REFORMING SOCIAL POLICY
This page intentionally left blank
Contents

Preface – Daniel A. Morales-Gómez ....................................................... vii

Chapter 1
Introduction: The Paradox of Development
– Necla Tschirgi ................................................................. 1

Chapter 2
Ghana: Social-policy Reform in Africa
– Ernest Aryeetey and Markus Goldstein ................................. 9

Chapter 3
Chile: Progress, Problems, and Prospects
– Dagmar Raczynski ........................................................... 45

Chapter 4
Canada: Experience and Lessons for the Future
– Terrance Hunsley ............................................................ 83

Chapter 5
Conclusion: A Research Agenda for Social-policy Reform
– Jennifer L. Moher ............................................................ 115

Appendix 1
Acronyms and Abbreviations ..................................................... 147

Appendix 2
Contributing Authors .............................................................. 149

Bibliography ............................................................................. 151
Social-policy reforms have been at the forefront of public attention in Chile since the mid-1970s. The objectives of these reforms have gradually expanded to include the search for an effective strategy to fight poverty, improve the efficiency and quality of services, and enhance equity and political inclusion (democratization). In the mid-1970s and 1980s, Chile was a pioneer in adopting neoliberal policies. This orientation included an emphasis on the subsidiary role of the state in the direct provision of services; the reduction and targeting of public expenditures; privatization and decentralization policies; and the prioritization of demand-driven over supply-driven subsidies. However, in the 1990s, concurrent with changes in the internal political and economic context, the debate is being refocused on the social reforms inherited from the neoliberal period. Policy priorities, content, instruments, and institutional arrangements are all being revisited, and although significant continuities exist with previous reforms, the orientations of social policy in democratic Chile suggest the emergence of a new model of social

Social protection in Chile to 1970

From 1920 to 1973, Chile’s system of social policies entailed increasing state involvement in the direct provision of social services. After the 1929 depression, Chile adopted an import-substitution policy, shut its economy to international trade, and promoted policies to foster the development of national industry and domestic demand. The beginning and later expansion of Chile’s public social policies was associated with building the nation-state, a process associated with industrialization, the growth of cities, and weakening of the traditional social order. Upheavals in the urban centres and the mining sector played an important part in the initial push toward state involvement in social issues; so too did emerging social-security laws in European countries, the social Encyclicals of the Roman Catholic Church, and recommendations of international organizations such as the International Labour Organization.

The evolution of the state’s approach to social policy during this period was also significantly influenced by the system of political representation and the existing power structure. Through their organizations and political parties, the urban middle sectors, the industrial bourgeoisie, and urban workers pressured the state for policies

---

2 Unless otherwise stated, the evidence for this section comes from Arellano (1985) and Raczynski (1994).
favourable to them. The result was an increased presence of the state in the economy and society, with political parties playing a central intermediary role. Of note during this period, the organizations of social representation within civil society were weak (Oxhorn 1995), and the gradual extension of the state into economic and social realms tended to limit the role of private entities, the community, and business and labour associations.3

This dynamic of state expansion displaced the idea that the state ought to protect only the weakest sectors. Yet, the Chilean welfare state developed in a piecemeal fashion, as a consequence of pressure from various labour and social groups. The final result was a fragmented and inequitable system. By 1970, the entire population was nominally entitled to similar social benefits, but the quality of, and access to, these varied across rural and urban areas, public and private sectors, and different labour categories within each. The most extreme illustration of such fragmentation was Chile's social-security system, which was structured around 35 withholding funds. These funds in turn administered 150 different programs (Foxley et al. 1979).

By the mid-1960s, state activity in the social sectors was significant. At this time, the government prioritized structural reforms affecting property, undertook progressive income and labour policies, and intended to incorporate the urban and rural poor through programs to foster neighbourhood organization (promoción popular) in urban areas and agrarian reform and unionization of peasants in rural areas. Further, the government introduced measures to improve salaries and lower the price of basic goods and services. It broadened housing programs and implemented reforms to expand educational coverage at the primary, secondary, and university levels. In 1970, the Popular Unity government accelerated structural reforms that directly affected wealth. Agricultural expropriations were massive, and the government created an area of collective property in industry under state control. Policies in education and health were oriented to creating unified national services (Servicio Unico de Salud [unified health service] and Enseñanza Nacional Unificada [unified national education]). These policies generated strong political opposition and failed.

3 These characteristics are not exclusive to Chile. On the expansion of the social-security system, see Mesa-Lago (1978). For a more general discussion on the role of the state, political parties, and private entities, see among others Garretón (1994) and Kliksberg (1994).
Throughout these years, public social spending expanded significantly. In 1970, such spending was 70% higher than that in 1965, representing 20% of the gross domestic product (GDP); by 1972, it had reached 26% of GDP. It is significant, however, that this expansion was not adequately financed, and this contributed to fiscal deficits and accelerated inflationary tendencies that annulled initial improvements in the monetary incomes of the population. By 1973, the public deficit had become unmanageable, reaching 30% of GDP. Economic problems, major political mobilizations by the opposition, and sharp political conflicts unseated the government. The crisis of 1972–73 was not impetuous but the culmination of unresolved economic and political conflicts that had been mounting for decades (Bitar 1979; Foxley 1983).

The military coup of September 1973 brought an end to five decades of continuous expansion of publicly financed and often state-administered social services. By 1973, Chile's social-policy system had experienced numerous successes but had also accumulated important difficulties. On the positive side, Chile had an infrastructure and supply of social services that benefited increasingly larger portions of the population: first the workers, then the urban middle- and lower-income strata, and finally, then, to a lesser extent, the rural population. By 1970, 94% of the population aged 6–14 years had access to elementary education, and 90% of students were enrolled in the free-of-charge public school system. Thirty-eight percent of adolescents aged 15–18 years were enrolled in high school; and 8% of the population aged 19–24 years were at university. About 90% of live births received immediate medical attention, and almost 90% of children under 6 years of age were covered by national child check-up, nutrition, and immunization programs. The Servicio Nacional de Salud (SNS, national health service), established in 1952, provided the bulk of this wide coverage, owning and managing around 90% of the health-care facilities in Chile. About 70% of the labour force was covered by the social-security system. The state was also directly involved in 60% of the housing units built each year.

Concurrent with processes of economic growth and industrialization, social policies contributed to improvements in human-development indicators. General- and child-mortality rates, which in 1920 were at 30 and 259 per 1 000, respectively, dropped to 9 and 73 per 1 000 by 1972. Illiteracy for people aged 15 years and over fell
from 37% in 1920 to 11% in 1970. The proportion of the urban population with access to potable water and sewage increased in 1972 from nil to 65% and 35%, respectively. Life expectancy at birth rose by more than 10 years from 1952 to 1970. The birth rate was more than 40 per 1,000 in 1930, and by 1972 it had dropped to 27 per 1,000. Fertility rates for the same periods dropped from 5.5 children to 3.6 children for women who had completed their fertile years. Also, the social structure in Chile was becoming increasingly urban centered. The urban population was 52% in 1940 and 75% in 1970, with increasing concentration in the metropolitan area of Santiago. Middle and lower strata in the cities benefited the most, particularly from job opportunities created in the public sector, which had expanded and, by 1970, absorbed 12% of the labour force (Muñoz et al. 1980). Overall, public social programs in Chile during this period achieved high coverage, compared with other Latin American countries.

Despite these accomplishments, ample room remained in all social programs to make the distribution of benefits more equitable. Also, the system was costly and plagued by administrative inefficiencies. It was highly centralized, with vertical bureaucratic decision-making processes; suffered rigidity and an incapacity to respond to the basic needs of the population; had geographic and economic inequalities; and paid low wages to professionals and functionaries. Social policy decision-making was based on scattered information. For example, basic data on the size, characteristics, and geographical distribution of poverty and evidence of the beneficiaries of public spending were almost nonexistent. Later, studies revealed that income-based poverty affected 17% of households; and poverty was not uniform, in that people who were poor in one respect (for example, housing) were not necessarily so in another (for example, children's education or household income) (ODEPLAN and Universidad Católica de Chile 1975; Cortázar 1977). The first rigorous study on beneficiaries of public spending was published in 1979 (Foxley et al. 1979).

