, health providers, and civil society. As a result, almost half of all Family Health Units participate in local or municipal health councils (Brasil 2004, 21). In Argentina, the implementation of Plan Nacer does not include a law mandating the participation of civil society. On the other hand, the participation of civil society for pushing towards universalistic health reforms has a long tradition in Brazil compared to Argentina. The incorporation of the SUS in 1988 constitution was partly the product of pressures from *Sanitarista* movement, a civil society movement that infiltrated the state since the 1970s. As a result of these societal pressures, the health sector became a participatory context, with councils and forums that monitor the implementation of the SUS across all levels of government (Côrtes et al. 2009; Falleti 2010b; Niedzwiecki 2014).

A major implication of these pure universal (Estrategia Saúde da Família in Brazil) and advanced universal (Plan Nacer in Argentina) health policies, is that they contribute to narrowing the gap between the quality of health services in the public and private systems. In this way, they advance social rights. The challenge is to modify the idea that the public system is "poor medicine for the poor" and raise the quality of the service to a level in which the middle class chooses to use the public system for primary healthcare. This topic is resumed in the next

chapter, where I draw the implications of conditional cash transfers and health policies for the advancements of the well-being of the population.

# CHAPTER 7: SOCIAL POLICIES IN DECENTRALIZED COUNTRIES. IMPLICATIONS, LESSONS, AND FURTHER RESEARCH

The previous chapters showed how national social policies are unevenly distributed in decentralized countries as a result of differences in partisan alignments, policy legacies, and territorial infrastructure. Partisan alignments shape the implementation of national policies when attribution of responsibility is clear. When recipients of a given policy can identify where the policy is coming from and therefore potentially reward that government level or political party in elections, opposition subnational units have an incentive to hinder the implementation of national social policies. They can do so by providing bureaucratic obstacles or direct policy competition through their own subnational policies. This was the case of the province of San Luis in Argentina and the state of Goiás in Brazil, both of which refused to sign agreements with the federal government, to whom they were in opposition, and used their subnational cash transfers to compete against *Asignación Universal por Hijo* in Argentina and *Bolsa Família* in Brazil.

Cash transfers enjoy clearer attributability than social services. Therefore, partisan alignments were significant in accounting for the successful implementation of the conditional cash transfers but irrelevant in the case of the health policies. In addition, attributability is a product of the political system – majority systems, compared to minority and coalition governments, generally enjoy clearer attribution of responsibility. As a result, the effect of credit claiming was stronger in Argentina's Peronist majority governments than in Brazil's highly fragmented party system. Finally, attributability can change as a product of politicians' strategies. This was the case of Brazilian conditional cash transfer Bolsa Família, for which the federal government proposed adding the logo of the subnational government in the ATM card in

exchange for collaboration in the implementation of the policy. This strategy produced the collaboration of a number of opposition states. In other words, the weakening of attributability diminished the effect of partisan alignments.

Provided that national and subnational governments are aligned, a strong territorial infrastructure that includes government and non-government institutions can enhance the implementation of national social policies. Territorial infrastructure is important from the initial provision of information about the policy, to its delivery, and to identifying potential recipients that are currently excluded. Civil society organizations proved to be allies in this process, particularly when they were vibrant and independent, such as in the Brazilian City of Porto Alegre. In this place, civil society organized councils in health and social assistance that effectively controlled the quality of the service provided.

Finally, positive policy legacies and feedback effects can further contribute to enhancing national social policies. Such was the case of previous conditional cash transfers in Argentina and Brazil that automatically transferred recipients to Asignación Universal and Bolsa Família when they were first implemented. Conversely, policy legacies that run counter to a given policy can hinder the implementation of national policies. This was the case of the health policy in Brazil, which suffered from set-backs from alternative primary healthcare strategies and high complexity provision.

This framework was developed in chapter 2 and tested empirically through a statistical analysis (chapter 4) and through case studies of conditional cash transfers (chapter 5) and health policies (chapter 6) in Argentina and Brazil's selected states, provinces, and municipalities.

**Policy Implications**

The policies analyzed in this study present a breakthrough in the expansion of social protection in their own countries and in the region as a whole. For the first time, cash transfers are broadly targeted, non-discretionarily distributed, and expected to be permanent; and health policies aim at expanding coverage and enhancing the quality of the provision of services, particularly with regard to primary healthcare. The universalistic characteristic of these new policies, compared to the narrowly targeted policies of the past, has the potential to make significant changes in the development of social capital and the well-being of the population. This is particularly true for Latin America, where contributory social insurance schemes exclude a major portion of the population (Huber and Stephens 2012; Pribble 2013).

In particular, good quality primary healthcare policies have the potential to reduce infant mortality, to strengthen human capital, and to have a redistributive impact (McGuire 2010b; Tobar 2004, 16). To improve the quality of public basic health provision, primary health clinics should be a real option for the middle class – in other words, they should stop being considered "poor medicine for the poor" (*medicina pobre para pobre)*. The good news is that attaining higher levels of commitment in primary healthcare is cheaper than structurally reforming the hospital or national health systems. Similarly, broadly targeted and non-clientelistic social assistance programs have proven successful at developing human capital, by requiring health check-ups and regular school assistance. These programs, together with increases in the minimum wage, have contributed to the decline in inequality of disposable income (Huber and Stephens 2012; Soares et al. 2010). The first policy recommendation is, therefore, that cash transfers and social services should be closer to the "basic universal" principle, as policies that are broadly targeted and provide good quality basic welfare (Filgueira et al. 2005; Huber and Stephens 2012; Pribble 2013).

The main critics of conditional cash transfers 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 the labor market has shown inconclusive results (Bertranou and Maurizio 2012, 5; Garganta 2011; Medeiros, Britto, and Soares 2008; Soares 2012, 23–25). Theoretically, CCTs may produce disincentives to accept a job, but only if that job is of low quality; policy recipients will probably choose a job in the formal sector if working conditions are adequate. In Brazil, I asked 39 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 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), "I would become independent from my husband" (Interview Brazil #28), or "Bolsa Família is not enough for supporting four children, and I do not like being unemployed" (Interview Brazil #20). At the same time, nine people clarified the obvious – that they would only choose the formal labor market if the salary was significantly higher than the monthly transfer through Bolsa Família. Contrary to the idea that social policy recipients are comfortable in this position and do not choose to have a job in the formal labor market, these initial qualitative interviews suggest that policy recipients would work if offered adequate conditions. The second policy recommendation is, therefore, that the creation of good quality formal employment go hand in hand with the development of social assistance policies.

This study carries a final policy recommendation: to be successfully implemented, social policies should avoid clear attributability. While clear attribution of responsibility may increase

the popularity of a leader and her party, it decreases the chances of that policy to succeed in opposition subnational units. In other words, the stronger the attributability, the more challenging it is for opposition subnational governments to claim credit and, therefore, the higher the incentives to hinder the implementation of such policy. The most successfully implemented social policies are those that share credit. Fortunately, attributability is not fixed and is therefore subject to changes. As explained in chapter 2, attributability is shaped not only by the type of policy (cash transfers enjoy clearer attributability than services) and of the political system (majority governments promote clearer attributability compared to minority governments), but also of politicians' strategies. Politicians adopt strategies for maximizing credit claiming and they can also decide to weaken attributability, as it was the case in Bolsa Família analyzed in chapter 5. As a consequence of this strategy in Brazil, a number of states, including several governed by opposition coalitions, have started to join the federal government in actively enhancing the implementation of Bolsa Família.

**Contributions to the Study of Welfare States and Multilevel Governance**

The study of the factors that shape social policy implementation in decentralized countries is informed by and contributes to welfare states and multilevel governance theories. By incorporating subnational variation and moving away from partisanship explanations of welfare development, this research contributes to welfare state theories. In particular, it incorporates subnational variation in state capacity (Ziblatt 2008; Charron and Lapuente 2013), levels of democracy (A. Borges 2007; Cornelius 1999; Gervasoni 2010b; Gibson 2012; Giraudy 2010; Snyder 1999), and party systems (Calvo and Escolar 2005; Krause and Alves Godoi 2010; Leiras 2007; Miguel and Machado 2010; Ribeiro 2010; Wilson 2012). This study argues that it is not the ideology of national and subnational governments that shapes the implementation of policies,

but rather multilevel partisan alignments. This is particularly true for countries in which parties are ill-defined ideologically, and in which coalitions vary at the national and subnational levels. In Brazil, for example, the number of coalitions between right and left parties has reached 60 percent for gubernatorial elections and the same party can join widely different coalitions at the three territorial levels (Krause and Alves Godoi 2010).

By including the role of partisan alignments at multiple territorial levels, this study builds upon fiscal federalism theories that incorporate the role of alignments for shaping cooperation (Garman, Haggard, and Willis 2001; Jones, Sanguinetti, and Tommasi 1999; Larcinese, Rizzo, and Testa 2005; Riker and Schaps 1957; Rodden 2006; Wibbels 2005). As extant research has been mostly focused on fiscal and macroeconomic policymaking, I contribute by adding social policy to the equation. In addition, I incorporate the possibility that subnational governments compete against national ones using their own social policies, a topic that has been mostly omitted in the literature. In doing so, this study fits into the works that study federations as they actually work, instead of using normative models of analysis (see Beramendi 2009).

**Lessons from Universalistic Policies in Argentina and Brazil - Generalizability**

The challenges and opportunities analyzed in the process of implementation of CCTs and health policies in Argentina and Brazil can be applied to the study of any decentralized country in any policy area. Any democratic country in which subnational levels of government enjoy high levels of authority will face challenges in the implementation of social policies when attribution of responsibility of these policies is clear. Following Hooghe et al. (Forthcoming), democracies with

high levels of regional authority include: Argentina, Australia, Austria, Belgium, Brazil, Canada, Germany, Malaysia, Mexico, Netherlands, Singapore, Switzerland, and the United States.[171]

To exhibit this, I focus on the process of implementation of the Patient Protection and Affordable Care Act (commonly called Affordable Care Act or Obamacare) in the United States, an advanced industrial democracy. I then adapt the framework to a training policy in Argentina to show how it also travels beyond universalistic CCT and healthcare to narrowly targeted training policies.

### *The Affordable Care Act (United States)*

After two years of congressional debate, the Patient Protection and Affordable Care Act (ACA) became law on March 23, 2010. The aim of this policy is to increase health quality, affordability, and coverage. In 2010, there were approximately 32 million Americans without health insurance due to its high costs (Jacobs and Skocpol 2010, 4). To achieve these aims, the policy mandates that every U.S. citizen should have health coverage (and provides subsidies for low income individuals), that businesses with more than 50 employees provide health insurance to full-time workers,[172] and that insurance companies provide minimum standards and not discriminate against patients based on pre-existing conditions or sex.[173] Individuals and companies can compare prices and services through health insurance marketplaces (or exchanges) which operate in every state. While the national government is in charge of designing and mostly

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[171] This list includes countries in which non-asymmetric intermediate regions (such as states in the United States) score higher than 15 points in 2010 in the Regional Authority Index (Hooghe et al. Forthcoming).

