

**Institutional Factors and Neo-Liberal Trends:
Maternal Child Health and Nutrition Programs
in Argentina and Chile in The Past Two Decades**

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ABSTRACT

This paper provides a comparative analysis of the characteristics and the most recent transformations of maternal child health and nutrition programs in Argentina and Chile during the past two decades, focusing on long-term institutional features and the central trends organizing social reforms along neo-liberal lines prevailing during the 1980s and the 1990s.

Whereas for the years 1945 to 1949 the average infant-mortality rate (IMR) in Chile more than doubled that in Argentina, in 1998 this rate in Chile represented barely 54 percent of the one of Argentina. How to account for such differences in policy performance in both cases? Are the neo-liberal reforms implemented in Chile since the late 1970s and early 1980s the main reason for such an impressive drop in IMRs? Are long-term coordinated social policy implementations and state institutional capacities the main factors accounting for this improvement? Do these implementation factors merely help realize neo-liberal reforms' potential?

I argue that despite relatively similar overall policy lines being implemented in both cases, the central and contrasting long-term historical and institutional characteristics in Argentina and Chile account for most of the variation in the overall process of reform implementation and in the socioeconomic effects and impact of social policies.

When analyzing the processes of state reform of social policies in Argentina and Chile during the 1980s and the 1990s some general questions arise. What are the roles of economic governance regulatory institutions in facilitating and shaping these reforms? How these different institutional contexts affect the specific characteristics of the reforms, their resulting policy programs, and their overall social and economic effects (in terms of redistribution of income, social policy scope and the new features of poverty groups)?

This paper provides a comparative analysis of the characteristics and the most recent transformations of maternal child health and nutrition programs (MCHNPs) in Argentina and Chile during the past two decades. It concentrates the attention on the long-term institutional features and the central trends organizing social reforms along neo-liberal lines prevailing during the 1980s and the 1990s. In both Chile and Argentina, these programs present the historical and structural similarities: a) early introduction (late 1920s/early 1930s); b) general features based on universalistic policies; and c) recent transformations from universal towards targeting features under neo-liberal auspices (Castañeda 1993; Schkolnik and Bonnefoy 1994; Vergara 1990). Despite these similarities, however, the overall impact of these MCHNPs presents striking contrasts.

----- Chart 1 about Here -----

Looking at infant-mortality rates, and despite considerable improvements in both cases the historical evolution of such indicator cannot differ more: Whereas for the years 1945 to 1949 infant-mortality rate (IMR) in Chile more than doubled that in Argentina, in 2000 this rate in Chile represented barely 54% of the one of Argentina.¹

How to account for such differences in social policy performance in both cases? Are the neo-liberal reforms implemented in Chile since the late 1970s and early 1980s the main reason for such an impressive drop in IMRs? Are long-term coordinated social policy implementations and state institutional capacities the main factors accounting for this improvement? Do these implementation factors merely help realize neo-liberal reforms' potential?

I argue that despite relatively similar overall policy lines being implemented in both cases --e.g., universalistic social insurance policies in the 1930s/1940s and targeting programs in the 1980s/1990s--, the central and contrasting long-term historical and institutional characteristics (state institutional capacities, and policy coordination, integration and continuity) in Argentina and Chile account for most of the variation on the overall process of reform implementation and

¹ Such divergent evolutionary patterns for both cases are also impressive when considering a longer-term historical perspective. IMRs for the years 1945 to 1949 are 149.6 per thousand and 73.9 per thousand live births for Chile and Argentina respectively. For 2000, IMRs are 8.9 per thousand and to 16.6 per thousand live births respectively (United Nations 1966; INE 1996; Programa Nacional de Estadísticas de Salud 2003; Dirección de Estadísticas e Información de Salud 2002)

in the socioeconomic effects and impact of social policies.

The specific historical comparison of MCHNPs of Argentina and Chile can be better depicted by historically comparing these divergent domestic policy paths, despite the overall similar international policy trends. My emphasis centers on political factors: Long-term historical institutional characteristics (i.e., state capacities, policy coordination, etc.) as well as long- and short-term characteristics of specific societal groups (i.e., center coalitions that also include state actors) that are directly involved in the processes of social policy making and implementation. My analysis centers specifically on differences in policy implementation between the two countries. MCHNPs in Argentina and Chile have similar historical origins on relatively similar “Mother and Child” Laws. After their original legislative foundations, however, programmatic transformations took place within public health institutions administering long-standing laws.²

Theoretical Background and Methods

As a part of a broader study of social policy reforms, this paper focuses on a historical comparison of the transformations of MCHNPs along targeting principles in Argentina and Chile as a consequence of the implementation of market liberalization reforms. The research methods for this study combined a thorough review of the literature on social policy and the welfare state for Latin America and the collection and analysis of multiple primary and secondary sources.³ The study of social policy in Latin American countries strongly contrasts with that for industrialized countries. Even when analyzing early innovators – cases such as Argentina and Chile with relatively long-lasting traditions of welfare benefits and social protection systems for developing countries standards – data availability, accessibility, and comparability presents a challenge for any heroic research. The present study employs a very carefully detailed collection of available data on MCHNPs in Argentina (the case that presented more difficulties regarding data availability and preexisting research on this topic). It attempts to provide a

² This emphasis on concrete program implementation contrasts with the more commonly found studies of social policy centering on policy adoption and legislative debates.

³ The following types of data sources were analyzed: 1) published secondary sources and primary statistical data from both state agencies and private associations for both cases – e.g., The World Bank statistics; UNICEF; Interamerican Development Bank (IDB); The Economic Commission for Latin America (ECLA/CEPAL); The National Bureau of the Census in Argentina and Chile (INDEC; INE); The Pan-American Health Organization (PAHO); The Federal Ministries of Health of Argentina and Chile; etc.; and 2) primary sources gathered through fieldwork such as in-depth interviews with policy makers and administrator and delivery personnel of MCHNPs in both countries who were questioned about the most traditional infant-maternity nutritional programs. These programs are the “*Programa de Salud Materna y Perinatal*” (PMI, Argentina), and the new modern MCHNP, the “*Programa Nacional Materno Infantil*” (PROMIN, Argentina); and the “*Programa Nacional de Alimentación Complementaria*” (PNAC, Chile). Fieldwork (conducted between 1996 and 1999) was imperative for effective data collection given the fact that updated, reliable, and comparable statistical information on Latin American public policy is generally difficult to obtain without going into the field (Mesa-Lago 1994; Lustig 1994). For a detailed list of libraries, archives, in-depth interviews, and official organizations consulted for data collection, see Idiart 2002, Appendix.

background and baseline for further work on these types of programs in this country. Regarding the Chilean case, better data availability allowed me to advance the analysis of MCHNPs.

My research intercepts two bodies of theory: 1) The literature on neo-liberal reforms – especially, though not exclusively, for processes experienced by developing nations since the mid 1980s–; and 2) the literature on social policy and the welfare state.

I will first provide a brief characterization of these theoretical perspectives (on neo-liberal reforms and welfare state development). Second, I will develop a comparative historical analysis of the transformations of MCHNPs in Argentina and Chile as a consequence of the implementation of neo-liberal reforms during the past two decades.

- *Neo-Liberal Reforms and Social Policy Implementation (1980s & 1990s)*

A historical analysis of MCHNPs in Argentina and Chile should be framed within the context of international tendencies for social policy implementation (Argentina's and Chile's economic and social neo-liberal reforms during the 1980s and the 1990s).⁴ The variations (or multiple paths) in reform implementation could be better understood when considering the contrasts across two dimensions: a) Argentina's and Chile's political and macroeconomic contexts with regard to neo-liberal reforms; and b) Argentina's and Chile's long-term historical state institutional capacities (or the lack thereof) for implementing public policies in a continuous and coordinated manner.

Macroeconomic reforms are central to neo-liberal programs.⁵ These neo-liberal programs, however, go beyond strictly technical macroeconomic reforms. These profound macroeconomic reforms are accompanied by changes in the institutional configuration of the state (in particular regarding the indirect effects associated with the goals of fiscal equilibrium

⁴These reforms include not mere neo-liberal economic measures but ancillary reductions and shifts in strict social policy, not merely policy change but (at least) initial marginalization of large sectors of the population vis-à-vis state and economy. Such marginalization, or exclusion generally acknowledged by the literature of adjustment policies in terms of "transitional social costs," are present in most countries experiencing such reforms. OECD countries (e.g., New Zealand, Australia), however, experienced such costs in a more reduced magnitude. The characteristics of the precedent extremely comprehensive, universalistic modern welfare state in OECD countries provided better social protection networks as tools to prevent such transitional costs to be as high as in Latin American cases. For a good work on the market liberalization experiments put in place in Australia and New Zealand since the early 1980s, see Castles, Gerritsen, and Vowles 1996.

⁵ The 1980s worldwide almost hegemonic economic policy recommendations (popularly known as the "Washington Consensus", mainly inspired by International Financial Institutions and strongly promoted in Latin America) revolve around ten basic reforms and typically characterizes the spirit of neoliberal trends (essential to end economic recession, high inflation, and fiscal crisis). For descriptions on The Washington Consensus and neo-liberal reforms, see Williamson 1992; Gamarra 1994; Nelson et al. 1989; Nelson 1990; Lustig 1994; Bulmer-Thomas 1996. It is interesting to note that these policies of market liberalization recall similar processes aiming at freeing up the factors of production that have taken place in the 19th century. These liberalizations of the factors of production allowed for the continuation of the processes of capital accumulation (Polanyi 1957).

and the reduction of public expenditures). Such changes at the state level have deep consequences on the state role as the central provider and administrator of social protection programs and have generally originated deep cuts on social programs expenditures. For state reforms of social policy --impossible to be understood in isolation from economic reforms and important in their own right-- are my central interest. Analysis of social policies, and their transformations, provides good insights into "who gets what" in the new neo-liberal order.⁶

Regarding social policy, the implementation of neo-liberal reforms generated a structural change of social programs. These social reforms, however, have not resulted from a conscious long-term planning and comprehensive strategy but as unintended byproducts of policies for achieving such economic goals as fiscal equilibrium. Therefore, the present form of social policy provisions is complex, fragmentary, and difficult to regulate, especially so in states whose regulatory capacities have been diminished by the strains of neo-liberal reform.

The present transformations of social provisions --within the broader context of neo-liberal reforms-- involve three central dimensions:

i- Decentralization: Transfers of responsibilities, administration, and/or implementation of social programs from the National (Federal) to Provincial (state), Municipal (county) levels and private providers. Such decentralization implies a redefinition in the role of central governments and it is usually justified by pointing at both a more efficient as well as an improved social control of the allocation of public social expenditures (e.g. public education, public hospitals, etc.) (Pizarro et al. 1995; Raczynski 1995; Lustig 1994; Midgley 1996; Mesa-Lago 1994; Barreto de Oliveira 1994).⁷

ii- Privatization of social programs: Transformations from public social provisions to public/private and private schemes, in different degrees (e.g., pension and health care systems). Privatization, it is often said, stimulates increasing competition and diminishes costs. From a different, less technical perspective, the state should get rid of the direct production of social provisions by transferring it to the private sector (Vergara 1990).⁸

⁶ Despite a virtual international ideological consensus for neo-liberal reforms in the 1980s, such transformations only appeared politically viable within either strongly authoritarian or conservative political contexts. In the early 1990s, Argentina's (democratically-elected) traditional "populist and working-class" party began implementing neo-liberal policies. Other "paradoxical" cases (e.g., New Zealand and Australia) pursued "neo-liberal experiments" lead by Labour Parties noted for state-led socioeconomic development (ISI and "welfarism").

⁷ For my specific cases such transformations began to take place in the early 1980s for Chile and since the beginning of the 1990s for Argentina.