Further, the country had unsatisfied needs for health care, a growing housing deficit, population sectors marginalized from social security, and high repetition and drop out rates in education, particularly in rural areas and in urban areas with high concentrations of poverty. Although the majority of the population was formally covered, access to services was often limited. In the 1960s, the criticisms of the public social system grew particularly acute, concurrent with
stagnation in economic growth, inflationary trends, the exacerbation of political conflicts, and social mobilizations around measures affecting the rights and the distribution of property.

Social-policy reforms in the mid-1970s and 1980s

The economic and political context

In the early 1970s, Chile experienced severe economic imbalances and sociopolitical conflict. The military government, which took power in September 1973, remained in place for 17 years, until March 1990. The ideology and doctrine of the government crystallized around a model that was both economically neoliberal and politically authoritarian, breaking sharply with the development strategy that had prevailed from 1930. Changes occurred in a closed political system that was characterized by strict control over social organizations (particularly political parties, unions, and professional associations), collective expressions of social demands, and the media.

With the advent of the military regime, an open economy replaced a closed and protected one. A strategy that favoured external demand and the growth of exports succeeded one that favoured import substitution, with the twin pillars of strengthening the industrial sector and internal demand. The state, which had strongly supported economic development, came to play a less interventionist role, limiting itself to the formulation of macroeconomic policies. Economic policies involved the privatization of commercial firms and banks, liberalization of prices (except wages), reduction of import tariffs, the free movement of capital, and a strict fiscal regime. The main elements of revised labour policies were promotion of labour flexibility, limitations on the power of labour unions and collective bargaining, and the reduction of labour costs. Economic adjustment and macroeconomic equilibria came to take precedence over social-policy concerns.

With this neoliberal reorientation, Chile saw more than a decade of economic instability. In 1975/76 and again in 1982/83, Chile experienced a major drop in GDP, and in 1988 and 1989, after precrisis levels were regained, it had the highest growth in Latin
America. The net result was a moderate annual growth rate of 2.6%, inferior to the rate between 1961 and 1971, which had reached 4.6%. After 1986, however, the economy began a sustained recovery and expansion, which coincided with an increase in state regulation, particularly in the financial sector, and a macroeconomic policy focused on domestic and foreign balance. The country experienced growth, investment, and the creation of jobs. Unemployment, which had averaged 13.7% between 1974 and 1988, dropped to around 9% in 1989, and real wages rose modestly. Together, these trends resulted in declining levels of income-based poverty from 1985 on. Whereas in 1990, 34% of households had an income below the poverty line (11% below the extreme poverty, or indigent, line), in 1985 and 1987 the figures were 45 and 38%, respectively (25 and 13% being below the indigent line) (Torche 1987; MIDEPLAN n.d. for 1987, 1990).

Despite these achievements, in 1990 poverty figures were still double those prevailing 20 years earlier. Moreover, the neoliberal economic strategy pursued under the military regime exacerbated distributive inequalities. In Greater Santiago, the share in total income of the poorest 40% of families, which fluctuated between 12 and 13% in 1965–73, fell to 11% in 1974–81 and to less than 10% in 1982–85. The Gini coefficient increased from 0.50 in 1970 to 0.55 in 1984 (Riveros 1984). In addition, surveys of household spending in 1969, 1978, and 1988 revealed a decline in household expenditures for the three lowest quintiles, the decline being greater in the poorest households. By contrast, the richest quintile alone increased its level of expenditure from 44.5% in 1969 to 54.6% in 1988 (Raczynski 1994, table 15).

A neoliberal approach to social policies

Oriented by the neoliberal model, Chile's military government pursued three general objectives in restructuring the country's social policies: first, it redefined the purpose, objectives, and spaces for public action in the social sectors; second, it modified institutional arrangements within the social sectors; and third, it reduced social expenditures and modified priorities and mechanisms for financing and allocating resources.

In contrast to the previous period, the objectives of social policy after 1973 were subordinated to the goals of controlling inflation.
Economic growth took precedence over redistributive and social objectives, the latter being limited to the alleviation of extreme poverty. Neoliberal policies aimed at restricting the role of the state, which in practice entailed reducing public spending and transferring the administration of social services to entities closer to the population, such as municipalities and the private sector. The dominant philosophy was that state-financed social programs should benefit only those households not in a position to meet their own most urgent basic needs; that the allocation of public resources to address social problems should be governed by demand- rather than supply-side forces; that subsidies should be transferred directly to beneficiaries; and that financing for social services should be based on services effectively rendered and not on static or historically based allocation schedules. Policies guided by these principles, it was asserted, would ensure that resources reached the poorest sectors effectively and encourage market competition, thus promoting efficiency in the management and delivery of social services. Castañeda (1992) described the principles and objectives of the reforms.

The most significant of these reforms were implemented in the 1980s. The 1970s had been a period of normalization, rationalization, and preparation for the reform projects. This decade was marked by significant reductions in public spending; the implementation of measures to eliminate some obvious inequities in social security and in health; targeting of the state's activities, particularly in education and health; development of a social safety net; completion of diagnostic studies on the magnitude, location, and characteristics of poverty; and development of poverty-screening instruments. During this time, the government also introduced the so-called modernizing reforms: the Administrative and Regionalization Reform, the Social Security Reform, and the Presidential Directive on Education and the Restructuring of Health. The main reforms and measures that affected the social sectors are summarized below (see also Table 1).

**Fiscal balance and public expenditures**
For the military government, a commitment to fiscal balance governed public spending. In the 1970s, the government had pursued this balance by implementing a tax reform, which simplified the existing system and launched a successful campaign against evasion and by reducing expenditures. At the end of the 1980s, when the economy
Table 1. Chilean social-policy reforms: 1973–90.

<table>
<thead>
<tr>
<th>Axis of Reform</th>
<th>Social Sector</th>
<th>Reforms and Policies Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public social expenditures</td>
<td>Reducing expenditures from 20–25% in 1970 to 15% in 1989</td>
<td></td>
</tr>
<tr>
<td>Targeting</td>
<td>Education</td>
<td>Transferring expenditures from the university to preschool and elementary education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Targeting of specific programs within the educational system (e.g., school food programs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revoking state-subsidized free university education</td>
</tr>
<tr>
<td>Health</td>
<td>Concentrating expenditures on the primary level and on children’s (i.e., under age 6 years) health and nutrition programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revoking free curative care in public establishments (except for children and pregnant women)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introducing copayment rules, according to level of income</td>
<td></td>
</tr>
<tr>
<td>Social safety net</td>
<td>Designing a social safety net</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Designing national instruments to screen the poor population and to identify actual beneficiaries of social programs</td>
<td></td>
</tr>
<tr>
<td>Decentralization</td>
<td>Defining a new regional administrative division across the country</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decentralizing government, partially, from the ministries to the regions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creating FNDR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Redefining, legally, the functions and roles of the municipalities</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>Disaggregating SNS into 26 health services</td>
<td></td>
</tr>
<tr>
<td>Education and social safety net</td>
<td>Transferring administration to the municipalities</td>
<td></td>
</tr>
<tr>
<td>Privatization</td>
<td>Social security</td>
<td>Creating an individual capitalization system, administered by the private sector</td>
</tr>
<tr>
<td></td>
<td>Health</td>
<td>Creating private for-profit health-insurance institutions</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>Creating incentives for the private administration of state-financed schools and for the creation of private post-secondary (i.e., university, technical centres) training institutions</td>
</tr>
<tr>
<td></td>
<td>Education, health, housing</td>
<td>Outsourcing of specific services to the private sector</td>
</tr>
<tr>
<td>Demand- or supply-driven subsidies</td>
<td>Health, education</td>
<td>Allocating resources according to services rendered (e.g., school enrollment, health services delivered)</td>
</tr>
<tr>
<td></td>
<td>Housing</td>
<td>Introducing demand subsidy (i.e., voucher)</td>
</tr>
</tbody>
</table>

Note: FNDR, Fondo Nacional de Desarrollo Regional (national regional development fund); SNS, Servicio Nacional de Salud (national health service).
was growing, the government lowered taxes on the basis of two assumptions: that economic growth would generate enough funds to finance public spending and that a reduction in tax rates would stimulate savings and investments and thereby accelerate economic growth.