[172] The implementation of this provision has been delayed until mid-2014.

[173] Insurance companies have to offer the same premium price to all potential patients of the same age and geographical location.

funding the policy, states can participate through expanding Medicaid (a healthcare program for low income individuals) or creating their own health exchanges.

The Affordable Care Act is commonly called "Obamacare" by both supporters and opponents. This shows the strong association between the U.S. President and the policy. In addition, the bill was passed in a context of high level of polarization across party lines where the majority party (Democrats) claimed credit for it and the opposition party (Republicans) rejected it. As a result, the policy enjoys strong attribution of responsibility directed to the majority party at the federal level and, more specifically, to the President. As a result of this strong attribution of responsibility, the implementation of the policy has been uneven throughout the territory due to challenges from opposition states.

While the original version of the law required that states expand Medicaid, a Supreme Court ruling in 2012 (National Federation of Independent Business v. Sebelius) opened the door for states to reject Medicaid expansion. The effects of this ruling have been damaging for the implementation of the ACA – an estimated eight million citizens will remain uninsured because they live in states that opted-out of Medicaid expansion and will therefore not qualify for either the existing Medicaid or for subsidized coverage (Patterson 2013). Effective January 2014, 24 states opted for not expanding Medicaid coverage to low-income adults – Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.[174] Most of these states have majority Republican legislatures and/or governors.

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[174] Medicaid.gov http://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html. Accessed March 21, 2014. The state of Arkansas has been using federal funds to expand Medicaid to buy private insurance since 2013, an alternative that is being considered by other Republican states (Goodnough 2014).

In addition to their refusal to expand Medicaid, opposition states have hindered the implementation of the ACA trough a number of additional measures. By March 2014, 32 states issued 152 bills and resolutions that challenged the health reform (Cauchi 2014).[175] The mechanisms and legal language to oppose the ACA vary across states – five states opted for passing restrictions to ACA compliance unless approved by the legislature, 16 states incorporated constitutional language for not enforcing the individual or business mandate to purchase health insurance, seven states passed laws to create Interstate Health Compacts that would enable a group of states broad healthcare programs outside of the ACA, 23 states tried unsuccessfully to nullify the legal validity of the ACA, and 12 states have restricted the function of people assisting consumers in choosing health insurance (Cauchi 2014).[176]

As a noticeable example, the state of Missouri enacted a statute that forbids state and local officials to cooperate with ACA implementation unless specifically required to by federal law; a fact that results in poor information among this state's residents (Pear 2013). The lack of cooperation with ACA was made evident when in January 2014, a federal court found that the state of Missouri was illegally obstructing navigators, federally designed personnel in charge of assisting consumers on how to select healthcare in marketplaces. This state required navigators to obtain state licenses and limited what they could say to consumers. Similar measures were passed in Tennessee (which settled the state court case, now allowing navigators to carry out their job) and Texas (Jost 2014).

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[175] At the national level, House Republicans attempted to delay ACA implementation in October 2013 through a 'government shutdown' (refusing to approve funds for 2014 fiscal year) and through numerous attempts at repealing the law. There have also been a large number of Supreme Court and Federal Court Actions that pose challenges to the law (Cauchi 2014).

[176] The effect and legality of these provisions will be made clear with time.

Conversely, most Democratic states aided the implementation of the ACA by expanding Medicaid. In addition, most of the states who decided to implement their own health exchanges, as opposed to going through the Federally-facilitated marketplace,[177] are aligned to the national government – California, Colorado, Connecticut, DC, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, and Washington.[178] While expansion of Medicaid enhances the normal implementation of Obamacare, the development of state health exchanges shows good intentions but mixed results. By March 2014, six of the ten states that showed the highest enrollment percentages used the federally run exchange and seven of the ten states that showed the worst enrollment percentages had developed their own state exchanges (Park et al. 2014). Besides expanding Medicaid and developing state exchanges, other ways of aiding the implementation of ACA is by distributing information through canvassing and media campaigns. In Colorado, for instance, employees of the state health exchange travelled around the state informing and enrolling residents. The Governor of the state, John W. Hickenlooper, is a Democrat and a strong supporter of the ACA. He expressed: "We'll do whatever it takes, I'll ride around the state on a bicycle if I have to" (Goodnough 2013).

Although the implementation of Obamacare has followed different trajectories in every state, it has overall been shaped by national and subnational partisan alignments (Haeder and

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[177] A third alternative is to enter a state-federal partnership.

[178] The name of the state health exchanges are: Covered California, Connect for Health Colorado, Access Health CT, DC Health Link, Hawaii Health Connector, Kentucky's Health Insurance Connection, Maryland Health Benefits Exchange, Massachusetts Health Connector, MNSure, Nevada Health Link, NY State of Health, Cover Oregon, HealthSource RI, Vermont Health Connect, and Washington Health Benefit Connect. Medicaid.gov http://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html Accessed March 21, 2014. It should also be noted that states may decide to develop their own health exchanges to protect their current policy autonomy, independently of not sharing the same party as the federal government (Haeder and Weimer 2013; Rigby and Haselswerdt 2013).

Weimer 2013; Regan and Deering 2009; Rigby and Haselswerdt 2013; Rigby 2012). This is in part because the policy has a clear attribution of responsibility and therefore the Democratic Party can claim credit for it and potentially be rewarded in the elections. In this context, Republican states have incentives to hinder its implementation. In addition to partisan alignments, it is possible that another variable that was insignificant in Argentina and Brazil also explains subnational resistance – ideology. In this programmatic party system, it is possible that conservative ideology against universalistic social policies also plays a role, as a recent study has argued (Rigby and Haselswerdt 2013). However, the relationship between ideology and opposition to the ACA is not straightforward – the concept of insurance exchanges had been advocated by the conservative Heritage Foundation, had been proposed by Republican legislators before the ACA, and had been operational in Massachusetts and Utah under Republican governors (Haeder and Weimer 2013, 35; Jacobs and Skocpol 2010, 6). Therefore, further theorizing needs to differentiate the insurance market place from universal coverage (and the government guaranteeing such coverage) when arguing for the ideological resistance to the ACA.

It is reasonable to argue that the analytic framework of this study travels to decentralized advanced industrial democracies, where parties have strong programmatic linkages to voters, although it may require the incorporation of ideology as a relevant variable. In other words, we would expect subnational governments to hinder or enhance national policies also based on their ideological affinity to the proposed reforms.[179] This may be a relevant addition to the analytic framework when it travels to countries such as Australia, Austria, Belgium, Canada, Germany, Netherlands, Switzerland, and the United States.

[179] Recent case studies analyzed the extent to which partisanship ideology at subnational levels influence policies and their outcomes (Chapman Osterkatz 2013; Kleider 2014; Turner 2011).

### *Narrowly Targeted Policies (Argentina)*

The framework developed in this study does not only travel across countries but also across policies. While chapters 5 and 6 analyzed universal, advanced universal, and moderate universal policies, the implementation of narrowly targeted policies is also shaped by partisan alignments when attribution of responsibility is clear. The implementation of these types of policies is susceptible to additional political processes – not just by the subnational but also by the national government. Such is the case of the narrowly targeted training program in Argentina (*Plan Jóvenes con Más y Mejor Trabajo*, Training Program for Young People, or Jóvenes). Jóvenes was launched in 2008 and it targets people between 18 and 24 years old who have not completed the mandatory years of formal education and are currently unemployed. The aim of the policy is to enhance their incorporation into the formal labor market. To do this, it provides different monetary incentives for job training and school completion.[180] This policy is an example of narrow targeting: only people who are young, unemployed, and with incomplete mandatory education can access it, and for a limited amount of time. In addition, there are no specific sources of funding to guarantee the continuity of this policy.

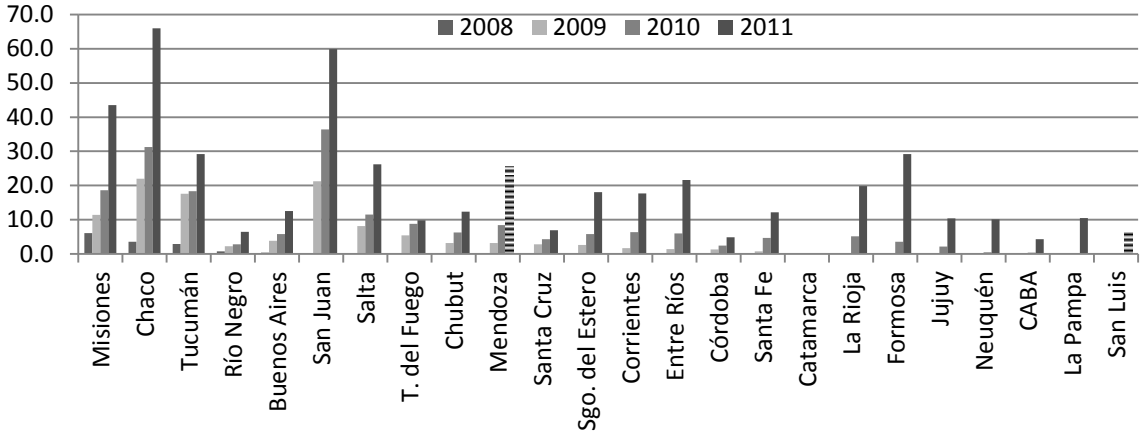
The National Ministry of Labor is in charge of coordinating this program; but implementation takes place at the municipal level through *oficinas de empleo* (employment offices). To implement this policy, the national government signs agreements with provinces and

[180] Ministerio de Trabajo, Empleo y Seguridad Social. "Jóvenes con Mas y Mejor Trabajo. Ayudas Económicas". http://www.trabajo.gov.ar/jovenes/ayudas.asp Last accessed December 3, 2013

municipalities. The principal responsibilities of provinces are to provide school infrastructure and to coordinate municipal employment offices.[181]

Figure 7.1 shows the level of coverage of Jóvenes in each province from 2008 to 2011 as a percentage of the population between 18 and 24 years old who have not completed mandatory schooling. As a cash transfer coupled with services, attributability of this policy is clear and one should therefore expect partisan alignments to be a relevant variable in explaining different levels of coverage across provinces and municipalities. The aligned province of Mendoza shows higher levels of coverage than the opposition province of San Luis. In 2011 there were 21,156 beneficiaries (25 percent of the targeted population) in Mendoza and only 1,028 in San Luis, or six percent of the targeted population (Argentina 2011a).

**Figure 7.1: Coverage of Plan Jóvenes as a percentage of 18-24 year old population who have not completed mandatory schooling.[182]**




Sources: Argentina; Census (2010). Note: Provinces' order from highest to lowest coverage in 2008 (first), 2009, 2010, and 2011 (last)

[181] Employment offices are originally created with national funds and provide job training for the population living in that municipality. The municipality staffs them, and the national government provides the funds to hire the personnel for the implementation of this policy.