⁸ International financial institutions have generally presented this tendency in public policy reform as a universally desirable and practically "unavoidable" one when the goal of increasing state efficiency is considered. However, later statements by The World Bank express a shifting emphasis --even ignoring prior strong policy recommendations-- on the appropriateness of a privatizing trend (e.g., such as its analyses on the crisis of the social security system in the former Soviet Union). See World Bank 1997:58.

iii- Targeting of the beneficiaries: Transformations from relatively solidaristic/universalist programs (benefiting the entire population regardless of any specific socioeconomic characteristic) toward more selective, targeted, "means-tested" programs (e.g., infant-maternity nutritional programs, welfare pensions, emergency anti-poverty programs). A social policy tendency strongly favored by international financial institutions, it constituted one of the most developed social policy proposals during structural adjustment programs (during the 1980s & 1990s.) Contrary to universal policies that provide benefits to all, targeting strategies are selective social programs that benefit a specific sector of the population. Preference for different types of targeting (or even for universal social programs) is closely related to the political conceptualizations of poverty and its main causal factors.⁹

Whereas privatization and targeting are based on the principles of "state subsidiarity" which in turns generates a segmentation in the provision of social programs --a private, market provided high quality services and public-assistance, residual minimum services--, decentralization affects all programs that are still provided by the state, shifting their administration, implementation and, sometimes, their regulation from the federal to the state or municipal levels as a way to increase efficiency, impact and, overall, to decrease social expenditures at the federal level. Contrary to decentralization processes that cut across the majority of the public programs, the other two transformations -- privatization and targeting-- affect programs in a selective way.¹⁰

Partial or total privatization processes have been more characteristic of economic reforms (i.e., state-owned companies and basic public services) and they could be only applied

⁹ When poverty is conceived as an individual phenomenon, the type of targeting used is a socioeconomic means-testing that identifies needs or gaps that should be satisfied, and supports programs are designated for isolated applicants who qualify as poor. When poverty is conceived as a collective/structural phenomenon resulting from the structure of power and opportunities in society, priority is given to programs that affect the socioeconomic and cultural context in which the poor sectors are found in order to open up opportunities. From this perspective, Sen emphasizes the concept of "capability deprivation" as another very important aspect of poverty that should be considered as well as individual income deprivation. Poverty in this context is *"the failure of some basic capabilities to function --a person lacking the opportunity to achieve some minimally acceptable levels of these functionings"* (Sen 1995:15)

Targeting criteria could vary from a very restrictive definition ("the extreme poor", used during the Chilean military government) to a more inclusive conceptualization of "vulnerable groups" --including groups with low levels of income, education, housing quality, etc. (Raczynski 1995). As implemented in the Latin American cases, these selective policies have two goals: 1) to better allocate social spending (increasing efficiency and, according to some authors, decreasing poverty levels); and 2) to decrease total social expenditures (to combat fiscal deficit). Despite a common consideration of targeting as synonymous with economic efficiency in social expenditures, several authors agree in criticizing this proposition by pointing at the unwanted effects of excessively targeted programs for the case of Chile (Lustig 1994; Raczynski 1995; Sojo 1990; Vergara 1990).

¹⁰ The present reforms along privatization and targeting appear to have a very limited scope, increasing the segmentation of the provision of social programs into private, high quality, sophisticated coverage, and expensive services --for a well-to-do reduced proportion of the population--, and public, low quality, and residual means-tested programs --for the ones who cannot afford to participate in the "market-provided" system.

to some specific social security programs (i.e. pension and health care systems). Contrary to these restrictive transformations, selectivity (targeting) principles have been broadly pursued in the present reforms of public and state provided social programs. These new types of reforms involve policies to assist "vulnerable groups" (e.g., the unemployed, indigent people, low-income families, etc.). Among the several vulnerable groups, programs targeted to assist children and low-income mothers (i.e., MCHNPs) are the most frequent programs promoted by the new social policies within the neo-liberal wave. Perhaps because of a neo-liberal tendency toward a paternalistic exception (for women and children) to norms of self-reliance, both cases have special nutritional programs for low-income mothers and children.¹¹

Whereas the privatizing dimension has been mostly stressed in the literature of social policy reforms (i.e., the privatization of public pension systems) less research has been devoted to the analysis of the programs that have been left out from this privatizing trend (e.g., family allowances, unemployment compensation, infant-maternity programs). How are endemic social problems being solved in those programs not affected by such privatization processes under the new conditions (rationalities, state regulatory scope and autonomy, etc.) brought about by anti-statist reforms?

Maternal Child Health and Nutrition programs (MCHNPs) are examples of these programs left out from the privatizing trend. MCHNPs have been traditionally administered and provided by the state (at both national and state levels) and have not been the object of privatizing strategies. In addition, MCHNP have shifted from universally administered to typically targeting programs to provide social assistance to vulnerable groups during the implementation of neo-liberal reforms. For the Argentine case, MCHNPs have been largely understudied in a systematic way.

Welfare State Theories and Social Policy Transformation

How to explain the formulation and implementation of public policy outcomes? In the

¹¹ For the Chilean case, the most successful results in terms of social policy have been the programs that combined universal and targeting strategies. Among the special targeted programs developed during the military government are: the *Programa de Alimentación Complementaria* (Complementary Nutrition Program --PAC) to meet nutritional needs for the poor; the *Programa de Alimentación Escolar* (School Nutrition Program --PAE) to serve school-age children; and the *Programa de Jardines Maternales* (JUNJI), a preschool program. During the democratic government, a new complementary program to traditional social policies was created, the *Fondo de Solidaridad e Inversión Social* (Solidarity and Social Investment Fund --FOSIS), funding programs to improve living conditions of the poorest communities (Vergara 1994; 1990). In Argentina, a similar shift from universal to targeted programs took place since the mid-1980s). Since 1993, a new targeted nutritional program, the *Programa Materno-Infantil de Nutrición* (Nutritional Program for Mothers and Infants --PROMIN) is being developed and financed with funding provided by the World Bank and it presents a typical case of this new type of social assistance programs. This new MCHNP, however, has not completely replaced the old one which is still in place but with diminishing financial and technical resources. This situation has generated lack of efficient expenditures of resources, lack of coordination between the two programs, overlapping provisions and, despite this, strong rates of targeted population without coverage.

literature on the origins and the development of the welfare state we can identify different, sometimes overlapped, sometimes contrasting theoretical perspectives. An exhaustive comparative analysis of these alternative theories, however, exceeds the purpose of this paper.¹² For the specific purposes of my research, two multi-dimensional integrative approaches are useful to illuminate my cases.

First, Skocpol's (1992) "polity-centered" framework --that explains U.S. social protection policies in the late 19th and early 20th centuries-- constitutes a middle-range integrative framework to account for social policy implementation. Skocpol's (1992) "polity-centered" framework attempts to provide a more complex theoretical framework that could account for the mechanisms operating at this "intersection" of state structures and social relations. Skocpol analyzes how political actors and groups successfully operate within the confines of the state structures within a particular society.

In terms of the study of the development and implementation of social programs in Latin America, Carmelo Mesa Lago provides a key reference for a theoretical framework as a pioneer for the study of social security in Latin America. Mesa-Lago (1989) develops a theoretical framework by taking into account not only the role and the bargaining power of the pressure groups (PG) but also the nature and the role of the state, as well as the interaction between state structures and the PG.¹³

The analysis of the clientelistic relationships between, on the one hand, the populist state and, on the other hand, political constituencies and organized social sectors are not explicitly theorized in Mesa-Lago's works. Nevertheless, from the analysis of Mesa Lago's students --which pursued concrete case-studies of welfare state formation in Latin America--, it is possible to infer some of these analytic links (Isuani 1985; Isuani and Tenti 1989; Isuani and San Martino 1993; Barbeito and Lo Vuolo 1993; Borzutzki 1993). These new populist regimes resulted from multiclass coalitions and involved ISI as well as expansions of the functions of the state (that included the extension of social security benefits for important sectors of the urban working classes).

In sum, the expansion of social provisions did not result from a universal or coherent approach but were developed in a piecemeal form as special benefits for certain sectors of the

¹² I develop such an exhaustive analysis of the alternative classical theories on the origins and development of the welfare state as well as on the development of this theoretical framework on my Ph.D. Dissertation "Neo-Liberal Experiments, State reform, and Social Policy in the 1980s and 1990s. The Cases of Argentina and Chile", Department of Sociology, Emory University, Atlanta, GA. (2002). Also see Hicks and Misra 1993; Pampel and Williamson 1988; Korpi 1983; Esping Andersen 1990, 1985 among others.

¹³ This perspective is similar to other students' of Latin American social policies (Isuani 1985; Barbeito and Lo Vuolo 1993; Malloy 1979). As Isuani (1985) points out, both models --one based primarily on the role of the PG, the other based on the state initiative-- are not mutually exclussory.

working class. According to these authors, the key explanatory factors to determine coverage and quality of benefits were political power and connections of different pressure groups with the state structures (Mesa-Lago 1989; Borzutzki 1993; Barbeito y Lo Vuolo 1993; Isuani 1985). This model specifically applies for the cases of Chile and Argentina, as well as for other pioneer introducers of social security in Latin America (i.e., Uruguay). According to this, the different paths in social policy implementation and further developments across cases (e.g., contrasting impacts and overall results in Chile and Argentina) could be explained by these political factors related to the characteristics of the pressures groups and their specific strategic links to state structures. This type of explanation, however, leaves out the institutional factors (state characteristics, party systems, etc) as well as the historical traditions (long-term political and social effects, sequencing) influencing the implementation and administering of social policy.¹⁴

Recapitulating and linking these models developed for the Latin American cases with Skocpol's polity-centered framework, it is possible to integrate Mesa-Lago's model for social security development in Latin America with Skocpol's stylized theoretical framework. Through this combination, Mesa-Lago's analyses benefit from a more refined theoretical framework that points to the mechanisms that connect state structures with societal factors ("pressure groups" in Mesa-Lago's terms). In addition, Skocpol's policy feedback, provides a analytic tool to introduce historical processes into the empirical analysis of social security expansion. The central explanatory factors accounting for the introduction of social policies are as follows: 1) political power of different pressure groups (this includes women's and feminist movements among them); 2) links between these each pressure group and the state agencies; and 3) specific institutional characteristics of the state (strength, relative autonomy, and administrative capacities).¹⁵

Whereas both Mesa-Lago's more complex framework based on the interaction of the pressure groups and the state and Skocpol's polity-centered framework provide good theoretical insights to understand the original formation and implementation of social policies, neither of these explanations by itself could account for the variations on policy paths (despite initial similar policy designs) as taking place in the cases of Argentina's and Chile's MCHNPs. The theoretical integration of both Mesa-Lagos' and Skocpol's frameworks will allow me to

¹⁴It is also interesting to notice that research based on this framework focused on traditionally defined pressure groups –i.e., political parties, corporations, trade unions, etc.– leaving out the role of women's organizations and feminist groups as possible explanatory factors. For the incorporation of these groups into the framework, when analyzing the role of feminists and maternalist organizations on welfare state historical development in Argentina, see Idiart 2004 (forth.)

¹⁵ For specific developments and graphs related to this integrative theoretical framework, see Idiart 2002, (ch. 1).

understand what kind of political factors --political contexts and state institutions-- allow for such divergent paths in social policy implementation and impact across my two cases, despite their initial similar departure points.

Argentina and Chile: Comparative Dimensions

Before specifically analyzing MCHNPs in Argentina and Chile, I provide an overall comparison of several structural factors that are useful for the understanding of variations in social policy in both cases. A synthesis of structural similarities and differences for Argentina and Chile is depicted on table 1. A detailed analysis of every factor as indicated on this table exceeds the limits of this paper. Some general points, however, are worth mentioning.

----- Table 1 About Here -----

Regarding my country selection, Chile and Argentina, both experienced radical economic and social neo-liberal reforms (the former since the early 1980s, the later since 1990). Despite similar dependent variables, explanatory contexts vary widely. Among common international conditions worth mentioning are the outbreak of a structural economic crisis, and the underlying exhaustion of the state-led model of economic growth (ISI) and social development (universalistic welfare state programs). In addition, the Latin American external indebtedness deeply affected both countries.

Among similar domestic factors are: the broad thrust of the neo-liberal prescriptions (targeting, selective programs for "vulnerable" groups; privatization of social provisions); the extremely high "social costs" associated with the reforms (high and long-term unemployment, increasing poverty and income inequality, increasing exclusion of sectors of the population from the market); and prior welfare policy legacies (though both cases with well developed welfare states, with typical characteristics of social insurance systems (highly fragmented and complex in terms of coverage, entitlement, benefits, and programs).

Contrasting domestic factors include: the type of political regime at the beginning of neo-liberal reforms (authoritarian and democratic for Chile and Argentina, respectively); the relationship between political transition and economic reforms (democratic transition after more than a decade of economic reforms in Chile; democratic consolidation with simultaneous implementation of neo-liberal reforms in Argentina); types of obstacles to neo-liberal reforms (e.g., labor regulations and social security programs, less problematic within Chilean authoritarian context, more problematic in the Argentine democratic context).

In terms of variation in social policy paths and their respective impacts across Argentina and Chile, the long-term historical tradition of a weak state with low administrative capacities, low levels of policy coordination, and highly fluctuating political contexts for the Argentine case -

-i.e., political regime instability, a stronger component of clientelistic parties instrumentalizing social programs in a Bismarkian sense, the lack of a tradition of professional public officials administering social programs, etc.-- could explain differences in the nature of policy change as well as in the overall impact of social programs.¹⁶

Maternal Child health and Nutrition Programs (MCHNPs) in Argentina and Chile

As I have mentioned above, MCHNPs have been traditionally administered and provided by the state (at both national and state levels) and have not been the object of privatizing strategies. In addition, infant-maternity nutritional policies have shifted from universally administered to typically targeting programs to provide social assistance to vulnerable groups during the implementation of neo-liberal reforms.