In accordance with these decisions, per capita public spending dropped sharply in 1973–76, relative to the level prevalent in 1970. It recovered toward the late 1970s, parallel to the economic upswing of these years, and then dropped again during the economic crisis of 1982 and did not recover. Cutbacks occurred — particularly in housing, education, and health — and these affected investments and wages more than operational costs (Marshall 1981; Cabezas 1988; MHDP 1997).

**Targeting and poverty alleviation**

The government’s targeting policy had numerous components. In education and health, spending was restructured intrasectorally (that is, priority was given to the less complex levels of care). Public investments in education and health, which dropped significantly, targeted primarily isolated and socially underprivileged areas. Emergency employment programs, welfare pensions, child subsidies, nursery schools, and community child-care facilities for poor families were created to assist the extremely poor segments of the population (Vergara 1990; Raczynski and Romaguera 1995). Nevertheless, despite targeting efforts, the percentage of fiscal spending that effectively reached the poorest sectors was low. In 1987, social expenditures constituted 13% of GDP; the goods and services that were directly distributed to people, 7% of GDP; and the social spending that directly benefited the poorest 20% of households, 2.2% of GDP. If the poorest 40% of households are considered, the latter figure reached 3.6% of GDP (Haindl et al. 1989). Still, the safety net played an important role in the survival strategies adopted by the poorest households (Raczynski and Serrano 1985; Raczynski 1987).

The literature on the Chilean experience with targeting points to a number of lessons that are worth noting (Vergara 1990; Raczynski 1992, 1995b; Sojo 1990; Grosh 1992; de Kadt 1993). Among the most important of these are the following:

- The preexistence of universal programs facilitates the introduction of targeting, as demonstrated by the experience with
the implementation of successful health-nutrition programs for mothers and children at risk (Raczynski and Oyarzo 1981; Raczynski 1987; Vergara 1990).

- In a situation of diminished public resources and heightened social needs, strict targeting may transform programs that traditionally invested in human capital through purely welfare-oriented assistance programs and discouraged the initiatives and efforts of family members to generate income by their own effort.

- Reliable information is a critical precondition for targeting. The information required is not limited to that obtained through screening the poor population. Targeting also requires assessments of the specific situations a program seeks to modify, the most efficient means to achieve the goal, the size of the target group, and identification of expeditious ways of reaching this group.

- There is no single mechanism to facilitate targeting, and a socioeconomic screening instrument that focuses on households is not necessarily the best. This type of instrument has considerable administrative costs, is vulnerable to unreliable information and discretionary decisions on the part of those who apply it, and often implies social stigmatization. Targeting can be implemented through program design or with reference to territorial areas, household-screening instruments, or information on risk and vulnerable groups obtained from regular services registers. Notably, preference for one or another targeting mechanism is not independent of perceptions of poverty and its determinants. If poverty is seen as rooted in individual causes (for example, characteristics of the poor person or family), a poor-nonpoor screening instrument will be privileged, the assumption being that direct transfers to the poor will take him or her out of poverty. Alternatively, if poverty is perceived to be rooted in more systemic or environmental causes, the priority will be to modify these dimensions, and targeting by geographical areas or by type of service offered will be seen as more appropriate. (For a more complete discussion of targeting mechanisms see Grosh [1992] and Raczynski [1995b].) The suitability of one or the other, or a
combination of these approaches, depends on the objectives and nature of the social program, the magnitude and characteristics of poverty, institutional factors, and the availability and cost of timely and reliable information.

- It is an error to assume that targeting will increase the effectiveness of social expenditures. A very well targeted program may have no effect whatsoever on the living conditions of its beneficiaries. The impact of a program on poverty depends more on its specific objectives, content, and coverage (that is, error of exclusion) of poor groups than on its spillover to nonpoor groups.

Probably the most beneficial impact of Chile's targeting policy in the 1970s and 1980s was the diffusion of the idea itself, along with improvements in the technical management of social programs. Included among such improvements were the development of baseline studies; economic assessments of programs; identification of the actual beneficiaries of social spending; implementation of standardized educational testing to determine achievement of minimum learning objectives; and regular measurement of the nutritional status of children of less than 6 years of age in public (municipal) health facilities.

**Decentralization policies**

Chile's military government implemented a political-administrative reform with two axes: regionalization and municipalization. With respect to regionalization, three territorial levels — regional, provincial, and municipal — were created below the national level, decentralizing the functions and tasks of the state ministries and creating Fondo Nacional de Desarrollo Regionala (FNDR, national regional development fund) to transfer resources for small investments to regional authorities. Also, the SNS, the central agency of the Chilean health sector, was subdivided into 26 territorial units.

Although decentralization aimed at relegateing some activities to subnational levels, in fact no significant decision-making power or resource was transferred to the regional levels. The resources administered by the FNDR were never more than 8% of public investment. Moreover, regional, provincial, and municipal authorities were all appointed by the presidency, and the participation of regional and
local actors, organizations, and agents was either nonexistent or under strict control (Raczynski and Serrano 1985; Serrano 1996). The subdivision of the SNS into 26 smaller geographical services did not effectively decentralize this area of social policy, as the means to finance and to define priorities, programs, and procedures were all retained by the national ministry (Celedón and Oyarzo 1998).

The government created a new municipal regime and transferred various functions, responsibilities, and resources to the municipalities. Municipalities were to analyze social problems, administer the social safety net, manage educational and health establishments, and formulate specific social projects to address problems specific to their area. Beginning in the 1980s, the central government provided incentives to transfer public education and primary health care to the municipalities. Initially, the process was voluntary in that municipalities requested the transfer, and they received economic compensation, administrative support, and technical assistance. These transfers were frozen during the economic crisis of 1982–83 and were reinitiated in 1986. Transfers were then massively imposed on the municipalities, without any special economic rewards, technical assistance, preparation, or training (Raczynski and Serrano 1987, 1988; Espínola 1991; Raczynski and Romaguera 1995; Serrano 1995). By 1989, municipalities managed almost 100% of the public educational establishments and urban and rural health clinics and posts. The transfer included real estate, equipment, and all personnel. Notably, the latter ceased to be state employees, losing both labour rights and benefits associated with their previous positions. This promoted significant opposition to the transfer.

Again, however, as with regionalization, there were difficulties. The municipalities restructured according to a centrally designed formula, which left little flexibility for local adaptation. Moreover, although municipalities received more resources than in the past, they had little managerial autonomy, as a large proportion of the resources was tied to specific activities. Also, after the economic crisis of 1982–83, the resources transferred to municipalities were not adjusted to account for inflation. The result was the development of significant municipal deficits incurred to meet the costs of administering educational and health establishments (Espínola 1991; Miranda 1990).

Initially, the government had hoped that municipalities would contribute their own resources, thereby increasing local-level social
expenditures. To some extent this did occur. In 1990, the municipal share was a full 12% of education and health expenditures (Stewart and Ranis 1992, table 5). Yet, this only partially compensated for the decrease in central-government spending. Additionally, and not unexpectedly, only a few municipalities had enough per capita revenue to support education, health, and poverty programs. (Chile's municipalities possess no independent revenue-raising power.) Most municipalities were at the other extreme: low per capita revenue and high concentration of poverty. A fund legislated to redistribute resources from rich to poor municipalities — the Fondo Común Municipal (common municipal fund) — was oriented in the right direction, but the size of this fund was insufficient to overcome the enormous initial territorial inequities (Raczynski and Cabezas 1988).

Finally, studies of municipal performance in the 1980s showed that local administrations were overwhelmed by requirements and poorly coordinated instructions from the central government. They were also saddled with responsibility for the direct provision of welfare benefits and for extensive administrative tasks. Lacking the necessary conceptual and practical tools to engage in effective or efficient social development, municipalities acted independently only exceptionally. Autonomous social projects tended to be scarce, discontinuous, and palliative, rather than preventive (Raczynski and Serrano 1998).

In sum, the decentralization policy of the military government made significant changes in social policies but ran up against a range of difficulties. Despite these challenges, the policy helped to legitimize the idea of decentralization and define a conceptual and practical basis for local social development in Chile. For example, in 1989–90, only the professional associations of teachers and medical and paramedical personnel demanded recentralizing measures to give them back their lost labour rights, particularly the rights against dismissal and to have wages scale up with seniority.