[182] People who have not completed mandatory schooling are those who "never attended" or are "currently attending" school, according to 2010 Census (Instituto Nacional de Estadísticas y Censos 2010). Coverage is overestimated because the denominator does not include those who attended school but dropped out.

In the opposition province of San Luis, Jóvenes has never been fully launched. It started being timidly implemented in 2011, only offering monetary incentives for mandatory school completion after the general training, but not yet engaging in specific training activities defined in the design of the policy. This late and incomplete implementation responds in part to subnational resistance. The province hinders the implementation of Jóvenes, first, by refusing to sign agreements with the national government. As a result, the policy has to be implemented through an alternative channel – through the national ministry of labor's branches in the province. In addition, the lack of signed agreements between the provincial and national governments also means that identifying incompatibilities between Jóvenes and the provincial workfare program (*Plan de Inclusión Social*, Social Inclusion Program) cannot be automatically identified through a shared database. Therefore, recipients had to originally receive the same certificate of negativity as in Asignación Universal, described in chapter 5, thus generating the same bureaucratic obstacles.[183]

A second way in which San Luis hinders the implementation of this national training policy is through direct policy competition. When Jóvenes was launched in 2011, the province implemented the program *Primer Trabajo* (First Job). This policy is targeted to a similar population as the national one (unemployed people from 18 to 35) and also offers work training for a limited amount of time (nine months). In personal interviews with 15 young people who were participating in Primer Trabajo, most (11 of the 15) had never heard of the national Jóvenes.[184] For those who did know Jóvenes, in the competition between the national and the

[183] There is now an informal agreement within the National Ministry of Labor's branches in the province that the certificate of negativity is not necessary, thus allowing recipients to have double coverage, from Jóvenes and from the subnational program (Interview F. González).

[184] In addition, 13 identified the provincial government as the institution responsible for Primer Trabajo.

provincial training programs, the latter won. The provincial program provides a significantly higher cash transfer and therefore becomes a more attractive option (Interview F. González).

Conversely, the aligned province of Mendoza supports Jóvenes by signing agreements and by complementing this policy with its subnational training program, *De la Esquina a la Escuela, De la Esquina al Trabajo* (From the Corner to School and From the Corner to Work, or Esquinas), mentioned in chapter 5. Esquinas was launched in 2008 and it is a narrowly targeted program with a very limited budget. Implementation is in the realm of municipalities and NGOs. The program is directed at young people between 14 and 26 years old who have not finished the mandatory years of formal education and are unemployed. Originally, this policy provided very similar benefits as Jóvenes in terms of scholarships for school completion and job training, so there was some overlap between the two policies. To avoid duplicating the national policy, the province soon decided to complement the national policy through three important changes to the provincial policy. First, Esquinas is now mostly limited to funding independent projects conducted by recipients, thus eliminating job training and school completion. Second, in the municipalities in which Jóvenes has not been implemented due to the lack of employment offices, the province strengthens Esquinas. Third, in the municipalities in which Jóvenes has been implemented, the province complements the national government by putting the coordinator of Esquinas at the service of Jóvenes. In the aligned municipality of Las Heras, for example, the personnel in charge of Esquinas *only* work toward increasing coverage of Jóvenes (Interview F. González). The creator of Esquinas explained this process in an interview:

> We are part of the national government. What happened is that we launched Esquinas before Jóvenes existed...When Jóvenes was implemented it provided a higher cash transfer. Therefore, we decided to use our coordinators to look for young people to incorporate to Jóvenes…We also found that there were municipalities in which Jóvenes had not been implemented. In those places, we implemented Esquinas…and we provided funding for independent projects conducted by young people…We accompany and complement national policies (Interview Ulises Moyano).

Aside from the resistance of the opposition province and the active participation of the aligned province, this narrowly targeted policy is unevenly distributed throughout national territory by actions of the federal government. The policy entered the allied province (Mendoza) in 2008, but was not launched in the opposition province (San Luis) until 2011. Within Mendoza, the aligned municipality (Las Heras) began implementing the policy in 2009, while the opposition municipality (Godoy Cruz) did so at the end of 2010. According to provincial and municipal actors in charge of implementing this policy, the decision to delay its implementation responded to the discretionary decision of the federal government (Interviews Zlotolow, Espinoza, Pettignano, F. González, Astorra).[185] As a narrowly targeted policy, it enables a number of discretionary actions in the process of implementation such as the federal decision to implement the policy at different times in different subnational units.

We should remember that the national government did not discriminate against opposition subnational units for the implementation of the broadly targeted Asignación in Argentina or Bolsa Família in Brazil, which were implemented throughout the country at the same time. This discretionary behavior is only possible in narrowly targeted policies. The question of when policies are implemented discretionarily versus as rights deserves further research and will be discussed at the end of the next section.

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[185] The Director of the Employment Office in the opposition municipality of Godoy Cruz explained that the delayed implementation in this municipality "has only one explanation and it is a political one. We had presented all the necessary documentation and met all deadlines, but they prioritized Peronist municipalities. I can say that it was not because we lacked the necessary procedures to launch it…We went to the GECAL [The Ministry of Labor's branches in the Province], but I guess that is a decision made from Buenos Aires. When you are in an opposition administration, those things happen all the time…There is an absolute disparity in how they treat municipalities" (Interview Zlotolow). The decision of the federal government to use Jóvenes politically has been documented beyond the analyzed case studies. Opposition municipalities in the province of Buenos Aires accused the national government through a major newspaper of cutting resources destined to Jóvenes right before the 2013 elections. The national government denied these accusations (Obarrio 2013).

**Issues for Future Research**

The findings in this study provide a number of avenues for future research. Perhaps the most politically relevant area involves the association between social policies and welfare outcomes within countries. The main explanation for differences in welfare outcomes at the national level is economic development – advanced industrial democracies fare better than developing countries. However, between-country differences show the significant effect of policies on outcomes. McGuire (2010b) finds that socioeconomic factors have a stronger effect on the *levels* of infant mortality but social provision is a better predictor of *progress* or change towards reducing infant mortality. The *tempo* of early death contradicts the economic development theory: periods of slow or negative GDP per capita growth coincided in some countries with sharp decline in infant mortality. The political causal mechanisms that account for socio-economic disparities within countries have been studied by only a handful of researchers (McGuire 2010a; Pushkar 2012; Singh 2010). This is surprising given the drastic inequalities found within countries (Maceira 2009; McGuire 2010a; World Bank Group 2011, 82–103; Zacaria and Zoloa 2006). Therefore, further research needs to be developed on the political and policy factors that shape welfare outcomes within countries.

One of the factors that shape the success of national policies and their outcomes is subnational policymaking. This study has called the attention to subnational policies, a topic that, with noticeable exceptions (Bonvecchi 2008; Borges Sugiyama 2013; Singh 2010; Tendler 1997), has been mostly omitted by the literature. The causes of subnational variation in policymaking may be numerous, including diffusion effects (Borges Sugiyama 2013), subnationalism (Singh 2010), active state government (Tendler 1997), access to subnational resources, state capacity, and electoral competition (Bonvecchi 2008). This study calls the attention to the latter –the effect of subnational regime type on subnational social policies. By bringing together the

literatures on subnational authoritarianism (Gervasoni 2010b; Gibson 2012; Giraudy 2010) and the effect of democracy on welfare development at the national level (Haggard and Kaufman 2008; Huber and Stephens 2012; McGuire 2010b), we may find a major source that explains the divergence of subnational social policies in federal countries. Some states in Argentina and Brazil have designed and funded non-contributory cash transfers that have widely different characteristics, ranging from clientelistic to citizenship-based. The more authoritarian states tend to choose the former and the more democratic the latter. Initial interviews with politicians and policy recipients in the most authoritarian and democratic states in these countries show a possible causal relationship between subnational regime type and policymaking that is worth investigating.

A final topic for future research involves the relationship between universalistic or non-discretionary and narrowly targeted or discretionary social policies. The policies analyzed in this study range from moderate universal to pure universal, and therefore we would not expect discretionary implementation. This is confirmed empirically in each of the national policies included in this analysis. However, when extending the framework to narrowly targeted policies, discretionary implementation becomes a real possibility. As explained above, the Argentine training policy Jóvenes is implemented earlier in aligned provinces and municipalities and this is also true for previous narrowly targeted employment programs (Giraudy 2007; Lodola 2006; Weitz-Shapiro 2006). Given that targeted policies open the door for discretionary implementation, the next step is to investigate the relationship between discretionary implementation and attributability — Does clear attribution of responsibility shape the strategy of the federal government in distributing targeted goods and services? Informed by the literature that explains particularistic transfers for core versus swing supporters (Cox and McCubbins 1986; Dixit and Londregan 1996; Stokes 2005), one could argue that if a given national policy

with clear attribution of responsibility allows for discretionary behavior, then the national government would be likely to implement it first in highly competitive subnational units to receive extra votes that may shape the outcome of elections. If the narrowly targeted national policy does not have clear attributability, then the central government might decide to reward core subnational supporters. These hypothesis need to be empirically tested.

The novelty for Latin America is that universalistic social policies are implemented in a non-discretionary fashion. Previous research has shown how policies that create automatic rights for those meeting clear criteria, thus treating beneficiaries as citizens and not clients, decrease patronage-oriented implementation of social policies (Amenta 1998). By closing the discretionary avenue, parties lack the ability to reward their supporters with social policies in exchange for party support. These novel universal and programmatic social policies are implemented side by side of narrowly targeted social policies – they affect clientelistic networks and are affected by them. On one hand, while networks of brokers and activists mediate access to particularistic goods (Calvo and Murillo 2012), they can actually enhance the implementation of universalistic policies by providing information. The local broker is in an invaluable position to reach the most vulnerable population – the broker knows the neighbors by name, where they live, and which their most pressing problems are. Without having the authority to distribute universalistic policies, this brokers' knowledge can be put to the service of the universalistic policy. On the other hand, the implementation of universalistic social policies may also have the long term effect of weakening the clientelistic network. 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…There are no more brokers in this neighborhood because there are less goods to distribute" (Interview Cristina). The weakening of clientelistic

networks is a possible outcome worth investigating, and one that could strengthen democracy in the long term.