The analysis of these two cases offers comparative opportunities across time as well as nation, for universalistic health MCHNPs were in place in both countries since the 1930s. Both, these continuities in terms of broad program types and discontinuities in terms of criteria for administering the programs and selecting their beneficiaries provide appropriate analytical empirical elements to analyze these transformations associated with general strategies of market liberalization (from universal to selective social programs). In addition, the contrasting state institutional capacities between Chile (with a stronger and longer state institutional tradition) and Argentina (with a weaker and oscillating state performance) provide a good insight in terms of differing results in concrete policy implementation (Schkolnik and Bonnefoy 1994; Castañeda 1990; Golbert and Lumi 1996). In sum, this comparison provides a contrast across cases within a specific social program.

The central goal of MCHNPs is to improve nutritional levels (by reducing the levels of malnutrition) in mothers, pregnant women, and infants (Vergara 1990; Castañeda 1993). This goal is accomplished by providing mothers, pregnant women and infants with free distribution of milk (and in some cases formula). This free provision functions as the excuse (or "bait") to keep a close control on the health of the beneficiaries, by forcing them to participate in periodic health examinations, vaccinations, etc. (Vergara 1990; Castañeda 1993; Raczynski 1995)

Argentina

Argentina presents a long tradition of social policy implementation, being together with Uruguay and Chile among the "pioneers" in Latin America for the development of systems of

¹⁶ For instance, the extreme inefficiency and lack of coordination within several MCHNPs at the federal level that could, in part, explain the contrasting long-term diminishing tendencies on infant mortality rates for Argentina and Chile as it has been pointed out at the beginning of this paper.

social protection programs.

Before the organization of an institutionalized public system for social protection, philanthropic and charitable organizations (e.g., Catholic Church, mutual-aid societies) were in charge of the protection of the needy population. During colonial times (pre-independence period), social assistance was performed through charitable organizations linked to the Catholic Church (e.g., Jesuits). From this initial period, social assistance performed through these pioneer voluntary associations was characterized by a mix of public and private, religious and civil, and social service and social control (moralizing) tendencies (Thompson, comp., 1995: 23).¹⁷ After independence with the beginnings of the process of state formation in Argentina, secularization tendencies will advance continuously along time. An indirect link with religious influences, however, would persist in the long-term for the design and the implementation of social policy in Argentina.¹⁸ The multiplicity of organizations for the provision of social assistance, as well as their heterogeneous, ambivalent, and contradictory aspects are characteristics that persist to present times (Thompson, comp., 1995).

When considering the predominant role of the state in social policy, the characteristics of social programs – programmatic goals, program design, and implementation strategies – and the evolution of public social expenditures, it is possible to identify four broad historical periods for social program development in Argentina. Table 2 provides a synthesis of the main historical periods regarding the evolution of social policy in Argentina during the 19th and 20th century.

----- Table 2 About Here -----

1- The Pre-universalistic (I) period (1820s-1910s) is characterized by the multiplicity of philanthropic organizations. The main organization in 19th century, the “*Sociedad de Beneficencia*,” (hereafter the *Sociedad*), originated by a state initiative in 1823, provides private secularized social assistance to the unprotected population.¹⁹ This organization monopolizes

¹⁷According to Thompson, comp., 1995, these “patrician charity” (*caridad señorial*) in colonial times was based on the religious superiority of the “notables” over the poor. This type of charity would determine the characteristics of “private social services” in Argentina.

¹⁸Conflicts resulted from the powerful influence of the Catholic Church over the implementation of social policy persist up to present times. During the 1990s, pressures from religious groups put serious obstacles to the development of a federal program for HIV prevention (LUSIDA Program) that had international financing (e.g., opposition by the Church to the use of the word “preservative” in media campaigns of the program that blocked and delayed the implementation of such a program for a considerable time). Another central case refers to the long-lasting, historical opposition from the Catholic Church to the implementation of public, nationwide programs for preventive reproductive health (e.g., against the propagation of birth control methods through the public health care network). The latter constitute one important factor to prevent and delay the long-term effectiveness of MCHNPs with respect to the improvement of mortality and morbidity indicators such as maternal mortality and morbidity rates, teenage pregnancy, mortality caused by illegal abortions, etc.

¹⁹This secularized provision was coherent with predominant local ideologies during the 19th century modeled on late 18th and 19th century European liberalism.

social assistance with public financing until the 1940s (Moreno, comp., 2000; Thompson, comp., 1995). Since its original foundation, the *Sociedad* was in charge of the administration of numerous philanthropic institutions, welfare, health care and even educational institutions (mainly, the largest children’s orphanages and hospitals).²⁰

This particular arrangement for administering social policy constitutes an organizational predecessor of the current non-governmental – or quasi-governmental – organizations (NGOs): private, not-for-profit organizations with voluntary workers and a considerable proportion of public financing.²¹ Later on towards the end of the century, mutual-aid societies (both ethnic-based and business-based) increased the myriad of available private organizations to provide social assistance for their members.

2- The Pre-universalistic (II) period (1920s-1940s) under state provisions is characterized by the implementation of numerous state initiatives, marking the transition towards the creation of a welfare state. This period shows the incipient, though increasing, participation in the design, administration, financing, and implementation of social programs. In addition, the coexistence of social organizations generated conflicts between state institutions and the traditional *Sociedad* for the monopolization of the social protection network. Such conflicts express the implicit tension resulting from qualitative changes of the state role.²² New federal-level organizations are created first to increase controls over social spending through the *Sociedad* and, later on, to better organize a coherent social policy.

3- The Universalistic (1950s to the mid-1980s) period is characterized by a welfare state organized along the lines of a more traditional social insurance system. A process of massification of privileges since the mid 1960s generated a highly-expanded, heterogeneous, fragmented, and extremely complex social security system, typical of pioneer countries. In this period, the state definitively expands on its multiple role of financier, direct producer, and manager of social services. Universal programs (e.g., public health care and public education

²⁰ For a comprehensive history of the *Sociedad*, see Correa Luna 1923. For details on this historical period, see also Moreno, comp. 2000; Mead 2000; as well as Idiart 2004 (forth.) and 2002, ch.4.

²¹ For details on this historical period, see Coll 1911; Moreno, comp. 2000; Mead 2000; as well as Idiart 2004 (forth.) and 2002, ch.4. Coll 1911, quoted in Thompson, comp., 1995: 38-9. Besides its links to the Catholic Church, a particular characteristic of the *Sociedad* was its feminine composition: powerful elite women were in charge of its administration. See Guy 2000; Mead 2000; Thompson, comp., 2000.

²² Regarding the tensions between the *Sociedad* and the Argentine state for monopolizing social assistance and social policy, see Guy 2000 and Mead 2000. Institutions created to impose increased state participation in the implementation of social policy and to pose regulatory mechanisms over the finances of the *Sociedad* were: 1) the Direction of Hygiene; 2) the administrative dependence of the *Sociedad* to the Ministry of Internal Affairs; 3) its subsequent dependence under the Ministry of Foreign Affairs (1903); and finally, 4) the Direction of Social Assistance (1948) that marked the end of the *Sociedad* in 1947.

systems, social security, family allowances, maternity benefits, etc) unified pre-existing and fragmented partial programs for the whole population.²³ Main goals of social policy in this period were the provision for the needs of the whole population, even though by “whole” generally implied those within the formal wage system, at least until the mid-1960s. Coverage beyond the formal wage system expands circa the mid- and late 1960s.²⁴

Towards the late 1970s and the early 1980s this now traditional social protection network entered a critical stage. This critical situation – clearly expressed through the crisis of the old-age and pension system – resulted not only from factors endogenous to the social protection network but also from the fiscal crisis of the state and the exhaustion of the model for economic development.²⁵

4- The Hybrid/Assistentialist stage (mid-1980s onwards) is characterized by numerous attempts to reform social policy after the 1980s crisis. Both implicit and explicit neo-liberal auspices underlined the multiple attempts to reform. Such neo-liberal attempts become a central component of social policy during the 1990s. New principles for social policy – in accordance to neo-liberal ideology – were privatization, decentralization, and selectivity (targeting) for social provisions towards the structural poor, moving away from previously hegemonic discourse propitiating traditional universalist policies. These new elements, however, coexisted with the prior universalistic model.

A combination of universal remnants from the traditional welfare state and new targeting criteria today dominates the design, administration and implementation of social policy at the federal level. The state still finances, designs, and implements pre-existing universalistic programs, though within a context of budgetary crisis and long-lasting administrative deficiencies, generating a process of de-financing of public social provisions (e.g., public education and health care sectors). These traditional programs coexist not only with newly privatized programs (e.g., the private pension system) but with new targeted, anti-poverty

²³ The social insurance system links social provisions to the formal labor market, except for the health care and educational systems that became, strictly speaking, universal. The social insurance system is universal within the formal labor market borders. For details on the historical implementation of the social insurance system in Argentina, please refer to Mesa-Lago 1978.

²⁴For instance, maternity benefits (as lump sums) were passed originally in 1934 during Justo's government for selected occupational workers such as women employed in industry, commerce, and home work. The extension of maternity benefits as paid leave of absence to all female workers took place in 1968 during Onganía's government (Mesa-Lago 1978: 170-1)

²⁵ The expansion of services and coverage levels, and the subsequent expansion of social and fiscal public expenditures, was not accompanied by a coherent financing strategy – depicted by continuous cycles and fluctuations of expenditure levels. Such structural deficiency, in addition to the above mentioned exhaustion of the Import-Substitution Industrialization model (ISI), predominant since the 1930s, marked the exhaustion of this model for social policy provisions as well.

programs to assist vulnerable groups as well (e.g., food-distribution programs, labor emergency programs, old-age assistance programs, community-based programs, educational programs, etc.).

In addition, decentralization combined with targeting and privatizing efforts favor the state financing of private and voluntary initiatives to implement social assistance, with an increasing emphasis on NGOs, not-for-profit, and religious organizations as central collective actors. The multiplicity of voluntary organizations, in addition to the lack of state coordination and/or regulation of such semi-private initiatives, seems to take the implementation of social assistance back to pre-universalistic times, completing in this way a sort of “historical circle.”²⁶

The crisis of the welfare state initiated during the late 1970s and 1980s is not solved during this period, but only delayed to the future. In addition, increasing demands for social protection overflow the capacity of the state to satisfy – or even provide a minimum provision – the explosion of increasing poverty levels that suffer a great proportion of the Argentine population. Such demands result in part from the “social costs” of adjustment reforms implemented during the 1990s, as well as from the deep and long-lasting economic recession that began in 1996 and 1997. This economic, social, and political crisis (without any precedent) increase proposals for increasing state participation and institutional strengthening (e.g., regulatory capacity, etc.) to provide answers to this situation.

MCHNPs in Argentina: Historical Evolution and Program Transformations

Historical information of the characteristics of the traditional MCHNP, the PMI (*Programa Materno Infantil*) is both scarce and hard to find in a regular, organized manner: the library and archives of the Federal Ministry of Health and Social Action (MSAS) “vanished” during a moving of the offices to a different building in 1992. Programs organized within the orbit of this Ministry – the traditional MCHNP in particular – seem to have “no history.” Scarcity of information – under both documented forms and/or verbal recounts – has been the dominant characteristic during this fieldwork.²⁷ The history of public MCHNPs can be understood according to similar

²⁶According to Moreno, during President Menem’s government once the state backs (retires) from protective functions, religious institutions and NGOs take care of issues associated with poverty and the population in need. This is so, in particular, after the application of a “un-piteous” policy within the framework of globalization. According to the author, however, whether these institutions are insufficient to cover individuals and families from the effects of unemployment, sickness, and hunger, the state will have to take charge again or, otherwise, running the risk of social dissolution (Moreno, comp., 2000: 20)

²⁷Officers in the PMI blamed the lack of recent historical information at both the moving process and a fire that took place in their offices in the mid-1990s. In one opportunity during an interview, one PMI officer insinuated the suspicion of the attribution of such a fire to personnel’s jealousy from another MCHNP, PROMIN. The information on Argentina collected for this work was dug on multiple and dispersed archives and libraries both within the country and abroad (e.g., Ministry of Finances, Argentina; UNICEF, Santiago, Chile; Library of Congress, USA; Harvard University Libraries; etc.), as well as on interviews with experts on MCHNPs in Argentina and Chile.

historical periods to the ones characterizing social policies in general (as indicated in table 2, above).