**Privatization-oriented reforms**

Before the 1970s, the provision of social services in Chile was primarily in the hands of the state. After 1973, however, the military government introduced the partial or full privatization of some services.

The private administration of publicly subsidized services — Outsourcing and the private administration of publicly subsidized services were stimulated, although this strategy had variable results.
Outsourcing was applied to nonmedical services in public hospitals and to food preparation within the national school food program. The experience was positive, with delivery of better quality goods or services at lower cost, so long as unambiguous definitions were provided of the goods or services to be outsourced and of the standards to be monitored.

By contrast, the private administration of publicly financed social services had mixed results. The administration of vocational high schools by business associations met with success, with improvements in the quality and relevance of the training for the productive sector, as well as enhanced funding from the business sector for the schools. Enrollment in state-subsidized, privately administered schools went up from 14% in 1980 to 30% in 1985. This expansion was associated with the introduction of a monthly student subsidy, Unidad de Subsidio Escolar (USE, unit for school subsidy). The expansion of these schools stopped in the mid-1980s with the failure to readjust the subsidy for inflation. Yet, a debate persists in the country regarding this experience. A national test, Prueba SIMCE (Sistema de Medición de la Calidad de la Educación [system for measurement of quality of education]), which measures the achievement of educational objectives, showed slightly higher scores and probably higher variability in scores in schools under private administration than in municipal schools. For some, this result suggests better quality of education and more efficient use of resources. For others, this interpretation is spurious, as the privately administered, state-subsidized schools enrol children from more advantaged socioeconomic backgrounds or represent schools managed by private, nonprofit foundations (including religious congregations) supported with resources additional to those of the state.

The private administration of public hospitals was a pilot experiment that failed, faltering on lack of decentralization of the health services; cumbersome legislation and administrative procedures; and a clash between the organizational culture and decision-making logic of the physicians — traditional hospital administrators in Chile — and those of the economists, engineers, and administrators.

In the housing sector, the selection of sites and the construction of housing units were also subcontracted to the private sector. Although the state defined the size of units, it possessed no adequate means to control the quality of construction and provided no norms.
Regarding neighbourhood equipment and availability of basic services. The result was that new residential areas for the poor and lower middle strata appeared on the outskirts of cities where the price of land was cheaper, exacerbating geographical segregation within the large cities.

In sum, a review of the Chilean experience suggests that the impact of private administration depends on a number of factors, including the traits of private administrators, economic incentives, legislation, administrative procedures, the strength of the organizational culture prevalent in the services that are privatized, and monitoring and evaluation processes that the state is able to develop and apply.

Privatization of social services — Beginning in the 1980s, the government undertook the full privatization of some key social services. The most important were in social security and in health. Other privatization reforms took place in post-secondary education (that is, universities and other higher education training centres) and in labour training. The pay-as-you-go social-security system was replaced with an individual capitalization system managed by the private sector and regulated by the state. Under the new system, contributions (10% of gross wages) are accumulated in individual accounts for workers. Pensions are drawn from funds accumulated over 20 or more years, managed by private corporations, Administradoras de Fondos de Pensiones (AFPs, administrators of pension funds), that invest the funds in the financial market, under state regulation. The new system is mandatory, as was the old, and workers are free to choose at all times the AFP they wish to join. The state guarantees a minimum return, based on the average return of the system in a given period, and a minimum pension for workers who, having accumulated funds for 20 or more years, lack enough savings to finance a pension above the legally established minimum. It also guarantees a welfare pension for poor people more than 65 years of age who contributed for less than 20 years (or not at all) to social security (Arellano 1985; Marcel and Arenas 1991).

There was a rapid and massive transfer of wage earners to the new system, encouraged by economic incentives (for example, increase in net wages through a reduction in the mandatory social-security contributions in the new system), declining benefits in the old system during the years immediately prior to the reform, and a general lack of trust in the old system. The new system has come to play a central role in the expansion and functioning of Chile’s financial market.
Conclusions about the success of the social-security reforms can only be tentative. In the protection of income levels of the population during periods of sickness and old age, the new system eliminates the demographic impasse that pay-as-you-go systems face as the population ages. Yet, its final test for Chile is pending — until it pays a majority of the pensions. So far, the social-security system has been accumulating funds — in 1994, these constituted more than 43% of gross national product — and has been paying out no more than 15% of the total number of monthly civilian pensions. On average, the value of pensions has been higher under the new system. The returns earned by the funds accumulated in each individual account depend on the behaviour of the financial market, and so far the average performance of this market has been favourable, particularly up to the early 1990s. Steady economic growth and stability are fundamental to the system. National and global crises, like the one in 1981, might easily destabilize it.

The coverage of the system can be measured as the percentage of the employed labour force that is affiliated and regularly pays its mandatory contributions, and this has not surpassed the figure prevalent before the reform, fluctuating around 60%. People have a high level of uncertainty concerning the future size of state-guaranteed pensions. Moreover, the system registers high administrative costs, augmented by the high rate of rotation between AFPs resulting from publicity and competition.

Another important privatizing reform of the military government was in the health sector. The creation of private health services was preceded by sharp debates between government authorities and the powerful Asociación Gremial del Colegio Médico (national medical association). Many issues were intertwined in the debate: the role of the public and private sector; the priorities of health-care policy; the amount of resources allocated to health care; the reorganization of the public sector; the salaries, training opportunities, and labour conditions of physicians and other health-care staff; and the participation of the medical association and physicians in the decision-making and management of health care (Raczynski 1983). The initial proposals for privatization gradually evolved to support a mixed, ill-defined public-private system. The social-security reform permitted affiliates to place their mandatory health-care contributions that previously went automatically to the public health-care fund in private health
institutions, Instituciones de Salud Previsional (ISAPREs, institutions for provisional health). Affiliates that opt for the private system enter into an annual contract with an ISAPRE that in turn establishes the monthly amount to be paid, the health care that is included, and reference fees and discounts. Health-care plans offered by the ISAPREs vary, depending on age, sex, and family size, as well as varying in terms of benefits, freedom of choice regarding the physician and treatment facility, amount of reimbursement, and exclusions or blackout periods. At present, there are more than 8,000 plans, rendering comparative analysis impossible, particularly as each ISAPRE uses a different unit to define the monthly age-sex costs of a plan, its benefits, and its reimbursement fees. The result is a lack of transparency in the market for health-insurance plans. Affiliation with a specific ISAPRE is highly unstable, and individuals frequently change from one ISAPRE to another and from the ISAPRE system to Fondo Nacional de Salud (national health fund) (Miranda 1990; CIEPLAN-CORSAPS-FLACSO 1996; Celedón and Oyarzo 1998).

The private system expanded slowly up to 1985 but more quickly from then on, as a consequence of government decisions resulting in increased economic incentives for the private sector. These incentives included an increase in health-care contributions from 4% to 6%, then in 1985 to 7%, of earnings; the transfer (in 1986) of financial responsibility for the maternity subsidy from the ISAPREs to the state; and the option for employers to make a 2%, tax-deductible increase in their contribution to the premiums of their workers who earned close to the minimum wage (Miranda 1990; CIEPLAN-CORSAPS-FLACSO 1996). The number of ISAPRE affiliates also increased through economic growth and rising wages. However, the health system that has resulted is effectively dividing the population into two groups: a high-income-low-risk group and a low-income-high-risk group. The private sector (the ISAPREs) cares for the former, and the public sector cares for the latter. The care of each is financed by mandatory health contributions, the absolute amount of which is tied to the level of the worker’s wage.