## APPENDIX 3.1: CODING SCHEME OF UNIVERSALISTIC POLICIES, ARGENTINA, AND BRAZIL

| | Pure Universalism | Advanced Universalism | Moderate Universalism | Narrow Targeting |
|---|---|---|---|---|
| **Eligibility** | All citizens | Broadly defined | Three dimensions of advanced universalism | Narrowly defined |
| **Sustainable financing** | Stable financing system | Stable financing | | Unstable source of financing |
| **Policy administered in universal manner (as a right)** | Automatic right for all citizens, no political manipulation | Automatic right for the targeted population. This group is transparently defined in legal terms and political manipulation is not present. | | Granted in a particularistic and non-transparent manner. Political manipulation is possible or present. |
| **Equality in size of transfer** | Yes | Significant, albeit imperfect improvement | | Policy exacerbates inequality in services and transfers |

**Note:** The coding scheme is adapted from Pribble (2013).[186]

[186] Pribble (2013, 8) measures instances of "reforms", while my interest is on the design of policies without comparing them to the status quo. With this in mind, Pribble's indicators include four dimensions to measure universalism: (1) universalizing coverage, (2) administration in a transparent (rather than discretionary) manner, (3) guaranteed quality public services or reduction in segmentation in the size of income transfers, and (4) financing mechanism equitable and sustainable. I partly take the last three of Pribble's dimensions and adapt the first one (coverage) to avoid confounding it with my dependent variable (coverage as a percentage of targeted population). Different combinations of these indicators produce different levels of universalism: "pure universalism," "advanced universalism," "moderate universalism," "weak universalism," "neutral," "regressive," or "failed reform." The categories "neutral," "regressive," or "failed reform" are not relevant in my study since I am not analyzing reform processes, but design of social policies

**Argentina**

| | **Asignación Universal por Hijo** | **Plan Nacer** |
|---|---|---|
| **Eligibility** | Broadly defined. Families with children who earn less than the minimum salary, including unemployed, under-employed, workers in the informal labor market, and self-employed. It excludes people without children | Broadly defined. Women (up to 65 years old) and children (up to 19 years old) with no health insurance. |
| **Sustainable financing** | Partly unstable source of financing: annual earnings from the Sustainability Guarantee Fund of the public pension system (*Fondo de Garantía de Sustentabilidad del Sistema Integrado Previsional Argentino)* and general contributions to social security (from wages in the formal labor market and earmarked taxes). | No. Partly funded by a World Bank loan (and partly by the federal government). |
| **Policy administered in as a right** | Yes. No political manipulation, non-discretionary allocation of transfer. | Yes. No political manipulation, non-discretionary allocation of transfers to provinces and health centers. |
| **Equality in size of transfer** | Yes. Non-contributory child allowance matches the highest child allowance from the formal labor market | It reduces the gap in quality between the private and the public health systems. |
| **Coding** | **Moderate Universalism** | **Moderate Universalism** |

**Brazil**

| | **Bolsa Família** | **Estrategia Saúde da Família** |
|---|---|---|
| **Eligibility** | Broadly defined. Families below the poverty line, or whose income per capita is less than US$70. | All citizens |
| **Sustainable financing** | Stable. Federal taxes, Função Programática 8: mainly *Fundo de Combate e Erradicação da Pobreza and Contribuição para o Financiamento da Seguridade Social.*[187] | Yes. Transfers from the National Health Fund (*Fundo Nacional da Saúde*) called Primary Care Baseline (*Piso de Atenção Básica, PAB*). |
| **Policy administered in universal manner (as a right)** | Yes. No political manipulation, non-discretionary allocation of transfers. | Yes. No political manipulation, non-discretionary allocation of transfers to family health units. |
| **Equality in size of transfer** | Yes. Transfer is higher than contributory family allowance. It also (marginally) reduces segmentation with minimum salary for individuals with no children. | It reduces the gap in quality between the private and the public health systems. |
| | **Advanced Universalism** | **Pure Universalism** |

[187] While Fundo de Combate e Erradicação da Pobreza funded more than 80 percent of Bolsa Família in 2007, Contribuição para o Financiamento da Seguridade Social funded more than 90 percent in 2009-2010 (Baddini Curralero 2012, 95).

**APPENDIX 4.1: SUMMARY STATISTICS (BRAZIL, 1998-2012).**

| Variable | Obs | Mean | Std. Dev. | Min | Max |
|---|---|---|---|---|---|
| ***Policy Implementation*** | | | | | |
| Bolsa Família (BF), 2003-2012 (% poverty) | 270 | 84.87 | 34.28 | 0 | 131.59 |
| Estrategia Saúde da Família (ESF)1998-2012 | 405 | 45.76 | 25.60 | 0 | 97.32 |
| ***Opposition*** | | | | | |
| Opposition Parties | 405 | 1.30 | 0.77 | 0 | 2 |
| ***Policy Legacies*** | | | | | |
| Coverage of previous to BF Policies | 270 | 39,978 | 75,219 | 0 | 580,261 |
| Hospital beds (per 1,000 people) | 405 | 2.37 | .48 | 1.25 | 3.89 |
| ***Territorial Infrastructure*** | | | | | |
| High Schools (Buildings) | 405 | 560 | 701 | 32 | 3919 |
| ***Resources*** | | | | | |
| Total transfers to states and municipalities (in 1,000,000 reais) | 405 | 3,930 | 4,408 | 111 | 33,739 |
| **Controls** | | | | | |
| Ideology of the party of the governor | 405 | -.18 | .70 | -1 | 1 |
| GDP per capita (constant 2000 reais) | 324 | 6.02 | 3.83 | 1.47 | 24.84 |
| Poverty Rate | 297 | 35.98 | 16.55 | 0 | 69 |
| Regional Authority Index | 405 | 19.77 | 0.68 | 19.5 | 21.5 |
| Lack of Pluralism | 405 | -0.11 | .97 | -2.27 | 2.90 |
| Population (in 1,000,000) | 405 | 6.65 | 7.87 | .32 | 41.26 |
| Area of State (in 1,000,000 square km) | 405 | .31 | .37 | .01 | 1.57 |
| Distance to Brasília (miles) | 405 | 817 | 362 | 0 | 1,557 |
| Population Density | 405 | 63.30 | 95.57 | 1.44 | 442.98 |

**APPENDIX 4.2: SUMMARY STATISTICS (ARGENTINA, 2007-2012)**

| Variable | Obs | Mean | Std. Dev. | Min | Max |
|---|---|---|---|---|---|
| ***Policy Implementation*** | | | | | |
| Asignación Universal por Hijo | 120 | 47.26 | 34.29 | 0 | 164.30 |
| Plan Nacer | 144 | 20.61 | 12.45 | 0 | 38.19 |
| ***Opposition*** | | | | | |
| Opposition Parties | 144 | 0.45 | 0.83 | 0 | 2 |
| ***Territorial Infrastructure*** | | | | | |
| Paved Roads (%) | 143 | 87.69 | 14.91 | 45 | 100 |
| Gas Network (%) | 144 | 46.36 | 32.41 | 0 | 95.4 |
| Community Centers (Buildings) | 144 | 20 | 19.93 | 0 | 84 |
| Births attended by professionals (%) | 144 | 98.98 | 1.51 | 87.60 | 100 |
| ***Legacies*** | | | | | |
| Employment Program – Plan Jefes y Jefas de Hogar Desocupados (Total) | 144 | 17,240 | 43,723 | 0 | 398,761 |
| ***Resources*** | | | | | |
| Provincial Taxes (in AR$ in 1,000,000) | 143 | 235.79 | 506.74 | 9.84 | 2641 |
| ***Controls*** | | | | | |
| Regional Authority Index | 144 | 23.50 | 0 | 23.50 | 23.50 |
| Lack of Pluralism | 144 | .63 | .38 | .03 | 1.47 |
| GDP per Capita (in 1,000) | 144 | 25.25 | 17.17 | 5.98 | 86.96 |
| Size of province (in 1,000,000 $km^2$) | 456 | 0.16 | 0.19 | .0002 | 0.99 |
| Distance to Buenos Aires (in miles) | 456 | 574 | 319 | 0 | 1476 |

**APPENDIX 4.3: VARIABLE DESCRIPTION AND SOURCES (BRAZIL).**

| Variable | Variable Description | Source |
|---|---|---|
| | **Social Policy Implementation** | |
| Estrategia Saúde da Família | Families covered by Estrategia Saúde da Família as a percentage of the total estimated population. Data is taken as of December of each year. | Minterio de Saúde - DAB - http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php |
| Bolsa Família | Families covered by Bolsa Família as a percentage of families targeted to be covered by the program according to 2010 Census. The first year, 2003, takes on the value of 0. | Secretaria de Avaliacao e Gestao da Informacao do Ministerio do Desenvolvimento Social e Combate a Fome - http://aplicacoes.mds.gov.br/sagi/mi2007/tabelas/mi_social.php |
| | **Party Alignments** | |
| Party Alignments | 0: governor's party same as presidents party, 1: governor's party allied to president's party (at least one party in the coalitions of the president and governor coincide), 2: governor's party opposed to president's party (no party in the coalition of the president and governor coincide). Data for 1988-2012 | Information on coalitions taken from Nicolau, Jairo: http://jaironicolau.iesp.uerj.br/ Last accessed on April 29, 2012. |
| | **Policy Legacies** | |
| Legacy previous policies | Quantity of people (children and teenagers) covered by the Programa de Erradicação do Trabalho Infantil (Peti, Program for the Eradication of Child Labor), Cartão Alimentação (Food ATM Card), Bolsa Escola (School Basket), and Bolsa Alimentação (Food Basket). Data for 2003-2012. | Secretaria de Avaliacao e Gestao da Informacao do Ministerio do Desenvolvimento Social e Combate a Fome - http://aplicacoes.mds.gov.br/sagi/mi2007/tabelas/mi_social.php |
| Hospital beds | Number of hospital beds, private or public, related to the Unified Health System for every 1,000 inhabitants. 1988-9 take on value of 1990, 1991-5 of 1992, 1996-8 of 1999, 2000-1 of 2002, 2003-7 of 2005, and 2008-12 of 2009 | Instituto Brasileiro de Geografía e Estadística (IBGE) http://seriesestatisticas.ibge.gov.br/series.aspx?no=2&op=1&vcodigo=MS33&t=leitos-mil-habitantes |
| | **Territorial Infrastructure** | |
| High schools (buildings) | Quantity of high schools. Data for 1995-2011; 2012 takes on the value of 2011. | Instituto Nacional de Estudos e Pesquisas Educacionais (INEP) - http://portal.inep.gov.br/basica-censo-escolar-sinopse-sinopse |
| | **Resources** | |
| Transfers to subnational units | Sum of transfers to states and municipalities from the federal government, measured in Brazilian Reais for 1997-2012. | For 1997-2003 Tesouro Nacional http://www3.tesouro.fazenda.gov.br/estados_municipios/transferencias_constitucionais.asp ; For 2004-2012 MDS |