Pre-Universalistic Programs

Argentina's National Infant-Maternity Program (*Programa Nacional Materno-Infantil*, PMI) has a long tradition, as did Chile's. Until the mid-1930s, several private philanthropic institutions dealt with infant and maternity well-being: the “*Patronato de la Infancia*” (1912), the “*Sociedad de Beneficencia*” (1823), and the “*Sociedad de Damas de Caridad*” (Charity Ladies' Association). Later, a public institution in the city of Buenos Aires, the “*Asistencia Pública*” (Public Assistance, created in 1883) implemented an office dealing specifically with infant and maternal well-being. Under the latter, programs known as “*Gotas de leche*” (Drops of Milk) developed everywhere, though their geographical dispersion was very unbalanced within the country (Aráoz Alfaro 1936).²⁸ The multiplicity of procedures, the lack of uniformity of actions to protect infant-maternity health, and the lack of coordination among services called for a unified, centralized office to provide for general guidelines, procedures, and coordination of infant-maternal health services since at least the late 1910s. According to Dr. Aráoz Alfaro – a renowned pediatrician and expert on maternal and child health – among several problems for providing good maternal and child benefits were the strong intervention of the *Sociedad* as well as other philanthropic institutions. According to his expertise, the solution was the creation of a centralized agency for the provision of maternal and child services.²⁹

At the end of 1936, the Mother and Child's Bill was passed, allowing for the creation of the new Bureau of Maternity and Infancy (DSMI), under the supervision of the National

²⁸“*Gotas de leche*” programs were sufficiently provided in the Capital City (Buenos Aires), as well as in the province of Tucumán that developed the first official coordinated campaign against infant-mortality. However, the “interior” of the country lacked sufficient services to provide for the population of mothers and infants. Aráoz Alfaro denounces the deficiency of infant-maternity services in the early 1930s, even for the city of Buenos Aires (Aráoz Alfaro 1936: 146-8). The analysis of infant-mortality rates in 1932 shows extreme regional disparities: whereas the national average was 113,5 per thousand live births, the range goes from 63,8 per thousand live births in the city of Buenos Aires to 161,9 and 182,4 per thousand live births for Jujuy and Salta (Northwest provinces) respectively. Whereas there were relatively good infant mortality rates in three Argentina provinces (Buenos Aires, Santa Fe, and Corrientes), there were critically high infant-mortality rates on other seven important provinces (Entre Ríos, Córdoba, Mendoza, Tucumán, San Juan, Salta, and Jujuy). Extreme regional disparities on IMR values would persist up to this date. From an international comparative perspective, figures for infant mortality rates at the time were: USA and Great Britain, over 60 per thousand live births; New Zealand with 34 per thousand live births; and The Netherlands and Norway with 30 per thousand live births (Aráoz Alfaro 1936: 161-2). For the historic evolution of IMRs in Argentina, refer to Idiart 2002, Ch. 3, section II (Tables 3.3 and Charts 3.3 and 3.4). For regional disparities on IMR at present times, refer to Idiart 2002, Ch. 3 (Table 3.4 and Charts 3.5.1 to 3.5.3).

²⁹Such a proposal was repeatedly expressed by Dr. Aráoz Alfaro in 1918 as well as the early 1930s (Oficina Sanitaria Panamericana 1939: 335, quoted in Guy 2000). Writings and public addresses by Dr. Aráoz Alfaro – the National Director of Hygiene at the time (1918) – called for both a National Infant-Maternity Law and the creation of a National Infant-Maternity Program (Aráoz Alfaro 1936: 97).

Department of Hygiene.³⁰ The main goal of this office was the propitiation of “perfecting future generations (...) by diminishing all causes of infant morbi-mortality as well as protecting women as mothers or future mothers.” (Law 12,341, Article 3). The Law also defined the central goals and activities of the Office of Maternity and Infancy.³¹ Among the functions of the DSMI, were the oversight of public and private institutions related to infant-maternity health, the development of agreements between the National Government (federal level) and provinces (state level) to develop and enact activities within the general PMI, and the provision of technical assistance to provinces for the implementation of the PMI.

Universalistic Programs

The creation of both a National Program for Maternal and Child Health (1937), and the Federal Ministry of Health (1946) results in the extension of MCHNPs policies towards the universalization of coverage.

As was anticipated by the Law (Article 6), the DSMI enacted the first National Infant-Maternity Program (PMI) in 1937, to protect infancy across the country. This program consolidated after the creation of the Federal Ministry of Health (1946) and it began distributing milk to its beneficiaries shortly thereafter (1948).³² All the activities developed by the DSMI were originally centralized ones (Giraldez and Ruiz 1997).³³ Since then, and for almost 40 years, this

³⁰Law 12,341 – known as “Palacios’ Law” because it was named after Dr. Alfredo Palacios, the Socialist Senator who wrote it – was passed on 12-21-36 and promulgated on 12-31-36 (Publishing Date: Official Bulletin 01-11-37). Direct institutional antecedents to DSMI, were the “*Sociedad de Beneficencia*” (1823), then the “*Dirección Nacional de Salud Pública y Asistencia Social*” (decree 12,311, October 21, 1943), when Social Assistance was absorbed by the Secretary of Labor under Peron (1944) it became National Direction of Social Assistance (created in 1948, Law 13,341; regulated in 1949, decree 20,492/49); and later the “*Consejo Nacional de Asistencia Social y Salud Pública*” (Guy 2000: 331; MASySP 1966: 621; Novick 1993). Since late 1960s and early 1970s, normative centralization and operational decentralization (transfer of health facilities to provinces and municipalities) (MBS 1970). The Bureau of Maternity and Infancy will present varying organizational hierarchies within the structure of the National Public Administration. It will alternate between being a higher-rank “The Federal Maternal and Child Health National Directorate” (“*Dirección Nacional de Salud Materno Infantil*” DNSMI) and a lower-rank “Direction” (DSMI) under the orbit of the Ministry of Health.

³¹Among these goals were: a) the study of infants’ social hygiene; b) the development of a permanent registry of private and public institutions related to the protection of mothers and infants (institutional coordination); c) the implementation of public media campaigns spreading information regarding “social hygiene” for mothers and infants; and d) the implementation and administration of public and private institutions involved in activities relevant to the main goals of the DSMI (Law 12,341, Article 3). These activities included as prenatal care and delivery assistance, newborn controls, promotion of breast-feeding, children nutrition, production, conservation, and distribution of cow’s milk, and well-being and protection of children with special needs (Law 12,341, 12-31-36).

³²The free distribution of milk existed since the inception of the PMI (1937), though it was regulated in 1943. The distribution of milk to the provinces became part of an organized subprogram within the PMI in 1973, under the new national infant-maternity plan. Purchases of milk were centralized by the DSMI and then distributed to provinces (DNMI 1985). As will be explained below, the decentralization of milk purchases took place in 1992.

³³In early 1960s, the PMI was under the supervision of the National Ministry of Social Assistance and Public Health. Its main goals appear to be very similar to the ones originally specified in the Palacios’ Law (1936). The definition of the goals and principal activities was as follows: coordination with provinces for the creation of PMI at the provincial

program maintained the same institutional structure and design, although its resources (technical and budgetary) suffered periodic reductions as a result of weak state institutional capacities, chronic political instability, and recurrent economic and fiscal crisis of the state.³⁴

During the 1963-1966 period of democratic government, national sanitary and social policy emphasized actions towards controlling infant mortality rates and ameliorating the socioeconomic conditions related to these. The formulation of a new PMI, with similar goals to the previous one, emphasized the required integration and coordination with other social programs (MASySP 1966).³⁵

In 1973, the Secretary of Public Health developed a new National Maternal and Child Plan, which had similar goals of protecting infants and mothers' health and of providing food assistance to the same group (particularly the population at risk) with an emphasis on the improvement of the system of primary health care (Moreno 1974).³⁶ As was mentioned above, the distribution of powder milk to provinces as a specific institutionalized subprogram within the PMI began at this time (1973).

During the last military government (1976-83), public health policy discourse emphasized primary care and infant-maternity health, with emphases on the regionalization and sanitary zoning in order to “avoid the overlapping of resources” (Belmartino 1991: 23).³⁷ In 1980

levels; development of a national infant-maternity health plan; definition of goals and priorities; opening of health centers, especially to provide treatment for diarrhea; and collection of statistical information on newborns' health. As is being done since, annual meetings with provincial ministers of health (state authorities) were organized in order to supervise and monitor PMI's results as well as to develop new program goals. The relationship between the PMI and the provinces seemed to be not a compulsive one, but one that suggested goals and activities to implement. There seemed to be no national capacity for sanctions in cases of non-compliance with the national plan (MASySP 1961: 48-9).

³⁴The Argentine Ministry of Health historically had a secondary role within the structure of the state apparatus. Its functions and responsibilities were periodically restricted, first by the Ministry of Labour – and its Secretary of Social Provision – and later by the Secretary of Social Security. When the Ministry absorbed the social provision activities – and became Ministry of Health and Social Action – the “Health” dimension took a lower organizational rank into a “Secretary of Health” – sometimes, even as an “Undersecretary of Health.” All these organizational changes showed a “profile of a purely technical instance, empty of resources and clientele, marginal in its function of bringing almost exclusively medical assistance to marginal sectors of the population (...) health policies subordinated to welfare policies” (Belmartino 1991: 32).

³⁵According to this source, Palacios' Law (12,341, 1936) was never fully accomplished. In order to fulfill its goals an increasing budget and reforms of the PMI were required (MASySP 1966: 455).

³⁶“Programa Nacional de la Madre y el Niño”, Law 20,445/73. Agreements between the Federal level (national government) and the provincial level were signed in exchange of technical assistance from the PMI (Moreno 1974). This plan was contained within the government's triennial plan (1973-76), that also attempted to create day-care centers, though the law for the creation of day-care centers was never passed (Novik 1993).

³⁷According to this author, despite the public discourse towards emphasizing public health and primary care – in order to increase legitimacy for the military government – the effective health policies during this period were towards the contraction of the state role as a provider of health services – e.g., public health expenditures went down from 6 percent to 2.5 percent of Total Public Expenditures between 1975 and 1983 respectively (Belmartino 1991: 23).

with the creation of the “*Programa Unico de Salud*” (Sole Health Program), the supplementary feeding subprogram was completed and put in place; transfers of funds to provinces started in 1981 (DNMI 1985).³⁸

Hybrid/Assistentialist Programs

During Alfonsín’s democratic government, the PMI was reformulated under the DSMI (1984). The underlying substantive change attempted to preserve the universalistic component of MCHNPs.³⁹ The main goal – though defined more specifically than before – remained basically the same: “to control the development and nutritional status of children under six years of age, and pregnant and nursing women” (DSMI 1996). In order to fulfill such a goal, unified criteria and procedures were required. Among the central activities of DSMI were: a) the design of national standards of normal infants’ growth and data collection); b) the definition of instruments, criteria, and a system to register information for monitoring PMI activities (1984); c) the development of norms for supplemental and ambulatory rehabilitative nutritional activities (1985); and d) the monitoring of maternal nutritional levels (1985) (DSMI 1996). In addition, the promotion of breast-feeding constituted a priority for MCHNPs.⁴⁰

In early 1990s, activities within the PMI and the DSMI were redefined according to new, “modern,” criteria that required planning, budgeting and increasing coordination with other health and nutritional programs. By 1992 (during the Peronist administration), the government ordered the pursuit of a study to evaluate the health and nutritional conditions of mothers and infants (and, indirectly, the evaluation of the traditional PMI). In this study participated experts from outside the government agencies (UNICEF, in particular) and from their final report a new MCHNP was created, PROMIN (1993). This program had the external financing of IFIs (WB and IDB) (about 60-70% of its total budget) and it was intended to last until about the year 2003 (10 years total).⁴¹ This new, “modern”, program presents a shift not only on the services provides but on the criteria for determining the population to be covered by the program as well. With a strong and definitive emphasis on strict targeting criteria, the program only benefits mothers, pregnant women and children under conditions of structural poverty. The program presents a

³⁸Resolution 1,885, 1,887/1979, *Programa Unico de Salud* (PUS) (DNMI 1985).

³⁹Simultaneously, the first federal feeding program –The *Programa Alimentario Nacional, PAN*– targeted to the poor sectors of the population was enacted without historical precedents. For research about the PAN, see Bianco 1984; Tenti 1987; Dieguez, Llach and Petrecolli 1990; Grassi, Hintze, and Neufeld 1994; Lumi, Golbert, and Tenti 1992; Golbert 1996.