The transfer of the care of higher-income groups to the ISAPREs meant a reduction in health quotas for the public sector. In 1994, the ISAPREs provided curative care for 27% of the population and collected more than 65% of the resources paid in as mandatory health contributions. The public sector collected 35% of the contributions
and provided preventive health care for the entire population and curative care for around 60–65% of the population (CIEPLAN-CORSAPS-FLACSO 1996). Low-risk–high-income groups tend to be overinsured in the ISAPRE system. Moreover, when that population ages and lowers its earned income as a result of retirement or any other cause, it must pay considerable additional premiums to the ISAPRE or switch back to the public system. Estimates show that average contributions paid by people more than 60 years of age are 150% higher than the average premiums for young adults. Thus, the public system operates as a reinsurance mechanism for the private system. Under these circumstances, and as a consequence of the population's aging process and changes in the epidemiological profile, increased costs for the state are to be expected in the future. In sum, the links between the public and private sectors are detrimental to the former and are socially regressive. In addition to the disadvantages described above, there are others. Most notably are the drain of qualified professionals from the public to the private sector and the tendency of public-sector beneficiaries to be dissatisfied with services available compared with those provided by the private sector.

It is important to note that the expansion of the ISAPRE system has encouraged for-profit health investments and led to the creation of a significant network of medical infrastructure in urban and high-income areas. This in turn has contributed to an emigration of professional resources from the public to the private sector. Private health investors currently represent a powerful interest group that has divided the unity of Asociación Gremial del Colegio Médico (national medical association) and diminished its traditional commitment to social medicine. In the 1990s, this private-sector interest group has played a central role in creating obstacles to new reforms. Other studies (CIEPLAN-CORSAPS-FLACSO 1996; Celedón and Oyarzo 1998) give a more complete, critical discussion of the interaction between the public and the ISAPRE systems, and the implications of this interaction for vulnerable groups.

**Allocation of resources: demand- and supply-driven subsidies**
The social reforms introduced by the military government included a greater reliance on market mechanisms to improve efficiency. Specifically, the government encouraged competition for clients and users among public establishments of a similar type (for example,
schools, health posts) by means of demand-driven subsidies. To allocate resources to schools and health services, the government put in place mechanisms that tied resources to levels of activity or usage. This approach required setting a price for the services rendered, a difficult task, particularly in the case of health. In education, the schools received a subsidy (the USE), according to the average level of students in attendance the previous month. The value varied according to the level of education but did not reflect variation in costs resulting from urban or rural setting, geographical accessibility, or poverty. After the 1982–83 crisis, the USE was not adjusted for inflation, and in 1989 it was worth 19% less than in 1982. This resource squeeze resulted in a decrease in teachers' wages. Also, as the economic resources of schools were contingent on students in actual attendance, teachers dedicated a significant proportion of their time to tracking down pupils. Overall, attention to student performance lapsed throughout the educational system (Espínola 1991).

In the health sector, resources were allocated through a mechanism that linked a range of different services with specific reimbursement fees. Health establishments received part of their resources (about 25%) according to the number and type of services provided during the previous month. The remaining percentage was allocated according to historical criteria and the number and type of personnel. As in the education sector, the real value of health subsidies deteriorated after the 1982–83 crisis. Also, the reimbursement fee for some activities was lower and for others it was higher than the real cost of the service, creating incentives for overbilling. These incentives also led to inflated reports of services rendered. These dynamics generated an increase in expenditures to the point that, in 1983, the government imposed both a ceiling on the amount of resources an establishment could bill for and a return to preexisting allocation mechanisms (Miranda 1990).

The implementation of social-policy reforms

The implementation of policy reforms confronted numerous obstacles. Some lay outside the scope of the policies themselves; however, others arose from imperfections in the design and implementation process. For example, as noted above, decentralization policies relegated tasks at local levels without providing the necessary support (for example, economic resources, training, professional skills) to effectively manage
programs. Furthermore, local authorities were appointed or "semi-appointed," in accordance with preferences of the central government, rather than in response to the interests of social-service clients. Moreover, an essential element in an effective process of decentralization was missing: organized and informed local groups, motivated to participate in regional government and local administration. In practice, the central government defined social policies and programs to the smallest detail, and the role of municipalities remained peripheral.

Another important obstacle to effective reform was the nature of the social agents involved. At issue was the tradition in Chile of having a strong state as financer and provider of social services. The force of this tradition prevented or altered the initial proposals for the privatization of health care and education and hampered the decentralization of the state apparatus. Strong opposition to the reforms came particularly from the medical association and the bureaucracy. It is important to register that the country's pre-1973 "institutional and cultural inheritance" (Richards 1997) was an important factor contributing to the positive trends in Chile's human-development indicators and made possible the successful implementation of highly effective targeted health and nutrition programs (Raczynski and Oyarzo 1981; Monckeberg 1984; Vergara 1990; Raczynski 1995b).

An additional obstacle to effective reform was the slow, weak response of the private sector to the privatization policies. The response was slower and weaker than the government had expected, so it was compelled to put particular incentives in place to encourage the private sector to provide public goods. This was an important factor in the creation of the private health-insurance associations.

As a consequence of these difficulties, in the early 1990s the central government continued to be largely responsible for funding and providing health care and education in Chile. About 65% of the population continued to be cared for through the public health system, a percentage only slightly lower than in 1970. Moreover, 90% of the elementary- and high-school enrollment was subsidized by the state, a proportion similar to that in 1970. Only one-third of this enrollment was in private and two-thirds in municipal public schools. The 26 regional health services of the SNS were highly dependent on the programmatic, financial, and operational decisions of the central ministry. Similarly, housing policy decentralized the building and some financing functions to the private sector, yet decisions on programs, selection of beneficiaries, and other aspects remained centralized.
Social policies in the 1990s: toward a new model

Toward a new model of social protection

The socioeconomic legacy of the military government had two general dimensions. On the positive side, Chile possessed an economy in macroeconomic balance, a price system without major distortions, a private sector that was planning its investments for the medium term, and, after 1986, a process of growth that had low inflation and created new jobs. Less positively, however, Chile's society still registered high levels of poverty; increased concentration of income, consumption, and wealth; deteriorated public health services, high housing deficits, educational services with high coverage but low and unequal quality; and social-sector personnel who had been hurt by the social reforms, particularly by those that had modified institutional arrangements and affected labour conditions.

The new democratic government, which assumed power in March 1990, was made up of a centre-left coalition of political parties, the Concertación de Partidos para la Democracia (coalition of parties for democracy), headed by President Aylwin. In March 1994, a new government assumed power of the same coalition of political parties, maintaining continuity with the political and socioeconomic strategy adopted by the first government of the Concertación. This government set out to make economic growth based on private enterprise and export promotion compatible with macroeconomic equilibrium and improved distributive conditions. The government's program was based on three fundamental premises: first, the success of the Chilean economy — based on the experience of the 1980s — depended on its export orientation and its integration into the international financial system; second, international competitiveness and the growth of the economy should be made compatible with greater domestic equity and a more rapid reduction of poverty than the market alone would permit; and, third, the reconstruction and reinforcement of democracy at the political-institutional and local levels was an urgent priority. The government proposed continuity in economic policy, gradual changes in social policies, and a new style of political decision-making. Pizarro et al. (1995) outlined the principles, key initiatives, and some results of the first government of the Concertación. Cortázar (1994) analyzed
the achievements and pending issues in the area of labour relations and policies. Weyland (1997) reviewed similar issues addressed in six books published between 1993 and 1995.

On the political front, the new government had to win the trust of national and foreign private investors, maintain macroeconomic balance, and respond to the social demands of the population. To achieve these objectives, it initiated a strategy of political and social agreement (concertación, in the sense of cooperation) between business, unions, and political parties, without precedent in the history of the country. The purpose of the initiative was to achieve a common vision of social, economic, and political development among the actors involved and to promote a system of political and social negotiation that would harmonize diverse social demands with each other and with macroeconomic and external restrictions.

The first step toward the Concertación included the so-called Master Agreement, a tax reform, and an amendment to existing labour laws. Under the Master Agreement, labour, business, and government met each year for 4 years and agreed on issues such as the adjustment of wages in the public sector, the value of the minimum wage, and minimum pension rates. This agreement also facilitated the approval in Congress of labour reforms to enhance equity between workers and employers in, for example, labour contracts, unions, collective bargaining, and the right to strike (Cortazar 1994; Pizarro et al. 1995). When the first democratic government took office in 1990, it inherited a “watertight” budget that had been strictly defined by the military government. Funds allocated in the budget to social spending were 7.8% below the commitment made in the 1989 budget.