| | | |
|---|---|---|
| | | http://aplicacoes.mds.gov.br/sagi/miv/miv.php |
| **Control Variables** | | |
| Ideology | Ideology of the party of the governor. Expert coding 1990, 1994, 1998, 2002, and 2006 . -1: left, 0: center, 1: right. The coding of party positioning is used for four years for 1988-2012. | Krause, Silvana; Danta Humberto; Miguel Luis Felipe; Dantas, Humberto; Miguel, Luis Felipe. 2010. Coaligações Partidárias na Nova Democracia Brasileira. Perfis e Tendências. Rio de Janeiro; São Paulo: Ed. UNESP; Konrad-Adenauer-Stiftung; Editora UNESP |
| Regional Authority Index | Additive Index of self-rule dimension (Institutional Depth, Policy Scope, Fiscal Autonomy, Borrowing Autonomy, and Representation) and shared-rule (Law-making, Executive control, Borrowing Control, Fiscal Control, and Constitutional Reform). Original data covers 1950-2010; 2011 and 2012 are a repetition of 2010. | Hooghe, Liesbet, Gary Marks, Sandra Chapman, Sara Niedzwiecki, Arjan Schakel, and Sarah Shair-Rosenfield. Governance Within the State. Oxford University Press, forthcoming. |
| Lack of Pluralism | Factor analysis of the following indicators: 1) Share of votes of the governor in the first round, 2) Percentage of seats of governor's party, 3) Dummy indicating whether the incumbent party won/lost the election (1/0). Elections 1986, 1990, 1994, 1998, 2002, 2006, 2010. Repeated in between | Borges, André. "Rethinking State Politics: The Withering of State Dominant Machines in Brazil." Brazilian Political Science Review 1, no. 2 (2007). Updated 2006-2010 from Tribunal Superior Eleitoral http://www.tse.jus.br/eleicoes/estatisticas |
| Poverty Rate | Percentage of people with income per capita below the poverty line. The poverty line is calculated as double the extreme poverty line, which is the monetary value of a basket of goods that contain the minimum amount of daily calories. Data for 1990-2009. | Instituto de Pesquisa Economica Aplicada (IPEA) - http://www.ipeadata.gov.br/ |
| Population | Total quantity of people, according to official census data. 1988-1995: Census 1991, 1996-2005: Census 2000, 2006-2012: Census 2010 | Sistema do Instituto Brasileiro de Geografía e Estadística (IBGE) de Recuperação Automática - http://www.sidra.ibge.gov.br/ |
| Area | Area of the state in square kilometers | Instituto Brasileiro de Geografía e Estadística (IBGE) http://www.ibge.gov.br/home/geociencias/areaterritorial/principal.shtm |
| Population Density | Population divided by Area | Instituto Brasileiro de Geografía e Estadística (IBGE). |
| Distance to Brasilia | Distance from capital of the province to Distrito Federal in miles. Constant values. | Google Maps |
| GDP per capita | GDP of each state in constant values of 2000 divided by total population, in thousands for 1988-2009. | Instituto de Pesquisa Econômica Aplicada (IPEA) - www.ipeadata.gov.br Regional-Estados-Contas Nacionales |

## APPENDIX 4.4: VARIABLE DESCRIPTION AND SOURCES (ARGENTINA)

| Variable | Variable Description | Source |
|---|---|---|
| | **Policy Implementation** | |
| Asignación Universal por Hijo | Percentage of people living with unsatisfied basic needs in the 2010 Census that are covered by Asignación Universal por Hijo. Data for 2009-2012; 2008 takes on value of 0. | Administración Nacional de la Seguridad Social (Anses). "Asignación Universal por Hijo para Protección Social. Datos de ccobertura por mes y provincia." 2013. Official data. |
| Plan Nacer | Average percentage of compliance with specific indicators of coverage. Government's data collection includes an average of: early capture of pregnant women, effectiveness of birth care and neonatal care, evaluation of the care procedure in mother and child deaths, immunization coverage, follow up of healthy children, and inclusion of indigenous population. Data as of March of every year. This policy is implemented in 2004 and starts in 2005 for 9 of the 24 provinces, and for most of the provinces Plan Nacer is launched in 2007. All provinces receive a 0 since 2004 until there is coverage data available. | Ministerio de Salud de la Nación, Plan Nacer, Official data. |
| | **Opposition** | |
| Governor's Opposition | Codings - 0: governor fully aligned with president; 1: governor's alignment with the president is not fixed; 2: governor is fully opposed to the president. This variable is updated every two years for 2003-2012. | Coding based on Cherny, Nicolás, Carlos Freytes, and Gerardo Schrelis. *Base de Datos. Proyecto PICT 1664: Federalismo, política provincial y comportamiento legislativo nacional*. 2010, Instituto de Investigaciones Gino Germani, Universidad de Buenos Aires; and Gervasoni, Carlos. "Measuring Variance in Subnational Regimes: Results from an Expert-Based Operationalization of Democracy in the Argentine Provinces." *Journal of Politics in Latin America, 2, 2, 13-52* 2, no. 2 (2010): 13–52. |
| | **Policy Legacies** | |
| Plan Jefes y Jefas de Hogar Desocupados | Total coverage of Plan Jefes y Jefas de Hogar Desocupados for 2002-2011; 2012 takes on value of 2011. | Dirección de Información Estratégica para el Empleo - Secretaría de Empleo, Ministerio Trabajo, Empleo y Seguridad Social de la Nación, Official Data |

| | | |
|---|---|---|
| **Territorial Infrastructure** | | |
| Births attended by professionals | Percentage of births attended by professional personnel. Given the stable nature of this data, 1994-1999 observations are completed with 2000 data, and 2010-2012 is completed with 2009 data | UNICEF - http://infoargentina.unicef.org.ar/home.aspx |
| Paved Roads | Percentage of national roads that are paved. Available data for 2007-2011; data of 2012 is imputed from 2011 | Ministerio de Planificación Federal, Inversión Pública y Servicios. Secretaría de Obras Públicas. |
| Gas | Percentage of the population whose houses have access to gas network. 2010 Census data is imputed in 2007-2012 | 2010 Census |
| Community Centers | Total quantity of community centers (CICs). 2012 data imputed in 2009-2011 | Ministerio de Desarrollo Social - http://www.desarrollosocial.gob.ar/cic/105 |
| **Resources** | | |
| Provincial Taxes | Total resources from provincial taxes, in current Argentine pesos for 1994-2010; 2011 and 2012 take on 2010 values. | Ministerio de Economía y Finanzas de la Nación - http://www2.mecon.gov.ar/hacienda/dncfp/provincial/recursos/serie_recursos.php |
| **Controls** | | |
| GDP per Capita | Gross Domestic Product by Province divided by population, in Argentine pesos. Data for 1994-2009, 2010-2012 take on 2009 values. | Ministerio del Interior de la Nación 2011 |
| Regional Authority Index | Additive Index of self-rule dimension (Institutional Depth, Policy Scope, Fiscal Autonomy, Borrowing Autonomy, and Representation) and shared-rule (Law-making, Executive control, Borrowing Control, Fiscal Control, and Constitutional Reform). Original data covers 1950-2010; 2011 and 2012 are a repetition of 2010. | Hooghe, Liesbet, Gary Marks, Sandra Chapman, Sara Niedzwiecki, Arjan Schakel, and Sarah Shair-Rosenfield. Governance Within the State. Oxford University Press, forthcoming. |
| Lack of Pluralism | Subnational Undemocratic Regimes Index. Includes level of contestation in executive and legislature, and turnover of party and governor. Original data available for 1994-2009; 2010-2012 repeat 2009. Provinces La Rioja, Mendoza repeat values 2007-2012 | Giraudy, Agustina (2009): Subnational Undemocratic Regime Continuity after Democratization. Argentina and Mexico in Comparative Perspective. PhD Dissertation. University of North Carolina, Chapel Hill. |
| Size of Province | Area in $km^2$, repeated values across time. | Instituto Geográfico Nacional - http://www.ign.gob.ar/AreaProfesional/Geografia/DatosArgentina/DivisionPolitica |
| Distance to Capital | Distance from capital of the province to Ciudad de Buenos Aires in miles, repeated values across time. | Google Maps |

## APPENDIX 4.5: SUPPLEMENTARY STATISTICAL ANALYSIS

**Determinants of Bolsa Família implementation measured as coverage as a percentage of targeted population (2003-2012). Randoms and Fixed Effects Models**

| | Randoms Effect | Fixed Effects |
|---|---|---|
| Opposition Parties | -0.32 (3.40) | 0.41 (6.20) |
| Legacy- Previous Policies | 0.00 (0.00) | 0.0001** (0.00) |
| Legacy - Estrategia Saúde da Família | 0.91** (0.17) | 3.75** (0.31) |
| TI - Hospital beds per 1,000 inhabitants | 11.04 (6.91) | -34.46** (16.61) |
| Federal transfers (in R$10,000) | 0.01** (0.002) | 0.001 (0.002) |
| Ideology of the party of the Governor | -3.34 (3.62) | -0.42 (4.17) |
| GDP per capita | 3.45** (1.07) | 6.22 (4.06) |
| Regional Authority Index | -- | -- |
| Lack of pluralism | -2.57 (2.68) | 0.86 (2.53) |
| Total population (in 1,000,000) | -4.25** (0.84) | 15.82** (5.31) |
| Size of state (in 1,000,000 miles) | 17.98** (7.82) | -- |
| Population density | 0.07* (0.04) | 0.46** (0.19) |
| Distance to Brasilia (miles) | 0.01 (0.01) | -- |
| Constant | -56** (27.6) | -156** (60) |
| $R^2$ Overall | 0.38 | 0.04 |
| Rho | 0 | 0.97 |
| States | 27 | 27 |
| Observations | 189 | 189 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. -- Empty Cells are omitted in the Stata regression output.

**Determinants of Estrategia Saúde da Família implementation measured as coverage as a percentage of total population. Randoms and Fixed Effects Models.**

| | Randoms Effect | Fixed Effects |
|---|---|---|
| Opposition Parties | 0.11 (1.12) | -0.27 (1.10) |
| Legacy-Hospital Beds' per capita | -20.48** (2.72) | -22.56** (2.93) |
| TI – High Schools | -0.002 (0.01) | -0.004 (0.01) |
| Federal Transfers (in R$10,000) | 0.001** (0.001) | 0.001 (0.001) |
| Ideology of the party of the Governor | -3.41** (1.17) | -2.87** (1.18) |
| Poverty Rate | -0.46** (0.10) | -0.72** (0.12) |
| GDP per capita | -3.28** (0.57) | -2.13** (0.66) |
| Regional Authority Index | -14.11** (1.14) | -12.96** (1.12) |
| Lack of Pluralism | -1.11 (0.78) | -1.64** (0.75) |
| Total Population (in 1,000,000) | -0.75 (0.66) | -0.34 (1.97) |
| Size of State (in 1,000,000 miles) | -23.63** (5.74) | -- |
| Population density | -0.03 (0.03) | -0.19** (0.07) |
| Distance to Brasilia (miles) | -0.01 (0.01) | -- |
| Constant | 428** (23) | 408** (24) |
| $R^2$ Overall | 0.61 | 0.33 |
| Rho | 0.45 | 0.87 |
| States | 27 | 27 |
| Observations | 297 | 297 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. -- Empty Cells are omitted in the Stata regression output.