⁴⁰The “*Propuesta de Normas de Complementacion Alimentaria*” (Proposal for Supplementary Feeding Norms, 1985) is the only national regulation of the PMI besides de Palacios Law (12,341) of 1936 (AGN [1994?]). Promotion of breast-feeding, Law 23,056/84, regulatory decree 908/84.

⁴¹ As of 2004, the program is still in place working under similar circumstances.

double criteria for targeting: a geographical one, based on the regions with population with Unsatisfied Basic Needs (UBN), and a demographic one, benefiting mothers, pregnant women, and children up to five years old. The basic goal of the program is to improve the basic indicators of life quality of the structural poor.

Also, regarding its services there is a shift from a direct curative and preventive care of the targeted population to the provision of basic infrastructure (e.g., building small preventive and primary care clinics, etc), in this way changing the basic configuration of the original MCHNPs. At the same time, this program has not completely replaced the old MCHNP which it is still in place, though with extremely reduced budgetary resources, a considerable lost in prestige and technical personnel because of this new program. Despite the original idea of an integral coordination between these two programs, there has been no program coordination between these two MCHNPs. A considerable overlapping of activities that combines with the lack of coverage of a considerable sector of the population that is excluded from both programs shows the inefficiency and the low administrative capacities of the Argentina state in terms of the implementation of social programs.

Chile

As in the case of Argentina, Chile presents a long lasting of social policy implementation.⁴² Even during periods of contraction in state social policy and reduction of public social expenditures, Chile's MCHNPs have maintained (and even increased) their centrality among her social protection programs.

A historical study of the evolution of nutrition policies in Chile from the 1930s to the mid-1970s underlines three basic factors: 1) the centrality of malnutrition as a public health problem and the implementation of malnutrition policies most exclusively through the health sector; 2) the implementation of supplemental feeding programs (basically, milk distribution) as the principal government intervention for nutritional improvement; and 3) the broad programmatic coverage of nutritional programs dependent on the outreach of the country's health and education institutions (Hakim and Solimano 1978: 27-28).⁴³

⁴² Antecedents regarding calls for the implementation of public social protection programs could be found in the proceeds of the First Meeting of the “*Sociedad de Beneficencia*” (1917): Among the state's duties, it was proclaimed, were the provision of public services for the elderly, sick, and indigent population. (MIDEPLAN 1991:5) For a classic and thorough historical analysis of social policies in Chile, see Arellano 1985. The “*Sociedad de Beneficencia*” –as it was the case in Argentina– was a private charitable organization with no similarities within the US. Furthermore, the *Sociedad de Beneficencia* in Chile was in charge of the administration of the public hospitals' network until the creation of the National Health Insurance (“*Seguro Nacional de Salud*”) in 1952. (Scholnik and Bonnefois 1994:20 (n.19)

⁴³ Hakim and Solimano (1978) indicate that the extreme dependency of IMPs on the education and public health care network excluded from nutrition program's coverage the most vulnerable groups during this period (until the early

Before the organization of an institutionalized public system for social protection, philanthropic and charitable organizations (e.g., Catholic Church, mutual-aid societies) were in charge of the protection of the needy population. The centralizing tendency within Chile’s public policy organization is apparent early on with the creation of the “*Sociedad de Beneficencia*” (1925), in order to organize and supervise local *Beneficencias* and hospitals. (Lavados 1983:93)

When considering the predominant role of the state in social policy, the characteristics of the social programs –programmatically goals, program design, and implementation strategies–, and the evolution of public social expenditures, it is possible to identify four broad historical periods for social program development in Chile, as indicated in table 3:⁴⁴

----- Table 3 About Here -----

1) Pre-universalistic period (1920s-1940s), characterized by a new protective role of the state, marking the beginning of direct state intervention over the development, implementation, and administration of social provisions. Social policies were basically centered on the protection of labor –e.g. legislation for the improvement of labor conditions, health and accident protection for organized workers, etc. The increasing number of social programs as well as the progressive extension of benefits for different groups generated the expansion of public fiscal and social expenditures in this period –e.g. public social expenditures tripled between 1930 and 1935. (Scholnik and Bonnefois 1994:11; Mideplan 1991:6; Arellano 1985:32)

2) Universalistic period (1950-1973), characterized by a welfare state organized along a more traditional social insurance system. A process of massification of privileges since the mid 1960s generated a highly-expanded, heterogeneous, fragmented, and extremely complex social security system, typical of pioneer countries.⁴⁵ In this period, the state definitively expands on its multiple role of financier, direct producer, and manager of social services (Raczynski and Cominetti 1994:9). Main goals of social policy in this period are the provision for the needs of

1970s). The extension of overall coverage of primary health care towards universalization (since the 1970s) partially solve this problem. The authors also point at the fact that only the health and the education sectors have been the ones paying attention to nutrition concerns for policy formulation. Since nutrition problems – as well as poverty – are directly related to overall economic and income distribution policies, an integrative approach should have been more effective to the improvement of nutritional indicators.

⁴⁴ Several authors identify similar epochs for the development of Chile’s social policy, with slight variations according to the differing prevalent criteria for defining the specific periods. I am combining periods developed by both Scholnik and Bonnefois (1994) –from a pre-universalist to an integrative one– and several Raczynski’s and Mideplan documents. See Raczynski and Cominetti 1994; MIDEPLAN 1991; Raczynski (ed.) 1995; and Raczynski 1993.

⁴⁵ For the specifics on the social insurance system and the massification of privileges, see Mesa-Lago 1978:15-6. Arellano (1985) also follows a similar model to understand this type of social protection system. Hakim and Solimano’s (1978) political economy study of malnutrition in Chile also points at the fact regarding the inequalities and high levels of stratification generated by the social protection system organized around social insurance models for the period 1930-1970

the whole population, even though by the “whole” was generally implied the formal wage system, at least until the late 1960s and, in particular, since the Popular Unity government in 1970.⁴⁶ The expansion of services and coverage levels, and the subsequent expansion of social and fiscal public expenditures, was not accompanied by a coherent financing strategy –depicted by continuous cycles and fluctuations of expenditure levels. Such structural deficiency, in addition to the exhaustion of the ISI (economic crises in the early 1970s), marked the exhaustion of this model for social policy provisions as well. (Scholnik and Bonnefois 1984:12)

3) Assistentialist period (1973-89), characterized by a state organized along the principle of subsidiarity and the breakup with the preexisting model of social and macroeconomic policy within an authoritarian political context. Principles organizing this period –in accordance to neo-liberal ideology– are privatization, decentralization, and selectivity (targeting) for social provisions towards the extreme poor, moving away from previously traditional universalist policies. This period is also characterized by the reduction of public fiscal and social expenditures –coherent with the principle of state subsidiarity and fiscal equilibrium–, and the redistribution of public social expenditures among and within specific programs along new priorities –e.g., MCHNPs over adult preventive and curative health programs, primary health care over more complex secondary and tertiary health care, anti-poverty programs over general universalist programs, basic education over college or tertiary education, etc.

4) Integrative period (1990-present), characterized by a state redefined along “integrative” functions or, as expressed by the new democratic government, along “*growing with equity*” lines. The state regains a fundamental role, though not an divorced one from the participation of the private sector, in which, again, social policy intends to provide for the entire population, whereas vulnerable groups have priority as targets for social policy. The expansion and development of social programs should be fiscally grounded, that is without interfering with the process of continuous growth and macroeconomic equilibrium. In this way, the social policy strategy is different from the prior expansionist periods before the 1970s.⁴⁷ This new stage implies both, continuity and change in terms of public policy with regards to the previous authoritarian government. (MIDEPLAN 1991:21; Raczynski and Cominetti 1994)

MCHNPs in Chile: Historical Evolution and Recent Transformations

Chile's long-term tradition of health and nutritional programs for mothers and infants

⁴⁶ In this latter period, governments intended the extension of benefits towards the population traditionally excluded from social security benefits (e.g. peasants/rural workers, unemployed or other urban informal workers, etc.).

⁴⁷ The expansion of public social expenditures since 1990 is been based on the 1990 Tax Reform (Law 18,985) that allow for increasing fiscal flows that were redistributed into both preexisting and new social programs by the democratic government. Pizarro, Raczynski, and Vial (Eds.) 1995.

begins in the late 1920s and early 1930s. In fact, it is possible to identify protective initiatives for mothers and children as early as 1901 with the development of free milk distribution programs known as “*Gotas de leche*” (Drops of Milk) to mothers unable to breast-feed and to malnourished preschool children. This Initiative was implemented by the “*Patronato Nacional de la Infancia*”, a private charitable foundation for children. Such programs were initially implemented in the poor neighborhoods of the cities of Santiago and Valparaiso and they continued to operate until the 1950s, though coverage was very limited to generate a significant impact on maternal and infant health and nutrition levels.⁴⁸ (Lavados 1984:119; Hakim and Solimano 1978:33). Prior to 1924, infant-maternity provisions were only provided by philanthropic organizations –such as the “*Sociedad de Beneficencia*”–, the Catholic Church or Mutual-Aid societies which preceded future institutionalized MCHNPs at the national level. Infant mortality rates (IMR) in 1924 were about 242‰, whereas professional deliveries represented only 25% of total documented births.⁴⁹ (Scholnik and Bonnefois 1984:19) The historical evolution of public MCHNPs can be understood according to similar historical periods to the ones characterizing social policies in general (as indicated in Table 3).

A) *Pre-Universalistic Programs*

In the early 1920s under the government of President Alessandri, numerous social initiatives began to materialize in social legislation proposals. Strong opposition in the Senate, however, made very difficult the effective implementation of those proposals. Almost by the end of his presidential term, and not as a result of a smooth policy-making process, social legislation was passed between 1924 and 1925; such a social legislation was the earliest in its kind in Latin America.⁵⁰ Within the provisions contemplated in the Compulsory Worker’s Social Insurance Fund, and as part of the workers’ medical coverage, were prenatal and infant care benefits and the distribution of milk –half a liter a day– for women workers and their children up to eight months of age.(Schkolnik and Bonnefois 1984; Vial, Camhi, and Castillo 1992; Hakim and

⁴⁸ According to Hakim and Solimano, coverage never exceeded more than 3,000 children in any given year. The authors also quote historical records that document lower levels of infant mortality and morbidity among the beneficiaries’ group when compared to the general infant population of the country. Such indicators justified increasing state intervention for infant-maternity health and nutritional policies. (Hakim and Solimano 1978:33-4). Annual Reports of *Patronato Nacional de la Infancia* were generally published in *Revista Chilena de Pediatría* and they provide extensive information of the Drops of Milk Programs.

⁴⁹ According to data provided by Arellano (1985), IMR in 1900 was about 300‰.

⁵⁰ The creation of the Compulsory Worker’s Social Insurance (“*Caja del Seguro Obrero Obligatorio*”, Law 4054); the creation of the Ministry of Hygiene, Assistance and Social Welfare; and the creation of the white-collar worker’s social provision fund (“*Caja de Previsión de Empleados*”) all took place in 1924. (Arellano 1985; Mesa-Lago 1978; MIDEPLAN 1991; Hakim and Solimano 1978:33). For historical details and political processes favoring the passing of these laws, see Arellano 1985; Mesa-Lago 1978.

Solimano 1978) Originally, the free distribution of milk intended to compensate women's workers for their presumed inability to breast-feed. In addition to these benefits, the Law of the Social Security Service (Law 4054/1924) provided a breast-feeding subsidy to women industrial workers equivalent to 12.5% of the worker's basic maternity subsidy for up to one year. (Mardones-Restat 1984; Schkolnik and Bonnefois 1994)

Despite a reduction of the IMR to 192‰ by 1932, the following year showed a new tendency for the IMR to rise, reaching 226.4‰ in 1936. (Schkolnik and Bonnefois 1984:19) Either new or extensive infant-maternity provisions were needed.