For the democratic government, as for its military predecessor, the pursuit of fiscal balance was the main criterion in determining the amount of public spending. Moreover, the government preferred to fund public spending through domestic resources and thus avoid external debt. Therefore, tax reform was a central component of the government’s approach to budget management, proposed in the presidential campaign. In June 1990, the tax reform was approved by a large majority in Congress, exemplifying a process of negotiation unprecedented in Chilean political tradition (Schkolnik 1992; Pizarro et al. 1995; Marcel 1997). The reform was approved on the understanding that the new resources would be used for social purposes and that the reform would remain in place only until 1994. However, in
1993, before the presidential election, the government negotiated with Congress a new bill to ensure that most of the taxes would remain, thus securing the financing needed for the public spending of the second government of the Concertación. The heated nature of the debate in Congress made it clear that future extensions of the reform or additional taxes would be nearly impossible. In future, additional social spending would have to be funded by economic growth; by new financing mechanisms, such as tariffs, copayments, and tax-exempt donations for social aims; and by improvements to efficiency within the public sector. Some initiatives are currently being implemented to achieve these ends.

Chile’s democratic governments: innovations in social policy

Since 1990 two democratic governments in Chile have not only struggled for more resources for provision of social services but also changed the policy space and priorities inherited from the previous administration, revised the institutional framework, and developed innovative policy instruments. Six particularly noteworthy changes are discussed below.

Articulation between social and economic policies

Currently, social policies are perceived by the government as mutually dependent and complementary both to economic and labour policies and to public investment. The guiding principles of the relationship between economic and social policies in democratic Chile are as follows: first, good economic performance is viewed as essential to the goals of equity and poverty reduction; second, given their contribution to strengthening human capabilities, social policies are viewed as investments that contribute to economic growth (rather than as expenses); third, good economic performance is not enough to overcome poverty and ensure social equity — public investments in basic social services for education, health, and sanitary infrastructure are critical, together with specific, complementary policies to target the poor and more vulnerable sectors.

---

4 This section follows Raczynski (1995a, b, 1998b).
Sociopolitical integration

Strategies for social development presently prioritize not only poverty alleviation but also social integration and political inclusion. A critical goal is to address exclusionary processes in society that affect the most disadvantaged groups, among them the poor and various other segments of the population (for example, women, youth, various ethnic groups). This involves a commitment to empower and strengthen the assets of not only vulnerable groups but also other agents (for example, public institutions, local administrations, entrepreneurs, universities, commercial actors, nongovernmental organizations [NGOs], professionals) to promote opportunities for the less advantaged.

This strategy has two principal components. First, sectoral policies secure a basic level of citizenship to the whole population in the areas of education, health, housing, and social security. Education, particularly the quality and equity of education, is considered of special importance because of its close link with improvements to productivity and international competitiveness. There is also a recognition that social policies must respond to evolving challenges (for example, vulnerabilities associated with the current epidemiological profile; youth training and employment; support to small urban and rural productive units; mental health and drugs).

The second component relates to the nature of policies targeted to the more vulnerable segments of the population. The approach departs centrally from the one inherited from the military government by emphasizing strategies to empower vulnerable groups, rather than distributing assistance or palliatives (that is, direct subsidies to the poor). Community involvement and social participation are favoured, as is support to groups, organizations, and communities, rather than to isolated individuals or families. Programs are intended to support productive capabilities and assets for the poor and other vulnerable sectors. Although measures aimed at poverty alleviation (that is, safety nets) exist for extreme situations, they are not the principal aspect of social policy.

The empowerment approach has translated in time into a demand for a territorial or community-based approach to poverty (Raczynski 1998b). The underlying assumptions are that for vulnerable groups, the place where one lives or works determines one's social opportunities and history of poverty; that the majority of the poor live in communities with high concentrations of poor people; that to fight
poverty, it is important to incorporate the characteristics of the places where the poor live or work within the broader societal context; and that in defining specific projects, it is necessary to build simultaneously on the needs, capabilities, and assets of the population, as well as on the development potential of the areas where they live or work. The understanding is that specific projects have to be formulated with the participants and respond to the diversity of poverty situations in economic, organizational, family, and cultural terms.

**Targeting**

As already noted, targeting is based on the principle that social policies must be selective. Although selectivity is considered a central tenet of policy design in Chile today, it is also recognized that not all social programs need to target the poor; rather, the specifics of targeting have to be decided with reference to concrete programs and contexts. For example, it is generally perceived as inappropriate to target services considered rights acquired by virtue of mandatory contributions (for example, social-security benefits). It is also viewed as inappropriate to target the operating costs of free or subsidized basic education and health services, as these programs are considered fundamental to a minimum level of opportunity for the entire population (Crispi and Marcel 1993). To enhance equity, universal programs must be supplemented by specific programs targeting the most vulnerable groups or the most neglected geographical areas or services. Multiple targeting mechanisms are recognized (for example, socioeconomic screening instruments or targeting by program design, territorial or geographical area, or selection of services), each with its advantages and disadvantages. The suitability of one or the other, or of a combination of them, depends on the objectives and nature of the social programs, the magnitude and characteristics of poverty (vulnerability), institutional factors, and the availability of timely and pertinent information. In accordance with the demand for a community approach to poverty, territorial targeting is being postulated as an important orientation for poverty programs.

**Decentralization**

The current democratic government aims to expand on the legacy of the military government in social policy through support for a gradual process of decentralization in the political, economic, and financial
spheres. The policies adopted in support of decentralization are numerous and include the following:

- Creation of regional governments, allocation of resources for the staffing and operation of these new levels of government, and constitution of indirectly elected regional councils, with representatives from the municipal level;
- Incremental growth in the proportion of public investment governed by the regional government and council (the target is to reach 42% by 2000, but by 1996 the percentage was 26%, only 6% higher than in 1989 [Serrano 1996]);
- Constitution of democratically elected municipal councils (the first postmilitary municipal elections took place in June 1993, then in October 1996);\(^5\)
- Development of training and technical assistance for regional governments and municipalities; and
- Improvement of financing and resource-allocation mechanisms for both health and educational establishments administered by the municipalities or the private sector.

The government also recognizes a particular need to enhance participation and community involvement and to develop linkages between decentralized government agencies and civil society if decentralization processes in general are to succeed. Measures are in place to accomplish these ends, but most of these efforts remain at a formal, legal level.

**Public–private partnership**

A key objective of the present government is to foster public–private partnerships in social matters. It is pursuing this objective at three levels: first, at the political level, the private sector and civil society have been explicitly invited to collaborate in formulating and designing social policies; second, at the financial level, the government has defined opportunities and incentives for the private sector and civil

---

\(^5\) This measure, coupled with the experience accumulated by the municipalities in the previous years, contributed to the establishment of Asociación Nacional Municipal (national municipal association), an entity that is playing an important role in furthering the autonomy of the municipalities vis-à-vis the government, as well as providing information, training, and technical assistance to local administrations.
society to support social programs; and, third, at the service-provision and project-implementation level, the responsibility for design and implementation of specific projects has been transferred to sub-national actors.

Overall, the goal of partnership-building is to have the state design lines of action and programs for implementation by a decentralized government agency or the private sector (for example, NGOs, social organizations, business associations, schools, universities, church associations). Toward this end, a competitive mechanism has been designed to subcontract implementation tasks. Bids from these agencies are evaluated according to quality, suitability, and cost criteria, among others. In this way, the state supports the constitution of spaces for diverse local actors to come forth with solutions to collective social problems. The instrument — the call for bids — and its implementation have not been without problems. These include dispersion and lack of coordination of effort; inadequate technical ex ante evaluation of projects; lack of experience among the implementing agencies; rigid standardization of social programs, which impedes local flexibility; inadequate supervision and monitoring of programs by new service providers; segmented and highly vertical organization of the Chilean state apparatus; and the precariousness of municipalities in heading the processes of local development (Raczynski 1998b).