**Determinants of Asignación Universal implementation measured as coverage as a percentage of people with unsatisfied basic needs (2009-2012). Randoms and Fixed Effects Models**

| | Randoms Effect | Fixed Effects |
|---|---|---|
| Opposition Parties | -3.28 (6.11) | -2.34 (6.87) |
| Legacy- PJJHD(2002-2012) | -0.001** (0.00) | -0.001** (0.00) |
| TI – Paved Roads | 0.63 (0.72) | 0.79 (1.18) |
| TI – Community Centers | 0.78 (0.56) | -- |
| TI – Gas Network | 0.26 (0.28) | -- |
| Provincial Taxes (in AR$10,000,000) | -0.02 (0.02) | -0.16** (0.04) |
| GDP per Capita | 0.04 (0.66) | 14.70** (1.64) |
| Regional Authority Index | -- | -- |
| Lack of Pluralism | 3.73 (18.75) | -42.19 (63.45) |
| Size of Province (in 1,000,000 miles) | 16.81 (50.77) | -- |
| Distance to Buenos Aires (miles) | -0.02 (0.04) | -- |
| Constant | 19.69 (82) | -336** (109) |
| $R^2$ Overall | 0.17 | 0.03 |
| Rho | 0.49 | 0.99 |
| Provinces | 24 | 24 |
| Observations | 119 | 119 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. TI: Territorial Infrastructure. PJJHD: Plan Jefes y Jefas de Hogar Desocupados. -- Empty Cells are omitted in the Stata regression output.

**Determinants of Plan Nacer implementation measured through government's indicator of percentage of coverage of medical practices (2007-2012). Randoms and Fixed Effects Models.**

| | Randoms Effect | Fixed Effects |
|---|---|---|
| Opposition Parties | 1.14 (1.44) | 3.74* (2.10) |
| Legacy- AUH | 0.10** (0.02) | 0.04 (0.03) |
| TI – Births by Professionals | 0.51 (0.73) | -2.10** (1.06) |
| TI – Paved Roads | 0.17 (0.17) | 0.74** (0.36) |
| TI – Gas Network | -0.09 (0.06) | -- |
| Provincial Taxes (in AR$10,000,000) | 0.01 (0.003) | 0.04** (0.01) |
| GDP per Capita | -0.08 (0.11) | 0.53 (0.63) |
| Regional Authority Index | -- | -- |
| Lack of Pluralism | -3.15 (3.84) | 10.26 (19.26) |
| Size of Province (in 1,000,000 miles) | -7.30 (11.33) | -- |
| Distance to Buenos Aires (miles) | 0.02** (0.01) | -- |
| Constant | -49 (73) | 134 (114) |
| $R^2$ Overall | 0.28 | 0.07 |
| Rho | 0.42 | 0.97 |
| Provinces | 24 | 24 |
| Observations | 119 | 119 |

Note: ** p≤0.05; * p≤0.1 Standard Errors in brackets. TI: Territorial Infrastructure. -- Empty Cells are omitted in the Stata regression output.

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## LIST OF INTERVIEWS

The following list provides the names, position (at the moment of the interview), and date of interview of all interviewees that agreed to disclose their names and positions. The interviewees who did not explicitly consent to have their names and positions disclosed, including all interviewed academics, are not included in this list.

Accorsi, Darci. Secretary of Social Development of the Municipality of Goiânia and Former Mayor of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, October 25, 2012.

Aguiló, Juan Carlos. Former PJ-FPV Deputy Candidate for the Province of Mendoza. Mendoza City, Argentina, April 4, 2012.

Alfonso, Dolores. Undersecretary of Social Development of the Province of Mendoza. Mendoza City, Argentina, May 16, 2012.

Algues, Marta. Secretary of Education of the Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Brazil, November 26, 2012.

Alvarenga, Marcela. Sub-Coordinator of Estrategia Saúde da Família at the State of Goiás. Goiânia City, Goiás, Brazil, November 6, 2012.

Alves, Marta. High Official of Primary Healthcare of the East/ North-East Region of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 20, 2012.

Alves do Nascimento, Helizangela. Coordinator of Social Assistance Reference Centers in the Municipality of Goiânia. Goiânia City, Goiás, Brazil, October 24, 2012.

Amorim, Nicilene. Director of State Program [Jovem Cidadão] of the State of Goiás. Goiânia City, Goiás, Brazil, October 23, 2012.

Antunes, Graciela. Coordinator of Estrategia Saúde da Família at Lomba do Pinheiro. City of Porto Alegre, Rio Grande do Sul, Brazil, September 27, 2012.

Arante, Henrique. Secretary of Social Development of the State of Goiás [SECT]. Goiânia City, Goiás, Brazil, October 30, 2012.

Arce, Guido. Director of Health Center [#15] of the Province of San Luis. San Luis City, Argentina, June 19, 2012.

Armiñana, Susana. Coordinator of School Cafeteria Program of the Province of Mendoza. Mendoza City, Argentina, April 12, 2012.

Artiaga, Airmeir. Coordinator of Bolsa Família in the Municipality of Goiânia. Goiânia City, Goiás, Brazil, October 24, 2012

Assman, Marinês. Justice Promoter of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 11, 2012.

Asso, Jorge. Former Labor Undersecretary of the Province of Mendoza. Mendoza City, Argentina, April 3, 2012.

Aurelio Pinto, Hêider. National Director of Primary Health. Brasília, Brazil, December 3, 2012.

Baddini Curralero, Cláudia. National Director of Unified Registry [Cadastro Único] of the Ministry of Social Development [MDS]. Brasília, Brazil, November 28, 2012.

Balada, Dora. Undersecretary of Labor of the Province of Mendoza. Mendoza City, Argentina, April 10, 2012.

Baltazar, Eva. Food Programs Manager of the Province of Mendoza. Mendoza City, Argentina, April 23, 2012.

Baltazar, Rosane Terezina. Director of Primary Healthcare of the East/ North-East Region of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 20, 2012.

Barale, Sebastián. Director of Provincial Program [Vivieros y Forestación, Plan de Inclusión Social] of the Province of San Luis. San Luis City, Argentina, June 18, 2012.

Barra de Azevedo, Denise. Coordinator of Bolsa Família in the State of Goiás. Goiânia City, Goiás, Brazil, October 29, 2012.

Barros, Enrique. President of the Health Council of the Municipality of Santa Maria do Herval. Santa Maria do Herval City, Rio Grande do Sul, Brazil, October 3, 2012.

Bartholo, Letícia. National Adjunct Secretary of Social Development [MDS]. Brasília, Brazil, December 3, 2012.

Batista, Sandro. Former Coordinator of Estrategia Saúde da Família at the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 5, 2012.

Bauer, Marcia. Director of State Program [RS Mais Renda Mais Igual] of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, August 7, 2012.

Bautista, Natalia. Manager of Food Program [Comer Juntos en Familia] of an NGO [Coloba]. Godoy Cruz City, Mendoza, Argentina, May 14, 2012.

Baylac, Gladys. Former Secretary of Social Development of the Province of San Luis. San Luis City, Argentina, June 22, 2012.

Baylão Lobo, Christiane. Manager of Social Development Planning of the State of Goiás [SECT]. Goiânia City, Goiás, Brazil, November 6, 2012.

Becerra, Marcela. Director of Provincial Program [Plan Estratégico de Niñez y Adolescencia] of the Province of San Luis. San Luis City, Argentina, June 15, 2012.

Belem, Patricia. Coordinator of Estrategia Saúde daFamília in the Municipality of Goiânia. Goiânia City, Goiás, Brazil, October 31, 2012.

Berrios, Gabriela. Coordinator of a Community Center [CIC-Borbollón] of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina April 24, 2012.

Berti, Yolanda. Coordinator of Anses Mobile Unit of the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, Argentina, June 12, 2012.

Biffi, César. Former Mayor of the Municipality of Godoy Cruz and Provincial Deputy. Mendoza City, Argentina, May 10, 2012.

Boniatti, Maria Dani. Director of Social Assistance Reference Center [CRAS-Harmonia]. Canoas City, Rio Grande do Sul, Brazil, September 24, 2012.

Borges, Danuzi. High Official at Department of Social Development of the Municipality of Porto Alegre [FASC]. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

Bosio, Marcelo. Secretary of Health of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 4, 2012.

Bragagnolo, María del Rosario. Director of Provincial Program [Programa Desarrollo y Protección Social] of the Province of San Luis. San Luis City, Argentina, June 17, 2012.

Brito, Rosana. Former Director of Social Development of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, September 26, 2012.

Calderón, Marcela. Representative of National Social Development Ministry in the Province of San Luis. San Luis City, Argentina, June 19, 2012.

Camara Pinto, Bruno. Advisor of National Ministry of Social Development [MDS]. Brasília, Brazil, November 29, 2012.

Camarcio Bezerra, Valdi. President of PT of the State of Goiás. Goiânia City, Goiás, Brazil, November 1, 2012.

Capitanio, Carla. Director of Social Development of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, October 1, 2012.

Cardello, Carlos. First Director of Plan Nacer of the Province of Mendoza and Director of Maternal and Child Health of the Province of Mendoza. Mendoza City, Mendoza, Argentina May 3, 2012.

Cardoso, Rogerio. Councilperson at the Health Council of the Municipality of Santa Maria do Herval. Santa Maria do Herval City, Rio Grande do Sul, Brazil, October 3, 2012.

Carvalho, Paola. High Official of State Program [RS Mais Renda Mais Igual] of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, July 30, 2012.

Carrizo, Susana. Health Agent at Primary Health Center [Llorente Ruiz] of the Province of San Luis. San Luis City, Argentina, June 21, 2012.

Castagnino, Carlos Oscar. Director of Department of Provinces in the National Ministry of Interior. Buenos Aires, Argentina, October 5, 2011.

Castilhos Gomes, Jeanice. Regional Coordinator of Primary Healthcare of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, October 1, 2012.

Castro Cassiano, Tales. Advisor to PT in Brasília. Goiânia City, Goiás, Brazil, October 21, 2012.

Ceballos, Walter. Former Secretary of Provinces of the National Ministry of Interior and Former Governor Candidate of the Province of San Luis. San Luis City, Argentina, June 19, 2012.

Chaveiro, Mirella. Director of Primary Healthcare of the Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Brazil, December 5, 2012.

Cobos, Julio. Former Vice-President of Argentina and Former Governor of the Province of Mendoza. Mendoza City, Argentina, May 16, 2012.

Conthe Astorga, Ingrid. Former Coordinator of Plan Jóvenes con Más y Mejor Trabajo of the Municipality of Las Heras. Mendoza City, Argentina, May 10, 2012.

Corengia, Carlos. Former Director of Employment Office of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, April 26, 2012.

Cornejo, Alfredo. Mayor of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 15, 2012.

Correa de Souza, Bruno. Coordinator of National Program [ProJovem Adolescente] at the Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Brazil, November 26, 2012.

Cosme Britzke, Nadia. Regional Coordinator of Primary Healthcare of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, October 1, 2012.

Costa Guadagnin, Simone. National Health Consultant. Brasília, Brazil, December 3, 2012.