In 1938, the Law 6174 for preventive medical care (“*Ley de Medicina Preventiva*”, 1938) was introduced for all insured workers. Such legislation consisted of annual checkups, paid rest, and medical care if illnesses were discovered. In addition, it extended maternity care to the wife of workers and general medical care to the wife and children of the insured. Simultaneously to this health care legislation, the “Mother and Child Law” (“*Ley de la Madre y el Niño*”, Law 6,236 passed in 1937) institutionalizes Chilean tradition with MCHNPs. The central goal of this legislation was the protection of pregnant women and children as well as the prevention of under nutrition. To these ends, the law extended prenatal and infant care as well as milk distribution benefits to children up to two years of age as well as to the spouses of the insured workers (Schkolnik & Bonnefoy 1994; Mardones-Restat 1984; Mesa-Lago 1978; Horwitz et al. 1995; Hakim and Solimano 1978:28). This initiative is the direct antecedent for the National Food Supplement Program (PNAC).(Ministerio de Salud 1988)

This protection, however, only covered the employed population, as in any other stratified social insurance system within the Bismarkian tradition. Even though it did not constitute a widespread coverage –benefiting approximately 5% of the population–, such initiative was an important step towards the extension of the state's participation in women's and children's health and nutrition. (Vial, Camhi and Castillo 1992; Schkolnik and Bonnefois 1994; Hakim and Solimano 1978)

In order to widen such a coverage a new institution was created in 1942 within the orbit of the Ministry of Health: The General Office for the Protection of Infants and Teenagers (“*Dirección General de Protección a la Infancia y Adolescencia*”, *PROTINFA*) that provided coverage to marginal groups (uninsured and indigent children and pregnant women). (Horwitz et al 1995; Hakim and Solimano 1978) In this case, the distribution of milk was tied to the beneficiaries' periodic health checkups, which represented a dual goal of preventive health and nutrition care of the program population.⁵¹

⁵¹ Hakim and Solimano provide a comparative analysis on national nutritional policies for mothers and infants (National Nutritional Plans of 1942 and 1974) and find a high degree of coincidence regarding basic diagnoses and

B) Universalistic Programs

With the creation of the National Health Service (“*Servicio Nacional de Salud*”, SNS, Law 10383) in 1952, a new stage towards the universalization of health services in Chile begins. The creation of the SNS meant the unification of the preexisting multiplicity of health provisions and public services in Chile. It represented the first unified, centralized, and nationwide organization for health care and prevention for the population.⁵² The SNS became the most relevant public health instance in Chile until the mid-1970s.

The following programmatic goals of the SNS guided Chile's health and nutritional policies for almost two decades: a) the protection of infant-maternity health, b) the propitiation of adequate nutrition levels, c) the development of a National Food Supplement Program (“*Programa Nacional de Alimentación Complementaria*”, PNAC), d) the implementation of vaccination programs at the national level, and e) the implementation of preventive and curative programs for the adult population.⁵³

Three fundamental social programs to protect mothers' and children's health and nutrition levels are organized during this period (1954): The maternal and perinatal Program (*Programa de Salud Materna y Perinatal*), the Children and Teen Aged's Health Program (*Programa de Salud del Niño y el Adolescente*), and the PNAC above mentioned. The basic goal of these programs was to diminish infant mortality rates.⁵⁴ These programs involved women's periodic check-ups before, during and after delivery, children's check-ups (up to six years-old); diagnosis and prevention of sicknesses in mothers and infants; vaccinations; health and nutritional education for mothers; propitiation of breast-feeding; actions of responsible parenting and birth regulatory actions (birth control); and nutritional interventions of several

policy prescriptions for Chile's nutritional issues. They also point at the fact that such coincidences indicate the lack of substantial progress regarding nutritional policies along that 40-year period (Hakim and Solimano 1978:32, Appendix A)., This study, however, was published in 1978 that is, before the substantial transformation and the increasing emphasis on MCHNPs during the military government (that also took advantage of Chilean long-lasting tradition on MCHNPs).

⁵² The SNS creation responded to multiple goals such as: 1) the restructuration and unification of health care provisions (previously dispersed); 2) the coverage of preventive actions for the entire population (100%) as well as of curative actions for beneficiary, insured population (dependent workers, active and passive workers of the SNS, and special groups such as the municipal workers, etc) that represented about 70% of the population. (Scholnik and Bonnefois 1984:20; Horwitz et al. 1995) For the history of the SNS, see Horwitz et al. 1995.

⁵³ In addition to these reforms, the breast-feeding subsidy was increased to 25% of the maternity benefits in 1952 (Law 13305). (Mardones-Restat 1984)

⁵⁴ Infant mortality rates in 1950 were 132.6 per thousand. Ten years later (1960), infant mortality rates went down to 119.5 per thousand. By 1995, infant mortality rates in Chile were 15.0 per thousand. Maternal mortality rates experienced considerable drops, from 29.9 per thousand in 1960 to 16.8 per thousand in 1970, and 4.0 per thousand in 1990 (United Nations 1966; Schkolnik and Bonnefois 1994; Horwitz 1995).

types. These programs worked in a coordinated, integrated way and had historical continuity despite changes at the political level.

The PNAC was organized at the national level in 1954 –in this way unifying the multiplicity of prior milk and infant maternity provisions–, and dropped the social security requirement for program beneficiaries. (Hakim and Solimano 1978) In addition, the creation of PNAC articulated food distribution activities with health care actions. (Ministerio de Salud 1988) This program has been continuously in place since then and all the subsequent reforms have been taking place within this unified national MCHNP. The general characteristics of this program were organized around a universalistic provision of benefits with a strong emphasis on preventive and curative care (in this order) of mothers and infants.

C) Assistentialist Programs:

During the military government (mid 1970s and 1980s), infant-maternity programs became the first priority within national health policy. That is why within a context of shrinking of public expenditures (even within the health sector), the budget allocated to obstetric and pediatric care in public hospitals increased (Raczynski 1993). At the same time, existing programs were improved and new complementary nutritional schemes were applied to malnourished children. One of the main characteristics of this set of programs was their interrelation (integration) as well as the chained (*cascada*, as characterized by Raczynski) effect generated by them. Three universal IMNPs covered about 95% of pregnant women and children: the program to assist pregnant women (*Programa de Control de la Embarazada*), the program to assist healthy children (*Programa del Control del Niño Sano*), and the National Program of Complementary Nutrition (PNAC).

Between the mid 1970s and the mid 1980s, several modifications of these programs took place along targeting principles. The PNAC suffered several internal transformations in provisions, selection of beneficiaries, and administration criteria with a shift towards a strict targeting policies to benefit the extreme poor --a targeting process initiated in fact since 1974 with the subdivision of the PNAC into a targeted subprogram for underfed children. In addition to the targeting shift, during the 1980s this program strongly focused on the curative aspect (as a direct consequence of this targeting process), diminishing in this way its historical preventive component. It should be emphasized, however, that the changes that were implemented resulted from specific nutritional studies of the Chilean population that defined the targeting population. Initial diagnostics, policy designs and identification of vulnerable groups were departure points to implement targeting instruments. This situation presents striking contrasts to the Argentine case, where targeting reforms during the 1990s were implemented without

specific baseline studies of children's and mother's health and nutritional deficiencies.⁵⁵

D) Integrative Programs:

In 1990, the new democratic government --even though continuing the overall general policies of market liberalization-- started to strongly emphasize the equity aspect of such reforms, in this way strongly promoting social programs tending to cope with the social costs associated with them. During 1990, the Chilean state ratified the International Convention of Children's Rights. As a direct consequence, the government enacted the National Plan for Children (*Plan Nacional de la Infancia*). Decentralization appeared as one of the main goals (regionalization) and targeting persists as an instrument for program implementation. The MCHNPs persist within this new plan and again, we can observe continuity --despite internal structural changes-- in the programs already in place (Maternal and Perinatal Program, the Program for Infants and Teen Ageds, and the Nutritional programs such as PNAC). By 1995 the coverage reached by the PNAC was about 70% of the total population of pregnant women and children under six years old. A combination of universal and targeting elements is still characteristic of its design, giving that the nutritional offer for vulnerable groups is higher than the milk distributed to the general population (according to a monitoring study of this program, targeting levels and mechanisms are adequate when considering that almost 90% of the two lower quintiles of the population are reached by the program) (Atalah, E. et al. 1995).

Only recently, since the mid-1990s, both students of social policy in Chile and Public Health experts from within and without the state have begun to voice some concern about the present status of MCHNPs. As will be detailed in sections below, changes in the epidemiological and nutritional structure of the Chilean population required a different public policy strategy with regard to health care and prevention. This is a result of multiple factors. The success of the continuous and long-lasting infant-maternity policy – PNAC and its articulation with health care MCHNPs – is central to explaining these changes. Such success, in fact, may have been also one of the reasons to discontinue – or at least to dramatically change – the traditional structure of this highly institutionalized nutritional program.

MCHNPs: Current Transformations in Comparative Perspective

The comparative historical analysis of MCHNPs in Argentina and Chile developed in previous chapters shows both similarities and contrasts across nations in policy design,

⁵⁵ The lack of a prior diagnosis generates deep problems of several kinds. First, the correct application of targeting mechanisms requires specific and precise diagnosis of the initial socioeconomic and health conditions of the population. Such studies are required to define the targeting population. In addition, it is impossible to measure impact and degree of effectiveness of a targeted program in situations where comparative measures of the conditions prior to targeting do not exist.

concrete implementation, and structural factors accounting for the effectiveness of long-run social provisions.

Argentina's infant mortality rates decreased in the long-run, though not as deeply as did Chile's rates. Argentina's relative position within Latin American countries has worsened by the end of the past decade.⁵⁶ This situation could be explained in two different, though not mutually exclusive, ways. First, preventive and curative health policies implemented during the past decade have neither been enough to compensate nor to ameliorate the negative effects associated with the increasing poverty levels and the "social costs" resulting from implementing neo-liberal reforms (SIEMPRO 2000). Second, the long-run lack of state capacities for social policy design and implementation contributes to the poor results – relative to the high social expenditure levels – of the new social programs put in place during the last decade.

----- Table 4 About Here -----

Table 4 provides a comparison among the two Argentine MCHNPs (the traditional PMI and modern PROMIN), and the long-lasting Chilean MCHNP (PNAC). This table constitutes a case-specific complement to Table 1 that provides general political and economic comparative dimensions for Argentina and Chile.⁵⁷

IMPs Duration and Political Tradition

Both the PMI and PNAC have long historical traditions as social programs. Argentina's PMI originates in 1937 (nationwide in 1943) and shows over 60 years as a national social protection program. Such a long-tradition, however, does not necessarily represent program consolidation nor increasing program efficiency levels resulted out of its long-lasting experience.

Chile's PNAC represents more than half a century of continuous and efficient maternal and child health and nutrition policy implementation. Since its origins in 1937 with the Mother and Child Law, and its further consolidation as a national public health care program in 1954 – under the creation of the National Health Service, SNS – it is possible to appreciate its increasing efficiency, and coverage levels as a social protection program for mothers and children. In this case, and in contrast with the Argentine PMI, PNAC officers capitalize program's activities, experience and tradition accumulated along the years in order to improve maternal and child health and nutrition (at least with respect to primary health care).

Argentina's PROMIN was created in 1993 not only in response to the critical situation regarding maternal and child health and nutrition in Argentina that proved critical despite the

⁵⁶According to UNICEF's indicators of infant and maternal mortality rates, Argentina improved in absolute terms. However, when other 15 Latin American nations are considered, Argentina's mortality rates below the age of five (MRB5) went from the place number 14th in 1960 to the place number 11th in 1998 (Unicef, 1999).

⁵⁷ Exhaustive comparisons among these programs are provided in Idiart 2002, Chs. 4 to 7.

existence of the long-lasting PMI. It was also created in response to the new, modern “neo-liberal” criteria for social policy implementation (i.e., targeting and decentralization) at both domestic and international contexts, which have recently been promulgated by stick-wielding financial IGOs.

IMPs’ Long-Term Goals (Constitutive Characteristics)

All these programs have similar initial long-term goals: the improvement of the overall maternal and child health and nutrition levels. The partial accomplishment of these essential goals is expressed through the improvement of basic maternal and child health indicators related to mortality and morbidity factors, via the implementation of primary health care and education.

Policy Design. Strategies to Accomplish Program Goals

Both Argentina’s PMI and Chile’s PNAC traditionally utilize the free distribution of milk (and, at times, other milk-substitutes) as the mean (excuse) for attracting potential beneficiaries – pregnant women, nursing mothers, and children – and maintaining their continuous participation in the program. According to both program officers and programmatic documents, the main goal is to attract potential beneficiaries to health care centers in order to provide adequate and continuous levels of primary health care and nutrition services. In this way, milk distributing activities are subordinated (secondary) to basic health care actions.

When comparing both discourse – e.g., official documents – and long-term effective programmatic actions some contrasts between these two programs appear. According to the analysis of innumerable program reports, audits, external monitoring and evaluations, and the long-term historic evolution of basic maternal and child health indicators, Chile’s PNAC has health care and nutrition transformations as central programmatic goals (subordinating milk distribution to primary health care goals, both preventive and ones). In addition, health and nutritional education to beneficiary mothers and pregnant women constitute a central characteristic of the program. Such initiatives propitiating beneficiaries’ health education (e.g., under the form of training regarding primary preventive care) together with the extensive use of midwives for nationwide prenatal care constitute fundamental pillars of the program, and partial reasons to help explain its long-term success.