The government has evaluated and tries to monitor the equity and efficiency of the systems for social security, health, and education and has taken measures to perfect these systems, strengthening the regulatory functions of the state and negotiating reform proposals, where necessary. A significant incremental reform is taking place in education, one that aims to improve the quality and equity of basic and secondary education through programs that directly affect the educational process, its financing, and the situation of teachers in state-financed private and municipal schools (Cox 1997). The government has put social-security measures in place to lower the administrative costs of the AFP system, elevate its transparency, and improve the investment possibilities for the pension funds accumulated by the AFPs. In the health sector, the situation is at an impasse. On the one hand, the increased budget allocated to the public health sector has had scant impact on the quantity and quality of health services delivered to the population (PAL 1994; Celedón and Oyarzo 1998). On the other hand, the private for-profit health investors have
boycotted measures to make the ISAPRE system more transparent to the population and protect the rights of the affiliates. Government efforts to negotiate basic minimum agreements have failed, in part because of a lack of vision or direction and in part because of the government's poor strategies for communication with private health investors and medical professions.

**Support for demand-over supply-driven mechanisms**

The continued emphasis on demand-over supply-driven social policies and programs assumes a heightened civic responsibility and participation in social matters. Citizens and civil-society organizations are expected to define priorities, choose among alternatives, develop projects, and participate in the implementation and evaluation of programs. Yet, demand-driven mechanisms also leave an important role for the state in strengthening and qualifying demand and in ensuring that demand converges positively with supply-side forces. The recognition is growing in democratic Chile that the consequences of social policies and programs governed by demand or supply mechanisms must be monitored closely to prevent social segmentation and exclusion. For example, mechanisms used to allocate resources in the health and education sectors have been revised to introduce effective incentives to improve the quality and efficiency of services. The government is about to have an evaluation of the new rules that guide the USE mechanism in education and to implement a capitation scheme on the basis of the population enrolled at municipal health facilities.

**Implementing the new approach to social policy**

Given the breadth of innovations to social policies and programs introduced by Chile's democratic governments, this chapter cannot provide a comprehensive review. The range of such changes includes the creation of qualitatively new social programs; improvements to education and youth training; support for urban and rural microenterprises; and the establishment of public institutions to support policies for vulnerable groups (MIDEPLAN 1996). In 1994, a new instrument to be used in the fight against poverty was established: Fondo de Solidaridad e Inversión Social (FOSIS, social solidarity and investment fund). This program departs from the emergency and compensatory character of the majority of the Latin American social
funds and defines itself as an innovative supplement to sectoral social policies and programs. Other initiatives have fostered cooperation between the private and the public sectors, whereas still others have encouraged the decentralization of social policy to regional government and local administrations.

A variety of challenges persist, however. The process of social-policy reform under Chile's democratic regimes has been hampered by numerous ambiguities and contradictions. For example, a study of Chile's antipoverty strategy completed in late 1993 analyzed the general strategy and three particularly important programs: the Chilean youth training program; the program to improve quality and equity of elementary schools, called MECE-básica (Mejoramiento de la Equidad y Calidad de la Educación [program for improvement of equity and quality of education—basic education]); and the program Entre Todos (all together) of FOSIS. Although Chile has a coherent and sophisticated social-policy strategy, the study (Raczynski 1995, p. 257) suggested that

the strategy becomes diluted in the process of implementation. The result is a series of programs that are successful in achieving their short-term sectoral goals but that fail to converge, or could converge better, on their effect on poverty.

The study pointed to the fragmentation and lack of coordination among programs, as well as to a mismatch between a traditional, centralized, sectoral model of social-sector management and a decentralized, flexible, participatory one.

With regard to decentralization, the responsibilities and functions of regional governments have been defined in general terms, leaving ample room for multiple interpretations concerning national-regional-local interrelationships. Policy issues tend to be addressed at a general, rhetorical level, rather than at a concrete level. Further, among policymakers and in Congress, there is no shared understanding about the meaning, limits, and potential of decentralization. A clear and effective communication strategy — a key prerequisite for effective implementation — is also missing.

Tensions also persist between trends to centralization and decentralization. Specifically, decentralization undertaken at the administrative, political, and financial levels coexists with, and contradicts, the centralizing measures taken at the managerial level. This imposes limits and rigidities on local capacities, especially in the health and education sectors. Preparation of the national budget continues to follow the
traditional, centralized, sectoral logic. Finally, this failure to decentralize effectively is grounded in, and partially explained by, the central administration's lack of faith in the capacity of regional- and local-level administrations to fulfill their new duties and manage more resources. Thus, questions of attitude and political will are playing a role in obstructing the transfer of resources and decision-making power.

Further barriers to effective social-policy reform in Chile are the technical weaknesses at the local level. Difficulties prevail at subnational levels in establishing competent and stable working teams. This is mainly because the public and private sectors compete for qualified professionals but the public sector cannot offer equivalent wages and promotion opportunities. The rotation of qualified personnel and instability of working teams also constitute significant problems at the central-government level. The difficulties at the regional and local levels are compounded by the ambiguous definition and delimitation of central-state functions and by bureaucratic resistance to the decentralization of service delivery. Also absent are methodological instruments and tools to permit the systematic monitoring of decentralization processes and to support interventions for empowerment from the central level.

Despite these obstacles, however, some progress can be acknowledged. Since 1990 regional governments have been installed and are functioning, and municipal administrations have been technically strengthened and politically democratized. Further achievements include the self-organization of local actors; the consolidation of regional governments; the development by municipalities of local participatory mechanisms; the local development of some strategic planning capacities; productive and locally unique public-private collaborative efforts; and the articulation of a culturally and socially relevant definition of poverty that emphasizes its diversity and its noneconomic dimensions (CNSP 1996). Taken together, these processes suggest the evolution of a new model of social protection.

Results and challenges: the context for social policy in Chile today

Today, Chile can point to numerous indicators of economic success, some of which date back to the last years of the military government. For the past 10 years, the annual rate of economic growth has been
about 7%; inflation has been low and under control; real wages have risen; unemployment rates have fallen and fluctuated between 5% and 6% since the early 1990s; the size of the informal sector has declined; and traditional human-development indicators in health, education, and life expectancy are among the best in Latin America, and they are improving. The number of people suffering income-based poverty has fallen significantly from 5.2 million in 1990 to 3.9 million in 1994, then to 3.3 million in 1996 (MIDEPLAN n.d.). This reduction is closely related to conditions in the labour market, specifically the rate of unemployment, the creation of new jobs and income-generating opportunities, and wage trends. Around 80% of the reduction in poverty can be explained by economic growth — not unexpectedly, given the interrelationship of the economy and the labour market (Larrañaga 1994).

Although poverty has been reduced, socioeconomic inequalities have not diminished significantly. Disparities in household-income distribution are among the highest in the region: the Gini coefficient is at 0.48; the wealthiest quintile absorbs around 57% of total family income; and the lowest quintile absorbs around 4%. The family income of the highest quintile is about 11–12 times that of the lowest. In the 1970s and 1980s the distribution of income worsened, but in the 1990s it has remained relatively stable (MIDEPLAN 1996).

Public expenditures do improve the distribution of income. Yet, it is premature to conclude that they do or do not generate greater social inclusion and fairness. The social programs currently being implemented can only have significant impact over the medium and long term. The results of educational reform will be observed in the next generation; the process of decentralization is still in its early stages; and the new programs and instruments to fight poverty do not aim at immediate increases in income but at local empowerment and strengthening of assets and capacities.

In future, these types of programs are particularly important because the reduction of poverty is likely to become more difficult and more complex than in the past. Already, the rate of reduction in poverty levels has slowed. Although in 1992, Chile had 0.9 million fewer poor persons than in 1990, in 1994 it had only 0.4 million fewer poor persons than in 1992. The rate continued to decline in 1996. Reductions in poverty in 1990–92 can be attributed to factors related to the labour market, as well as to policy decisions that increased the
real value of minimum income, monetary income transfers (for example, child allowances, welfare pensions), and wage levels. Since 1992 the value of these transfers has been adjusted according to inflation. Unemployment has reached its "natural," or "normal," level, making further reductions difficult. Further, it is likely that the population that overcame poverty in the early 1990s had a higher potential to do so: more education; access to more diverse support networks; and residence or work, or both, in areas with greater possibilities for development and upward mobility (Bengoa 1995). Thus, it will be more difficult to reduce poverty in the future, and empowerment-oriented antipoverty programs like those implemented in recent years will be very important. However, a critical element of their success will be the capacities for rigorous monitoring and impact evaluation, which remain underdeveloped in Chile.