Cristina. Neighborhood Leader [Referente Barrial] of Santo Tomás. Las Heras City, Mendoza, Argentina, May 7, 2012.

Da Peña, María Elvira. Manager of Plan Nacer at Hospital [Lentini]. Mendoza City, Argentina, April 19, 2012.

Dariva, Maria Veronica. Councilperson of the Social Assistance Council of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, October 5, 2012.

De Arimateia, Jose. Advisor of Chief of Staff of Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Brazil, November 26, 2012.

De Camargo, Miriam. Director of Primary Healthcare of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 2, 2010.

De Farias Nobre, Rudilene. Secretary of Education of the Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Brazil, November 26, 2012.

De Jesus, Maria Joaquina. President of Social Assistance Council of the State of Goiás. Goiânia City, Goiás, Brazil, October 31, 2012.

De Oliveira. Kácius. Secretary of Labor Department of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, October 29, 2012.

De Ponce, Janjir. Coordinator of Estrategia Saúde da Família at the Municipality of Novo Hamburgo. Novo Hamburgo City, Rio Grande do Sul, Brazil, October 11, 2012.

De Rose, Viviana. Director of Social Development of the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, June 21, 2012.

De Souza Nolasco, Stefania. Councilperson of the Health Council of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 8, 2012.

Dhein, Mario Antonio. President of Health Council of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 9, 2012.

Di Chiacchio, Mariela. Press Secretary of Anses of the Municipality of San Luis. San Luis City, Argentina, June 5, 2012.

Di Cristófano, Carlos. Coordinator of Provincial Program [Plan de Inclusión Social] of the Province of San Luis. San Luis City, Argentina, May 29, 2012.

Diva, Cleu. Coordinator of National Program [ProJovem Urbano] at the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 23, 2012.

Domingues, Vanesa. High Official at the Department of Education of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 10, 2012.

Dornelles Machado, Gilberto. Coordinator of Programs at the Department of Youth of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 14, 2012.

Dos Santos, Alberto Albino. National Coordinator of ProJovem Adolescente. Brasília, Brazil, December 4, 2012.

Dunker, Kelly. High Official of NGO [Centro Cultural James Kulisz, CEJAK]. Porto Alegre City, Rio Grande do Sul, Brazil, August 31, 2012.

Dutra, Olivio. President of PT of the State of Rio Grande do Sul, Former Governor of the State of Rio Grande do Sul, and Former Mayor of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, October 9, 2012.

Edith. Neighborhood Leader [Referente Barrial] of Algarrobal. Las Heras City, Mendoza, Argentina, May 17, 2012.

Edson. Executive Secretary of the Social Assistance Council of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 2, 2012.

Elizalde, Guillermo. Secretary of Social Development of the Province of Mendoza. Mendoza City, Argentina, May 10, 2012.

Espejo, Claudia. Private Secretary of the Department of Social Development of the Municipality of San Luis. San Luis City, Argentina, June 11, 2012.

Espinoza, Miriam. Undersecretary of Employment Office of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, April 25, 2012.

Farjado, Ana. Director of Primary Healthcare of the Province of San Luis. San Luis City, Argentina, June 15, 2012.

Febre, Verónica. High Official of Provincial Program [Pasantías, Programa de Inclusión Social] of the Province of San Luis. San Luis City, Argentina, June 21, 2012.

Fernández, Marcela. Secretary of Social Development of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 5, 2012.

Frantz, Vânia Maria. Coordinator of Health Region [Partenon e Lomba do Pinheiro] in the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 13, 2012.

García, Claudia. Former Secretary of Health Planning of the Province of Mendoza. Mendoza City, Argentina, April 4, 2012.

García, Paulo. Mayor of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 1, 2012.

Godoy, Roberto. Neighborhood Leader [Referente Barrial] of Campo Pappa. Godoy Cruz City, Mendoza, Argentina, May 14, 2012.

Goldar, Rosa. NGO Director [Fundación Ecuménica de Cuyo]. Mendoza City, Argentina, March 30, 2012.

Gomes, Darcy. National Coordinator of ProJovem Urbano. Brasília, Brazil, December 7, 2012.

Gómez, Carlos. Founder of Newspaper [El Popular] and Advisor of Councilperson of the Municipality of San Luis. San Luis City, Argentina, June 14, 2012.

González, Fabiana. Director of the Ministry of Labor Branch in the Province of San Luis [GECAL]. San Luis City, Argentina, May 28, 2012.

González, Germán. Secretary of Youth Department of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, May 17, 2012.

Gómez, Juan. Director of Newspaper [El Popular]. San Luis City, Argentina, June 20, 2012.

Gómez, Martín. Director of Anses of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, April 24, 2012.

González, Pablo. Undersecretary of Social Development of the Province of San Luis. San Luis City, Argentina, June 6, 2012.

Guerreiro Osório, Rafael. Director of Social Studies and Policies (Disoc) at the Instituto de Pesquisa Economica Aplicada [IPEA]. Brasília, Brazil, Deceber 5, 2012.

Heguiabehere, Diego. Director of Health of Pedernera Region of the Province of San Luis. San Luis City, Argentina, June 12, 2012.

Hernández, José. Pastor [Iglesia Cristiana Evangélica Manantial de Vida] of Eva Perón Neighborhood. San Luis City, Argentina, June 19, 2012.

Janette. High Official at Social Assistance Reference Center [CRAS Leste]. Porto Alegre City, Rio Grande do Sul, Brazil, September 6, 2012.

Jorge da Silva, Ademir. Secretary of Social Development of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, September 24, 2012.

Knorst, Beno. Secretary of Health and Social Development of the Municipality of Santa Maria do Herval. Santa Maria do Herval City, Rio Grande do Sul, Brazil, October 3, 2012.

Kopittke, Alberto. Councilperson of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 2, 2012.

Laborda, Juan José. Former provincial deputy [Frente Juntos por San Luis] of the Province of San Luis. San Luis City, Argentina, June 8, 2012.

Lecaro, Patricia. Advisor to Department of Social Development of the Province of Mendoza. Mendoza City, Argentina, March 29, 2012.

Lagemann, Eugenio. Advisor of former Governor [Yeda Cursius] of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, August 8, 2012.

Lemis de Jesús, Venerando. President of the Health Council of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 8, 2012.

Lermen, José Inacio. Director of Monitoring of Health Policies of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

Leyes, Analía. Coordinator of Health Agents of the Province of San Luis. San Luis City, Argentina, June 15, 2012.

Lewandowski, Telassim. Director of Women's Policies of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, September 11, 2012.

Liese. High Official of Primary Healthcare of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

Lima, Bernardo. Vice-President of the Health Council of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 8, 2012.

Lisángela. High Official of Primary Healthcare of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

López Conde, José. Advisor of National Senator [Daniel Pérsico]. San Luis City, Argentina, June 25, 2012.

Lourdes, Elena. Councilperson at the Regional Council of Social Assistance of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, September 26, 2012.

Ludwig, Maria Judite. Councilperson at the Council of Social Assistance of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, September 25, 2012.

Lumacagno, Gabriela. Coordinator of Provincial Program [Viviendas del Plan de Inclusión Social] of the Province of San Luis. San Luis City, Argentina, June 6, 2012.

Macagno, Luis. Chief of Staff of the Municipality of San Luis. San Luis City, Argentina, June 14, 2012.

Maccio, Carlos. Former Director of Health of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 3, 2012.

Machado, Selma. Coordinator of National Program [ProJovem Trabalhador] at the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 17, 2012.

Machado Freitas, Gorete. Coordinator of Bolsa Família at the Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Brazil, November 26, 2012.

Magnaldi, Vanesa. Coordinator of Plan Jóvenes con Más y Mejor Trabajo at the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, April 25, 2012.

Mallmann, Janine. Director of Social Assistance Reference Center [CRAS Leste]. Porto Alegre City, Rio Grande do Sul, Brazil, August 23, 2012.

Manoni, Flavia. Director of Non-contributory pensions of the Province of Mendoza. Mendoza City, Argentina, April 9, 2012.

Mardemattos, Rosi. Director of Basic Social Development of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, September 19, 2012.

Mariz de Medeiros, Lorena Fonseca. National Coordinator of Integration of CCT Programs. Brasília, Brazil, November 28, 2012.

Martin, Irene. Coordinator of Provincial Food Program [Comer Juntos en Familia] of the Province of Mendoza. Mendoza City, Argentina, April 12, 2012.

Martines, Samy Alves. Coordinator of National Program [ProJovem Adolescente] at the Municipality of Goiânia. Goiânia City, Goiás, Brazil, October 23, 2012.

Martínez, Emilio. General Coordinator of Community Centers of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, April 24, 2012.

Martínez, Ernesto. Undersecretary of Health of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 9, 2012.

Martins, Paulo. Councilperson of Health Council of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 9, 2012.

Massolo, Noemí. Director of the Right to Food Program of the Province of Mendoza. Mendoza City, Argentina, April 10, 2012.

Mattar, Arminda. Director of Health of the Pueyrredón Region. San Luis City, June 22, 2012.

Maza, Dante. High Official of Social Development Department of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, April 23, 2012.

Medaglia, Walter. Director of Anses at the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, Argentina, June 12, 2012.

Medeiros, Marlí. Neighborhood Leader [Dirigente Comunitaria] of Vila Pinto. Porto Alegre City, Rio Grande do Sul, Brazil, August 31, 2012.

Mendes Santos Servo, Luciana. Coordinator of Health at Instituto de Pesquisa Econômica Aplicada [IPEA]. Brasília, Brazil, December 4, 2012.

Mercado, Mario. Coordinator of Plan Nacer at the Province of San Luis. San Luis City, Argentina, May 31, 2012.

Merlo, Mario Raul. Mayor of the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, Argentina, June 24, 2012.

Miatello, Ricardo. Director of Health Centers of the Province of Mendoza. Mendoza City, Argentina, May 2, 2012.

Miranda, Daniel. Former Coordinator of Primary Healthcare of the Municipality of Godoy Cruz. Mendoza City, Argentina, April 24, 2012.

Miranda, Rubén. Mayor of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, May 8, 2012.

Morais da Silva, Vanesa. Coordinator of National Program [ProJovem Urbano] at the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 10, 2012.

Moyano, Rafael. Undersecretary of Social Development of the Province of Mendoza. Mendoza City, Argentina, May 10, 2012.

Moyano, Ulises. Creator of Provincial Program [Esquinas] of Mendoza. Mendoza City, Argentina, May 14, 2012.

Musotto, Mariano. Coordinator of Plan Nacer of the Province of Mendoza. Mendoza City, Argentina, May 11, 2012.

Musri, Gustavo. Director od Primary Healthcare of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina, May 4, 2012.

Natal Cemin, César. Coordinator of National Programs [ProJovem Urbano, Trabalhador] at the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 1, 2012.

Netto Fayad, Mauro. Secretary of Science and Technology of the State of Goiás. Goiânia City, Goiás, Brazil, November 8, 2012.