In turn, when contrasting PMI’s official documents with effective programmatic activities along time – e.g., composition of program expenditures, provincial PMIs audits, and program performance according to basic maternal and child health indicators – milk distribution appears in this case as the central, organizing programmatic component. This may not be the result of explicit policy decisions, but the unintended consequence of several factors such as the federal organization of the program, the low capacity of the central PMI administration to monitor and

control program implementation at local levels, recurrent budgetary cuts and de-financing, etc. The overall result is given by the program beneficiaries themselves (as will be detailed on sections below) who know the program as the “*milk program*” (mostly with an assistentialist connotation), and not, as in the case of Chile’s as the health and nutrition program for mothers and children.

Argentina’s PROMIN has a design which goals center on institutional strengthening of institutions (facilities) associated to maternal and child health, nutrition and development. Such goals are provided by PROMIN through implementing infrastructure works in health care and child development centers, and providing training (human resources) and technical assistance to local subprojects in order to improve health, nutrition, and developmental care for mothers and children. Milk distribution constitutes only a secondary activity within this program.

Finally, an important contrast between the Argentine programs and the Chilean program constitutes the type of health care provision in both cases: whereas in Argentina general health care (and infant-maternity care) is organized according to the “spontaneous” demand of the population within the health care network, in Chile general health care (and infant maternity care) is organized not only according to such a spontaneous demand but to the development of explicit outdoor (extramural) activities to reach the most vulnerable sectors of the population. This difference also constitutes, in the long- term, a fundamental factor for understanding contrasts on program effectiveness regarding the improvement of maternal and child health and nutritional care.

Universal versus Targeting

Traditional MCHNPs, such as the PMI and PNAC, are historically organized upon universalistic foundations. Program provisions are delivered to all mothers and children participating within the public health care network, regardless of both socioeconomic and labor status, only as “citizens’ rights.” These programs, however, have implicit self-selection (built-in self-targeting) mechanisms since the fact that provisions are delivered within the public health care network operates such a selection.⁵⁸

For the Argentine PMI, explicit targeting procedures for selecting beneficiaries are introduced during the 1990s. Such introduction does not result out of a national policy strategy towards selectivity within PMI, but as local, uncoordinated and non-regulated strategies at provincial PMIs because the relatively low amounts of milk to be distributed.⁵⁹

⁵⁸Furthermore, research on PMIs beneficiaries in Chile documented the fact that some potential beneficiaries that participated in periodic health care checkups opted for not claiming the milk – nor any other milk substitute – that was supposedly assigned to them.

⁵⁹Audits performed by the AGN to several provincial PMIs between 1994-1996 document irregular situations as follows: reduced ratios of milk to be distributed (when compared to national or provincial norms); implicit selection of

Chilean PNAC introduces targeting strategies during the 1980s along more general neo-liberal reforms of public policy. The universal component, however, coexists with this new targeted component, even though the latter receives relatively higher levels of financial resources (e.g., according to the internal composition of PNAC's budget). Even though by mid-to late 1990s, external PNAC evaluations propitiated the implementation of deeper targeting mechanisms to increase even more program efficiency while lowering program's costs, there was a strong support for maintaining the universal component among the population (see below section on program's constituencies).

Finally, with respect to PROMIN, targeting mechanisms are included since its inception according to the general international guidelines of modern social program implementation. Mechanisms applied correspond to geographical targeting according to socioeconomic information provided by general census data.⁶⁰ In addition to these fundamental targeting elements, there are some “unintended” universal effects. Such universal effects result from the fact that institutional strengthening indirectly benefits the whole population that participate within the public health care network.

IMPs' Organization (Centralization versus Decentralization)

Argentina's Federal organization requires a decentralized execution of federal social programs, and MCHNPs in particular. PMI at the national level (DSMI) provides general programmatic guidelines, norms and regulations, financial resources (transfers to provinces basically for purchasing milk), some supplies, and technical assistance. Agreements between the national (central) PMI level and provinces (provincial PMIs) provide the general framework for the provincial implementation of the program. Provincial levels, in turn, effectively implement MCHNPs across jurisdictions. By the early 1990s, PMI at the national level did not possess any specific mechanism to control program implementation at local levels. During the past decade, several attempts and initiatives to increase program regulation by the national level resulted in a relatively improved controlling capacity of the DSMI (specially since 1996 onwards). However, DSMI's monitoring capacity is still very low. The PMI lacks mechanisms for monitoring and controlling in terms of efficacy, efficiency and impact of its activities and goals.

PROMIN, in turn, possess in part some of these mechanisms through the signing of agreements between the UCP (program's central level) and the specific local subprojects for

effective beneficiaries to receive milk (performed by medical and non-medical personnel at public health care facilities); implementation of provincial targeting criteria to distribute milk according to local jurisdictions, etc. (AGN 1995-1998).

⁶⁰See more details in Idiart 2002, ch.5-7.

program implementation. PROMIN's central level provides stronger guidelines for overall program implementation, strategies, targeting criteria, etc., even though local jurisdictions are in charge of designing their own subprojects according to specific local needs and criteria (i.e., along the decentralization principle). According to a more recent study on PROMIN (2002), UCP's organization and everyday activities (program design and implementation) are relatively autonomous, independent from immediate political oscillations and conflict. However, social and political conflicts at provincial levels affect all public policy provincial activities, and this include PROMIN's subprojects.⁶¹

The effective implementation of PROMIN's programmatic goals, however, neither has been smooth nor easy. In fact, pervasive traditional procedures developed by the provincial units (social policy making) as well as local political changes and discontinuities have attempted against an efficient program implementation within a decentralized organization. This situation is not characteristic of PROMIN, but of the social policy organizations in Argentina in general.

Chile's unitary political organization requires, and resulted in, a strongly centralized model for social policy provisions. The national (central) level, in the case of MCHNPs the Federal Ministry of Health, assumes the overall design, general as well as specific guidelines, regulation, implementation, and the provision of resources (financial and technical) for PNAC.⁶² Such an extreme centralized organization favors a better organized, more coherent program's implementation and allow central program officers to monitor and supervise more closely program activities. In the Chilean case, the highly centralized nature of the state and its specific programs make possible a solid design and implementation of targeting mechanisms, homogeneous delivery of services and benefits, standardization of procedures and decentralization of actions at the local level – always following strong norms from the national level. Despite some decentralizing policy delivery during the past decade, there are no deep transformations on the centralized and unitary tendencies organizing policy design and implementation.

Decentralization tendencies were favored in both cases, though the implementation varied according to the specific institutional structures already existent in each country. In Chile, a pre-existent unitary system allows for a national articulated system. In the Argentine case, in

⁶¹These conflicts affect program's staff, training of new personnel at local levels, all factors related to the repeated technical assistance activities organized by PROMIN (Fundación Grupo Sophia 2002a).

⁶² This extreme centralization even included the purchases and storage of powder milk and milk substitutes for the entire nation. Only by mid- to late 1980s framed within decentralizing tendencies in social policy, PNAC becomes financially decentralized (1987). Such a process is very limited, however, since milk storage and purchases remain as centralized activities.

contrast, a pre-existing federal system generates higher levels of mediation. In addition, compromises and a predominant fiscal logic of the allocation of funds to the provinces weakened regulatory and monitoring capacities. Decentralization in this case, makes more difficult minimum levels of program implementation according to the initial national norms and goals.

Policy Coordination and Integrality

Argentina's MCHNPs present low levels of integration and coordination both between different federal programs and among national and provincial programs. This phenomenon is not exclusive of these type of programs, but of social protection programs in general. During the 1990s – and even today – there are multiple MCHNPs functioning at suboptimal conditions. Problems associated with overlapping, competition for beneficiaries, financial and technical resources, fragmentation and lack of cooperation among programs are documented not only through the present study but through different information sources as well (Golbert and Lumi 1996; Pérez Esquivel 1998).⁶³ This lack of integration and coordination presents not only among MCHNPs (intra-level integration and coordination), but across other social protection programs (cross-level integration). The latter refers to lack of articulation among relevant social sectors (e.g., health care, social assistance, and education programs).

During the past decade, official public policy discourse emphasized integrality and coordination of social initiatives and program's actions. However, at the level of concrete program implementation, integral and coordinated programs are very difficult to implement within the Argentine context. Integrality and coordination of maternal and child health and nutrition programs is among PROMIN's fundamental pillars. Such integrality, as expressed directly through official program documents, involves both intra-program integration and coordination and cross-programs' integration and coordination (basically between health and initial level education services). However, during most of the decade, the most visible structural problem regarding Argentina's MCHNPs points at the lack of such integration among MCHNPs. The lack of effective integration at the planning and design levels between PROMIN and the PMI persists during most of the decade. The fact that only more than five years after its creation, some incipient coordinating initiatives are in place express both the difficulties and the

⁶³ In addition to the two MCHNPs analyzed in this work (which depend on the Federal Ministry of Health, PMI and PROMIN), by 1996 there were other nine programs of nutritional assistance at the national level (a total of 11) with extreme degrees of overlapping of goals, beneficiaries and geographical coverage (Golbert and Lumi 1996). More recent information drawn on both a private foundation working of issues related to public policy and press articles, document a similar situation (e.g., overlapping, lack of coordination, and multiplicity of nutritional programs): according to these reports, by 2002 there were 11 nutritional programs ((federal and local) organized by the City of Buenos Aires and the Buenos Aires Province (Sophia 2002, Internal Documents; La Nación June 1st, 2002).

lack of political will to effectively put such an articulation in place. The creation of a coordinating office within the Federal Ministry of Health by 2000 reflects a political decision for propagating coordinating activities.

In turn, Chile’s MCHNPs are characterized by their integral, articulated design both within the health care sector and across social sectors (e.g., education). In addition, MCHNPs in Chile are also articulated with equivalent health care and nutritional programs for children at school age (*“Programa de Alimentación Escolar,”* PAE) in order to provide the continuous provision of health care and nutrition services for the Chilean population.

IMPs’ Constituencies

There is a contrast between the characteristics of MCHNPs’ beneficiaries between Argentina and Chile. In Argentina, despite the long tradition of PMI as a maternal and child health and nutrition program, beneficiaries do not constitute a strong constituency with specific expectations and demands towards the program. Furthermore, beneficiaries – mostly mothers and pregnant women – know the program as the “milk program” and do not even consider the health care curative and preventive component, which is supposedly the fundamental dimension of PMI according to its program representatives. According to specific case studies, potential beneficiaries do not often frequent primary health care centers beyond the required monthly visit to withdraw the milk and to some prenatal monitoring (Grassi, Hintze, and Neufeld 1994). Also, audits to provincial MCHNPs performed between 1994 and 1997 – times with frequent delays regarding the transfers of federal funds and, subsequently, numerous irregularities concerning milk purchases and distribution – indicate that the proportion of mothers and children’s participation in periodic primary health checkups was considerably reduced at times when PMI’s milk was not available for distribution (AGN 1995-1998).

Despite relatively new nature of PROMIN, it seems to be better known among its beneficiaries. Perhaps, this is because PROMIN is perceived as a more efficient social program. This perception, however, varies according to jurisdictions and subprograms; There are heterogeneous situations regarding program implementation according to specific jurisdictions (decentralized nature of the program plus the federal organization of Argentina’s public policy). We need to consider this information with caution since the information provided by PROMIN contrast with data from other sources.⁶⁴

⁶⁴ A study pursued in 1999 by a former PROMIN’s collaborator (and funded by the World Bank) on popular perceptions of the social services documents extremely high levels of mass ignorance regarding the existence of federal social programs in general: about 71 percent of the poor population surveyed did not know about any federal social program for which they might become beneficiaries. Among these surveyed population, 89 percent did not know what PROMIN was (Página 12, 1999: 2) Cecilini, Sandra 1999 “Social Evaluations of Self-Perception of the Poor Population in Argentina,” funded by the World Bank. The evaluation study comprised 29 cities and involved 1200 households’ interviews, plus 600 interviews collected in the Buenos Aires Metropolitan area. Quoted in Página 12, June 1st 1999: 2.

PROMIN seems to be better and more extensively known among program officers than among potential beneficiaries.⁶⁵

For Chile's PNAC, the situation is very different. Potential and effective program beneficiaries constitute a strong constituency, resulted from the long, continuous historical tradition of PNAC and the primary health care program for mothers and children. Basically pregnant women, nursing mothers and mothers consider IMP's benefits as “citizens' rights,” and not as mere assistentialist (palliative) actions – as it may have been traditionally the case in Argentina. At time of this fieldwork (ca. 1997 and late 1998), when several officers at the Federal Ministry of Health consider operating structural changes in PNAC (after almost 50 years), mothers mobilized to oppose the changes. Such changes were, according to this program's constituency, against their long-entrenched citizens' rights to maternal, and child health and nutritional benefits.