Conclusions and key research issues

The design and provision of social services in Chile is entering a phase that differs from the neoliberal approach prevalent in the 1970s and 1980s, as well as from the state-dominated one prevalent during the first six decades of the century. The new approach is currently in flux: it does not rest on a shared vision, and its implementation confronts significant obstacles. However, innovative elements in the new approach can be found in the new interplay between the state, the market, and society at the national, regional, and local levels. The latest model for social development in Chile promotes autonomy among actors and agents and fosters complementarity and partnership between them and a new philosophy of governance that gives priority to grass-roots demands and strives to empower vulnerable populations. Whether and how the model will be consolidated depends on several critical factors. These include the empowerment of civil society and its organizations, including improvements to strengthen the commitment and technical capacity of NGOs and other nonprofit organizations; the development of capabilities at national, regional, and local levels to set priorities, design flexible programs, and monitor and evaluate them; and the engagement of commercial and for-profit organizations with the values of equity, social integration, and responsibility for the provision of public goods.
Some of the most important challenges also relate to the future functions and operation of the state. First, the state must assume leadership in articulating a vision, mobilizing support, setting policy priorities, and constructing flexible and innovative mechanisms to engage civil society and the private sector in the provision of public goods. A second priority for the state is to strengthen its managerial capacity. This will entail the state's being very active in its policy-setting and regulative role but limiting its traditional responsibility for direct provision of services and execution of programs. Third, the state must strengthen its role in monitoring and evaluating social policies and develop instruments to support this. So far, little has been done in this respect, and the methodological challenge is enormous. Decentralization and public-private partnerships can only be made compatible with equity if the state adopts systematic mechanisms to monitor results and evaluate the social impacts of the reforms. Fourth, the state must make efforts to diminish the incongruence between its own traditional, sectoral, vertical organization and the requirements of decentralization, community involvement, and public-private partnerships. This requires flexibility in programs and procedures and participatory decision-making processes that encourage collective strategic planning among actors at the local level. Finally, the state must make genuine efforts to ensure community involvement and social participation without reducing these to mere formal or juridical processes of participation, as has usually been the case. A particular effort must be made to sensitize the nonpoor and institutional actors to work both with and for the poor.

The Chilean experience is rich with policy lessons. Some of these lessons have been highlighted above. The following is a list of research issues that are of outstanding importance. These issues occur at four levels; the first two are directly relevant to policy-making, and the latter two are more academic but have important policy implications.

Program design, implementation, and evaluation

The list of key research issues relating to program design, implementation and evaluation includes

- Monitoring and evaluation of social programs and improved collection of relevant information, particularly regarding
beneficiaries and the changes that beneficiaries or the communities, or both, undergo as a consequence of social programs;

- Identification of common bottlenecks in the design and implementation of social programs and recommendations for the improvement of these processes;

- Evaluation of the capacity of public social programs to reach different communities and identification of the means to make these programs more accommodating and responsive to local organizations and groups; and

- Evaluation of the strengths and weaknesses of a territorial approach to poverty, as opposed to one that centres on categories of the population, and development of policy instruments appropriate for use with a territorial approach (for example, community assessments, strategic planning, monitoring, evaluation).

Institutional frameworks

The important issues relating to institutional frameworks include

- Analysis of decentralization processes, with special attention to national–regional–local relations, functions of agents at each level, incentive structures, linkages between political and technical aspects in decision-making, issues of participation and accountability, and the means of strengthening policy design, regulation, and evaluation at the national level; and

- Examination of the interrelationship between public and private sectors in the formulation, design, implementation, and evaluation of social programs.

Compatibility between market principles and social equity

The key issues for research relating to compatibility between market principles and social equity include

- Analysis of the relationship between economic growth, labour-market conditions, capital accumulation, and social policies; and
• Identification of the challenges for social and labour policy presented by national integration and participation in the global economy.

Current social-welfare model and social structure

Important issues relating to the current social-welfare model and social structure include

• Identification of the main characteristics of the society and social-welfare structure currently emerging in Chile;

• Evaluation of how effectively the country is building a new model of social well-being that points toward equity and social integration;

• Identification of the central actors in the system and the main axes of conflict;

• Analysis of the ways the new actors are evolving;

• Evaluation of how well the citizens' voices and demands are incorporated into the system; and

• Identification of emerging social vulnerabilities and the ways society and social policy respond to these.
<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Traditional state-dominated model</th>
<th>Neoliberal model</th>
<th>Emergent model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic–social policy</td>
<td>Weak relationship; fiscal imbalance</td>
<td>Social policy subordinated to economic policy; fiscal balance achieved mainly by cuts in expenditures</td>
<td>Social policy integrated with, and complementary to, economic policy; fiscal balance looking both at revenues and expenditures</td>
</tr>
<tr>
<td>Goal–purpose–function of social policies</td>
<td>Nation-state building, industrialization, social integration</td>
<td>Poverty alleviation, satisfaction of basic needs of the poor</td>
<td>Growth with equity, social integration, poverty reduction</td>
</tr>
<tr>
<td>Policy content and orientation</td>
<td>Supply and coverage of social services (education, health, social security, housing); standardized programs and procedures; absence of adaptation to regional or local conditions Protective labour legislation Price subsidies for basic consumer goods</td>
<td>Supply of basic social services for the poor; reach directed to poverty pockets; special poverty-alleviation programs (safety nets); standardized programs and procedures Minimum of labour regulation; maximum of flexibility for the firm Privatization of social security and social services for the nonpoor</td>
<td>Equity and quality of education and health Reach directed to poverty pockets with programs that support capabilities and opportunities (youth training, urban and rural small productive activities, support to community organizations, and social participation); adaptation of program content and methodology to the diversity of poverty situations Labour regulations that protect labour mobility</td>
</tr>
<tr>
<td>Roles of the state, market, and civil society</td>
<td>State dominance (formulates, regulates, finances, delivers social services and programs) Little space for private markets or for community initiatives</td>
<td>State designs, regulates, and finances programs for the poor; privatization of social services for the nonpoor and administration and delivery of state-financed services for the poor by the private sector and local units of the state</td>
<td>“State plus civil society”; strategic or catalytic role of the state with emphasis on policy setting, regulation, and monitoring and evaluation functions; state also contributes to financing services and may, under special circumstances, deliver services, preferably in a decentralized form</td>
</tr>
<tr>
<td>Centralization–decentralization</td>
<td>Centralized</td>
<td>Centralized national programs oriented to the poor; deconcentration of education and health services</td>
<td>Deepening of decentralization at the political, technical, and social-participation dimensions</td>
</tr>
</tbody>
</table>
### Annex A concluded.

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Traditional state-dominated model</th>
<th>Neoliberal model</th>
<th>Emergent model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic of decision-making</td>
<td>Bureaucratic; state dominance, with heavy influence of corporate interests and groups; centrality of political considerations; top-down decision-making</td>
<td>Incorporation of technical–analytic and economic considerations; top-down decision-making</td>
<td>Incorporation of technical–analytic and economic considerations; development of instruments for regional and local decision-making, community participation, and public–private collaboration</td>
</tr>
<tr>
<td>Financing</td>
<td>General and specific taxes, plus worker and employer mandatory social-security and health contributions</td>
<td>Taxes and worker mandatory social-security and health contributions; state finances only services for the poor; cost recovery</td>
<td>Taxes and workers mandatory social-security and health contributions; state finances basic social services for the population; cost recovery</td>
</tr>
<tr>
<td>Allocation of public resources — supply and demand</td>
<td>Supply-driven mechanisms; historic allocation trends</td>
<td>Introduction of demand-driven mechanisms; allocation according to poverty indexes</td>
<td>Combination of demand- and supply-driven mechanisms, which vary, depending on the objectives of specific programs; allocation according to poverty indexes in some programs</td>
</tr>
<tr>
<td>Level and trends in public expenditures</td>
<td>Growing</td>
<td>As low as possible, depending on the size of the poor population and fiscal balance</td>
<td>No definite trend; fiscal balance is central and can be obtained through less spending and more revenues</td>
</tr>
</tbody>
</table>