Nichimura, Elso. Technical Secretary of Social Development of the Municipality of Porto Alegre [FASC]. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

Nieto, Franco. Director of Training Provincial Program [Primer Empleo] of the Province of San Luis. San Luis City, Argentina, May 24, 2012.

Nievas, Patricia. Consultant of Asignación Universal por Hijo in the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, Argentina, June 21, 2012.

Ninov, Daniel. High Official of State Program [RS Mais Renda Mais Igual] of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, July 30, 2012.

Nunes, Maria Izabel. Former Secretary of Social Development of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Octiber 4, 2012.

Nunes de Freitas, Christiane. Director of Primary Healthcare of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 20, 2012.

Nuñez, Fernando. Director of Administration of Plan Nacer at the Province of San Luis. San Luis City, Argentina, May 24, 2012.

Olegário, Assis. High Official of State Program [RS Mais Renda Mais Igual] of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, August 8, 2012.

Olguín, Jorge. Former Candidate to Vice-Mayor of the Municipality of Villa Mercedes. San Luis City, Argentina, June 13, 2012.

Olmos, Andrea. Director of Plan Nacer in Hospital [Policlinico Regional Juan D. Perón] at the Province of San Luis. San Luis City, Argentina, Villa Mercedes City, San Luis, Argentina, June 12, 2012.

Osch, Zenaite. High Official at the Department of Education of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 10, 2012.

Paulizzi, Anabella. Secretary of Family Agriculture of the Province of San Luis. San Luis City, Argentina, June 1, 2012.

Peralta, Rubén. National Director of Communication with Provinces, Ministry of Social Development. Buenos Aires, Argentina, September 22, 2011.

Pereira, Cassiê. Coordinator of National Policy [Projovem Aldolescente] at the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 12, 2012.

Pettignano, Diego. Director of the Ministry of Labor Branch in the Province of Mendoza [GECAL]. Mendoza City, Argentina, May 15, 2012.

Pinto, Juliana. High Official at the Department of Health of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 17, 2012.

Pisonique, Marli. Former Secretary of Social Development of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, October 2, 2010.

Ponce, Moira. Director of NGO [Vamos Juntos] and Former Councilperson of the City of San Luis. San Luis City, Argentina, June 14, 2012.

Rabelo, Mercedes. High Official at Statistics Department of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 12, 2012.

Ramos Camargo, Karen. High Official at Social Assistance Reference Center [CRAS Extremo Sul]. Porto Alegre City, Rio Grande do Sul, Brazil, September 3, 2012.

Rassi, Elias. Secretary of Health of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 5, 2012.

Reales, Adriana. Co-Director of an NGO [Coloba]. Godoy Cruz City, Mendoza, Argentina, May 14, 2012.

Regane Alves, Susana. High Official of NGO [Centro Cultural James Kulisz, CEJAK]. Porto Alegre City, Rio Grande do Sul, Brazil, August 31, 2012.

Regina de Moraes, Flavia. President of the Municipal Council of Social Assistance of the Municipality of Goiânia. Goiânia City, Goiás, Brazil, November 7, 2012.

Rezende Machado, Iris. Former Governor of the State of Goiás, Former Mayor of the Municipality of Goiânia, Former Federal Senator, and Former National Minister of Agriculture. Goiânia City, Goiás, Brazil, November 1, 2012.

Ribeiro, Carmen. Director of State Program [Bolsa Futuro] of the State of Goiás. Goiânia City, Goiás, Brazil, November 8, 2012.

Ribeiro, Janice. High Official at NGO [Centro Cultural James Kulisz, CEJAK]. Porto Alegre City, Rio Grande do Sul, Brazil, August 31, 2012.

Ribeiro Guimarães, Patricia. Director of Social Development [SECT] of the State of Goiás. Goiânia City, Goiás, Brazil, October 23, 2012.

Rodriguez Assaf, Alberto. Former Director of Primary Healthcare of the Province of Mendoza. Mendoza City, Argentina, April 12, 2012.

Rodriguez, Inajara. High Official of Estrategia Saúde da Família at the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 18, 2012.

Rodriguez Vieira, Patricia. Regional Coordinator of National Program [ProJovem Adolescente] at the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 14, 2012.

Rodríguez Saa, Alberto. Former Gobernor of the Province of San Luis. San Luis City, Argentina, June 21, 2012.

Rosa, Gilmar. President of the Council of Social Assistance of the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, September 25, 2012.

Rousselet de Alencar, Heloisa Helena. High Official of the Health Council of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 15, 2012.

Ruggeri, Silvia. Former Secretary of Social Development of the Province of Mendoza. Mendoza City, Argentina, April 4, 2012.

Russo, Andrés. Director of Information Control in Ministry of Social Inclusion of the Province of San Luis. San Luis City, Argentina, May 29, 2012.

Sabignoso, Martín. National Director of Plan Nacer, Argentina. [Phone Interview] May 30, 2013.

Salcedo, Ivana. Volunteer of Soup Kitchen [Comedor Virgen del Valle]. Godoy Cruz City, Mendoza, Argentina, May 14, 2012.

Sales Fagundes, Sandra. Director of Health of the State of Rio Grande do Sul and Former Secretary of Health of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, October 4, 2012.

Salomón, Fanny. Planning Manager of the Department of Social Development of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 8, 2012.

Samper, José. Former General Attorney of the Province of San Luis. San Luis City, Argentina, June 26, 2012.

Sandra. High Official of Primary Healthcare of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

Sant'ana de Lima, Ciro. Regional Coordinator of Vigilance in Health of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, October 1, 2012.

Santos, Carmen. Councilperson at the Regional Council of Social Assistance of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, September 26, 2012.

Santos, Fernanda. Coordinator of Estrategia Saúde da Família at the Municipality of Canoas. Canoas City, Rio Grande do Sul, Brazil, Septemver 25, 2012.

Santos, Leandro. Secretary of Health of the Municipality of Canoas. Canoas City, Rio Grande so Sul, Brazil, September 25, 2012.

Santos, Lucrecia. Director of Social Programs of the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, Argentina, June 21, 2012.

Sanzi Souza, Djalmo. Former Manager of Hospital Conglomerate [Grupo Hospitalar Conceição]. Porto Alegre City, Rio Grande do Sul, Brazil, October 10, 2012.

Saracco, Sergio. Former Secretary of Health of the Province of Mendoza. Mendoza City, Argentina, April 19, 2012.

Saralago, Liliana. Health Agent of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 3, 2012.

Saravia de Abreú, Mayra Regina. Former Advisor of Social Assistance at the State of Goiás. Goiânia City, Goiás, Brazil, November 2, 2012.

Schiller Thomas, Miriam. Secretary of Social Assistance Council of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, October 8, 2012.

Schmidt, Davi Luiz. Director of Citizen Participation of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, October 1, 2012.

Seadi, Marco Antonio. Secretary of Social Development of the Municipality of Porto Alegre [FASC]. Porto Alegre City, Rio Grande do Sul, Brazil, September 17, 2012.

Serú, Alberto. Secretary of Social Development of the Municipality of Las Heras. Las Heras City, Mendoza, Argentina. May 4, 2012.

Silva de Paiva, Henrique. National Secretary of Social Development [MDS]. Brasília, Brazil, December 3, 2012.

Silva de Souza, Salete. Director of Social Assistance Reference Center [CRAS-Guajuviras]. Canoas City, Rio Grande do Sul, Brazil, October 2, 2010.

Soares Tannús, Erika. Manager of Training Activities of the State of Goiás. Goiânia City, Goiás, Brazil, October 26, 2012.

Soria, Arnaldo. Director of Provincial Program [Plan de Forestación] of the Province of San Luis. San Luis City, Argentina, June 6, 2012.

Souza, Lucia Elena. Coordinator of Bolsa Família in the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, September 6, 2012.

Spessatto, Rosane Ines. Director of Social Assistance Reference Center [CRAS Mathias Velho]. Canoas City, Rio Grande do Sul, Brazil, September 24, 2012.

Spoliansky, Patricia. NGO Conglomerate Director [Federación de Entidades de Niñez y Adolescencia de Mendoza]. Mendoza City, Argentina, April 20, 2012.

Tabosa, Germana. Secretary of Social Development of the Municipality of Valparaiso de Goiás. Valparaiso de Goiás City, Goiás, Gracil, November 26, 2012.

Teixera Bagattini, Carmen Luisa. Director of Primary Healthcare of the State of Rio Grande do Sul. Porto Alegre City, Rio Grande do Sul, Brazil, September 10, 2012.

Teixeira, Solange. Advisor of National Ministry of Social Development [MDS]. Brasília, Brazil, November 29, 2012.

Témoli, Gastón. Director of Anses at the Municipality of San Luis City. San Luis City, Argentina, June 5, 2012.

Tévez, Jorge. Councilperson of the Municipality of Godoy Cruz and Former Secretary of Social Development of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, April 27, 2012.

Timmen, Elaine. Director of NGO [Aelca]. Porto Alegre City, Rio Grande do Sul, Brazil, September 6, 2012.

Toazza Tura, Lourdes Maria. High Official of the Health Department of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 21, 2012.

Torres Guimarães, Claudia. National Director of Education Policies for Young People. Brasília, Brazil, December 7, 2012.

Torti, Luciana. Director of Education Program at NGO [Vínculos Estratégicos]. Las Heras City, Mendoza, Argentina, May 17, 2012.

Tula Barale, Federico. Secretary of Social Development of the Province of San Luis. San Luis City, Argentina, June 5, 2012.

Traversi, María Fernanda. Consultant of Asignación Universal por Hijo in the Municipality of Villa Mercedes. Villa Mercedes City, San Luis, Argentina, June 21, 2012.

Valla, Ana María. Coordinator of NGO [Fundación para el Desarrollo Humano y Regional]. San Luis City, Argentina, June 13, 2012.

Varcalcel, Carlos. Secretary of Health of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 3, 2012.

Vecchio, Kizzy. Former Coordinator of National Programs [ProJovem Urbano, Trabalhador] at the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, October 11, 2012.

Velloso, Marizete. Director of Social Assistance Reference Center [CRAS Extremo Sul]. Porto Alegre City, Rio Grande do Sul, Brazil, September 2, 2012.

Vergés, Alfonso. Former Mayor of the Municipality of San Luis. San Luis City, Argentina, June 26, 2012.

Verle, João. Former Mayor of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, October 13, 2012.

Vilar da Cunha, Heverson. Councilmember of the Health and Participatory Budgeting Councils of the Municipality of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 21, 2012.

Wanize. High Official of Primary Healthcare of the East/ North-East Region of Porto Alegre. Porto Alegre City, Rio Grande do Sul, Brazil, August 20, 2012.

Zamora, Inés. High Official of the Department of Health of the Municipality of Godoy Cruz. Godoy Cruz City, Mendoza, Argentina, May 3, 2012.

Zlotolow, Alejandro. Director of Employment Office at the Municipality of GodoyCruz. Godoy Cruz City, Mendoza, April 24, 2012.