Coverage Levels

PMI's coverage in Argentina has traditionally been relatively low when compared to the programmatic expected coverage goals. Even after ten years of social policies diffusion increasing PMI efficiency (e.g., reflecting in higher coverage levels) – at least within the discursive domain – program coverage remains relatively low and below expected coverage goals (on average among program components, around 35 percent). The preponderance of the milk distribution component, and extreme dependency on this factor for effective participation in the PMI, contribute to this recurrent low coverage rates. In addition, it is important to reiterate the fact that PMI's coverage figures are only indirect estimates, since there are no accurate and exhaustive records of program beneficiaries at the national level. (This problem, in turn, hinders the program to estimate effective coverage levels).⁶⁶

PROMIN, in turn, has relatively higher coverage than PMI's. Coverage rates, however, vary according to jurisdictions and subprograms (heterogeneity across subprogram implementation). In addition, because of the differential activities pursued by PROMIN – more complex actions beyond distributing milk, e.g., infra structural works, technical assistance and training, etc. – measurement of coverage rates are more difficult to pursue, in particular regarding consolidated data at the national level.

In contrast to the Argentine situation, Chile's PNAC offers a record of continuous high

⁶⁵When users of the public health care network go to specific health care centers, they do not know whether they are under the orbit of PROMIN or they are not: “people know their doctors and nurses, but they do not know PROMIN as an institution” (Fundación Grupo Sophia 2002a: 17).

⁶⁶ For specifics on coverage levels, and problems associated to the number of beneficiaries, see Idiart 2002, Chs. 4-5.

coverage rates, even when controlling by both socioeconomic status and age groups (average rates around 70 to 80 percent). In addition, according to program evaluations performed during the late 1970s and the mid-1990s, PNAC’s targeted component is also effective in terms of adequate and high coverage rates according to income level groups. Coverage is higher for groups corresponding to the lower quintiles of income, and it is relatively lower (though still very relevant) for higher quintiles of income among the population. In addition, PNAC’s evaluation studies report high levels of continuous participation rates among program beneficiaries, even across socioeconomic groups.

IMPs’ Monitoring and Information Systems

Information systems and monitoring capacities of social programs show notable contrasts between Argentine and the Chilean cases. Up to at least the mid-1990s (at least), traditional PMI lacked mechanisms for monitoring and control in terms of efficacy, efficiency and impact of its activities and goals. The only program monitoring activity constituted financial (accountable) audits of PMI at selected provincial and national levels.

Modern PROMIN possesses some these monitoring mechanisms, though this new mechanisms initially are not linked to the traditional procedures developed at the provincial units (difficulties regarding coordination of provincial and federal levels for implementing innovative program management procedures). One of the main components of PROMIN is the organization and implementation of a program information system (SIP) to systematize comparable information on MCHNPs in general across jurisdictions.⁶⁷ Again, Chile’s PNAC present a contrasting situation regarding information systems and monitoring capacities. The unitary structure facilitates uniform data collection and monitoring procedures. Higher degrees of coordination and centralization improved the levels of coverage and program monitoring. Contrasting to the Argentine situation, there is a periodical and accurate updated system of information that allows for the development of monitoring and diagnosis of program performance. Such an extensive and updated information system organizes in mid- to late 1970s as a result of “urge” to implement targeting mechanisms towards the most vulnerable groups. This situation strongly contrasts to the one in Argentina during the 1990s, where targeting appears as a new wave in social policy design and implementation, though information systems on targeted potential beneficiary population required for its implementation is at least

⁶⁷ . According to PROMIN’s evaluations from several sources, information on program’s evolution, implementation and impact are at extreme disaggregated levels (subprograms, which means counties, municipalities at most). Collected information should then be consolidated at both provincial and national levels. However, as late as 1998 consolidated information (e.g., national level program indicators) was not readily from the UCP (Albáñez Barnola, Colmenares and Acuña 1998). A program audit indicates a similar situation of unconsolidated indicators of program implementation and effectiveness (SIGEN 2000).

scarce, when not chaotic.

In addition, the bureaucratic structure of PNAC – with high administrative capacities – facilitates such monitoring and regulation of the local implementation of the programs.

IMPs' Impact

Regarding the Argentine situation, the lack of baseline information to evaluate MCHNPs' impact and for decision making in terms of policy design (e.g., implementing targeting procedures) is a central problem, not only of these two social programs but for the area of social policy in general. In this case, overlapping competitive programs with high levels of heterogeneity in terms of both provincial and local program implementation, make all implementation, regulation and monitoring very difficult tasks. The relative success of PROMIN to organize procedures and some levels of monitoring (though impact studies are still impossible to develop), shows the role of IFIs (The World Bank and The Inter American Development Bank) as a support for the central state with traditionally weak administrative and institutional capacities.

Despite the strong investment on PROMIN, the national nutritional survey, a study of the impact of MCHNPs, and a cost assessment study – three activities included on PROMIN I documents ca. 1993 – are still pending by 2002. The lack of an adequate knowledge of the nutritional status of the population at the national level is the main factor for not possessing a baseline to measure social policies reforms during the 1990s (mainly effectiveness of targeting, decentralization, management strategies, etc.). The fact that such a knowledge is still lacking provides an indication of the problems associated to the capacities by the national state to implement long-term social policy initiatives that require state capacities and financial resources, though the latter are in this case provided by the World Bank.

In Chile, PNAC's evaluation studies show long-term positive impacts of the program. Also, the availability of periodic studies allows for the comparability in time of PNAC performance (1979, 1995). In particular, for the group of children below three years of age, and under-nourished pregnant women, PNAC shows very positive effects on their health and nutritional status. Later during the 1990s, and because of epidemiological and nutritional transformations of the Chilean population, PNAC as traditionally designed seems to have negative effects on some population groups (i.e., higher strata and over-weight pregnant women). Among the recommendation effectively implemented by 1999 is the transformation of the traditional characteristics of PNAC according to the new nutritional status of the Chilean population.

MCHNPs in Argentina and Chile: Synthesis

A close comparison among MCHNPs in Chile and Argentina shows noticeable contrasts. For Chile we may characterize them as well articulated chain (“*cascada*”), composed of well integrated maternal, child health care and nutritional programs. For the case of Argentina, we may speak of as an overlapping patchwork of programs in mutual competition.

First, relative to Argentina, Chile emerges from my research characterized by historically higher state administrative capacities, levels of technical expertise, degrees of isolation from short-term political instabilities, levels of party institutionalization, degrees of isolation from pressure groups – including corporatist organizations, and beneficiaries groups and political parties – and levels of state autonomy. Moreover, all these factors appear to correspond with the higher levels of continuity and coordination in social policy implementation that emerge for Chile relative to Argentina.

Second, Argentina presents higher numbers of similar specific social programs at the national level of program proliferation and policy fragmentation than Chile. Consequently, Argentina shows increasing problems associated to the state’s administrative and regulatory capacities to oversee these programs’ implementation. These factors generate higher levels of implementational inefficiency in Argentina than in Chile.

The overall success of Chile’s PNAC is documented on the impressive improvement of its bio-demographic and nutritional indicators regarding maternal and children’s health, in particular from the 1950s onwards. Such improvements resulted from the conscious implementation of a national public policy regarding primary health care, the long-term continuity (despite governmental and political regime changes) and institutional capacity of the state to implement nationwide integral primary health care programs.

The originally-intended, and long-lasting, universal character of this program in Chile constituted a solid base for the implementation of targeting reforms in these social protection programs during the 1980s. Such a targeting wave, however, could not eliminate its universal component. PNAC became a mixed-type of program, a “hybrid” form that combined universal and targeting components. This ideal mix constitutes one of the factors for the continuing improvements of MCHNPs.

The changes in the epidemiological and nutritional structure of the Chilean population – as one can observe during the past decade – require a different public policy strategy with regards to health care and prevention. The success of the continuous and long-lasting infant-maternity policy – PNAC and its articulation with health care IMPs – is central for explaining these changes, even though it cannot be identified as the only factor behind them. These success, in fact, may be also one of the reasons for discontinuing – or at least for dramatically

modifying – the traditional structure of this highly institutionalized nutritional program.⁶⁸ Public health care policy in Chile requires fundamental changes regarding its nutritional component, as well as with regard to overall health care policy in so far as it addresses important problems beyond the compass of infant and maternal primary health care.

In contrast to Chile’s uninterrupted and successful maternal, child health and nutritional policy implementation, Argentine policy presents a depressing panorama. Despite extremely high levels of investment and the ostensibly sound PROMIN, Argentina’s decade-long 1990s national attempt to upgrade its health and nutrition sectors remains short on accomplishments.

The main problem, however, resides not within the program itself but at the core of the Argentine social policy network. First, the fact that this program has not completely replaced the old PMI – which is still in place, albeit with extremely reduced budgetary resources, and considerable drain of prestige and technical personnel to the new program – repeats some of the recurrent failings of Argentine social policy: federally fragmented, overlapping, competitive, uncoordinated social programs.

Second, despite the original idea of an integral coordination between PMI and PROMIN, effective coordination between these two programs has been slow coming. Only by late 1998 – five years after the creation of PROMIN – did a coordinating committee under the orbit of the MSAS started to get organized. Only under the new federal administration (ca. 2000), the government officially creates the Coordinating Unit to Execute Maternal Child Health and Nutrition Programs (“*Unidad Coordinadora Ejecutora de Programas Materno Infantiles y Nutricionales*”) under the authority of the Federal Ministry of Health (Secretaría de Hacienda 2000: 275). At provincial levels, coordination between these two programs also presents a confused and confusing situation that has depended more on local political and institutional conditions than on federal initiative.

A considerable overlapping of activities combined with the lack of coverage for a substantial sector of the population (in fact excluded from both programs) demonstrates the low administrative capability and inefficiency of the Argentine state where implementation of social programs is concerned. The end of PROMIN’s second operational stage in 2003 leaves uncertain what scenarios will figure in the future of maternal and child health nutrition programs in Argentina. This is even more serious given the deep socioeconomic crisis being undergone by Argentina since at least early 2000. Such a socioeconomic crisis leads rather directly to a downgrading of the nutritional and health conditions for pregnant women, women of fertile age,

⁶⁸ As it has pointed out by a program evaluation, by the mid-1990s the structural changes regarding the nutritional and epidemiological conditions of the Chilean population called into question the validity of the original programmatic goals of PNAC at the time of its creation (Torche et al. 1995: iv-v, 199).

and children – indeed all the intended MCHNPs’ constituency. This new scenario also poses a challenge: How to provide ameliorative public policy answers?

Neo-liberal reforms, at least as implemented in Argentina during the past ten years, have not provided the “promised bright results,” not even after a decade of “good work” on behalf of the federal state’s liberal designs.

Given the extreme increases in indicators associated with poverty, unemployment, and overall vulnerability of populations, merely deepening targeting strategies has been tantamount to establishing universalistic social provisions.

Chile faced a similar challenge during its deep social, political, and economic crisis of the mid-1970s and its responses could provide long-term insight into how nations respond to increasing population demands. The Chilean answer rested on a long historic process, contrasting authoritarian and democratic political regimes, and distinct international arenas. In addition, Chile’s continuous tradition of social policy implementation in the areas of maternal and child health and nutrition policy, aided by a relatively autonomous state, resulted in the “Chilean Paradox”: a positive evolutionary trend of IMRs despite both economic downturns and decreasing overall funding for public social provisions.

Argentina’s present crisis differs from Chile in terms of points of departures, legacies of social policy implementation and, overall, state capacities and autonomy.

Thinking about the general questions stated at the beginning of this paper, institutional characteristics seem to have interacted with simple policy lines and trumped them. In fact, according to the events taking place in Argentina from 2001 onwards, it is evident that after a decade of neo-liberal reforms, Argentina not only does not show signs of middle-run success. Quite the contrary, the strong and persistent economic recession, together with its subsequent social crisis and political stalemate seem likely to soon reveal reversals of health and nutritional indicators.

Once again, we witness the neo-liberal paradox appearing after a decade of neo-liberal reforms: in order to *dismantle* the state – or at least to reduce it to a minimal, subsidiary one – one needs a state that has institutional capacities strong enough both to regulate and maintain the ideal “free market,” and to provide a social protection net sufficient that is able to sustain the political feasibility of neo-liberal reform. At present, Argentina is suffering from the combination of an historically weak state capacities and from the aftermath of a decade of neo-liberal de-regulation. An underfunded state threatened with dismantling may be especially unable to provide the social policies solutions required for this social and economic emergency, most particularly so if it has been a weak state from the start.

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