Institutional Capacities and Social Policy Implementation: Maternal Child Health and Nutrition Programmes in Argentina and Chile (1930-2000)

Capacidades institucionales y ejecución de políticas sociales: Programas de salud y nutrición materno-infantil en Argentina y Chile (1930-2000)

Capacidades institucionais e execução de políticas sociais: Programas de saúde e nutrição materno-infantil na Argentina e no Chile (1930-2000)

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Abstract

This article compares maternal child health and nutrition programmes in Argentina and Chile, focusing on long-term institutional features and the central neo-liberal trends organizing social reforms during the 1980s and the 1990s. *Objective*: To carry out a comparative study of the transformations of Maternal Child Health and Nutrition Programmes, taking into account three intertwined issues: social policies, institutional capacity, and policy implementation. *Methodology*: The documentary analysis done in this article is framed in the structural force model of Carmelo Mesa-Lago and the polity-centred structure model of Theda Skocpol. *Conclusions*: Despite relatively similar policy lines implemented in both countries, the contrasting long-term institutional features (Chilean programmes addressed maternal and child health more efficiently than the Argentines) account for most of the variation in the overall process of reform implementation and the performance of maternal and child health policies.

Keywords: *social policy, maternal child health and nutrition, institutional capacities, Argentina, Chile.*

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Resumen

Este artículo compara los programas de salud materno-infantil en Argentina y Chile, prestándole especial atención a las características institucionales de largo plazo y las tendencias neoliberales presentes en la organización de las reformas sociales de las décadas de 1980 y 1990. *Objetivo*: Llevar a cabo un estudio comparativo sobre las transformaciones de los programas de salud y nutrición materno-infantil, teniendo en cuenta tres aspectos conectados entre sí: las políticas sociales, las capacidades institucionales y la ejecución de políticas. *Metodología*: El análisis documental realizado en este artículo se enmarca en el modelo de fuerza estructural de Carmelo Mesa-Lago y en el modelo de la estructura centrada en el estado de Theda Skocpol. *Conclusiones*: A pesar de la relativa similitud en los lineamientos de las políticas de salud aplicadas en ambos países, los contrastes en las características institucionales a largo plazo (los programas chilenos abordaron la salud materno-infantil de forma más eficiente que los argentinos) representan la mayor parte de la variación en el proceso general de aplicación de las reformas y el desempeño de las políticas de salud materna e infantil.

Palabras clave: *políticas sociales, salud y nutrición materno-infantil, capacidades institucionales, Argentina, Chile.*

Resumo

Este artigo compara os programas de saúde materno-infantil na Argentina e no Chile, prestando-lhe especial atenção às características institucionais de longo prazo e às tendências neoliberais presentes na organização das reformas sociais das décadas de 1980 e 1990. *Objetivo*: levar a cabo um estudo comparativo das transformações dos programas de saúde e nutrição materno-infantil, tendo em conta três aspectos conectados entre si: as políticas sociais, as capacidades institucionais e a execução de políticas. *Metodologia*: a análise documental realizada neste artigo enquadra-se no modelo de força estrutural de Carmelo Mesa-Lago e no modelo da estrutura centrada no estado de Theda Skocpol. *Conclusões*: apesar da relativa similitude nos lineamentos das políticas de saúde aplicadas em ambos os países, os contrastes nas características institucionais a longo prazo (os programas chilenos abordaram a saúde materno-infantil de forma mais eficiente que os argentinos) representam a maior parte da variação no processo geral de aplicação das reformas e o desempenho das políticas de saúde materna e infantil.

Palavras chave: *políticas sociais, saúde e nutrição materno-infantil, capacidades institucionais, Argentina, Chile.*

A comparative study of the transformations of Maternal Child Health Programmes (MCHPs) illuminates three intertwined issues central to comparative political sociology and public policy: social policies; institutional capacities; and policy implementation. Researchers analysing transformations and impacts of health programmes in developing countries agree that institutional capacities are central to formulating, implementing, and producing

effective results in maternal and child health (1-3). A study on institutional state capacities defines these as the ability of public organisations 'to perform appropriate tasks effectively, efficiently, and sustainably' (1, p. 34).[2] Implementing these tasks generally requires coordinated actions among several organisations. Gaps between programmatic goals and policy results can be attributed to limitations in institutional capacity to perform specific tasks according to these goals. The analysis of factors either promoting or constraining the performance of these tasks constitutes a fundamental issue for social programme delivery. The problem of deficiencies in public policy implementation can be better understood when applying a comparative historical perspective.

Challenges for improving maternal and child health in developing countries include considering nutrition as a priority public health problem, implementing effective actions with adequate targeting of beneficiaries, and building strategic and operational capacities.[3] The current debate combines changes derived from the epidemiological and nutritional transition in developing countries –Latin America in particular– and the 'double burden' of malnutrition: indeed, the existence of under-nourishment and overweight conditions within the same population is a central problem to be addressed (4-7).

A long-term analysis of maternal and child health indicators shows striking contrasts in Latin America. Although one can observe long-term improvements, Argentina's indicators performed poorly when compared to neighbouring countries with similar, or even lower, levels of public health and social expenditures.

Table 1 presents historical trends for Infant Mortality Rates (IMRs) in Argentina and Chile, a classic indicator that allows longer-term comparisons for both countries. Divergent evolutionary patterns are impressive: whereas early 1950s IMRs in Chile more than doubled those of Argentina, by the year 2000 Chilean IMRs represented barely fifty-four percent of those of Argentina. Although Argentina's IMRs improved in the long term her relative position *vis-à-vis* other Latin American countries worsened by the end of the millennium (8,9).

IMRs in Argentina show a positive evolution only in recent years. Maternal Mortality Rates (MMRs), in turn, do not show such a favourable pattern.[4] How does one account for such differences in social policy performance?

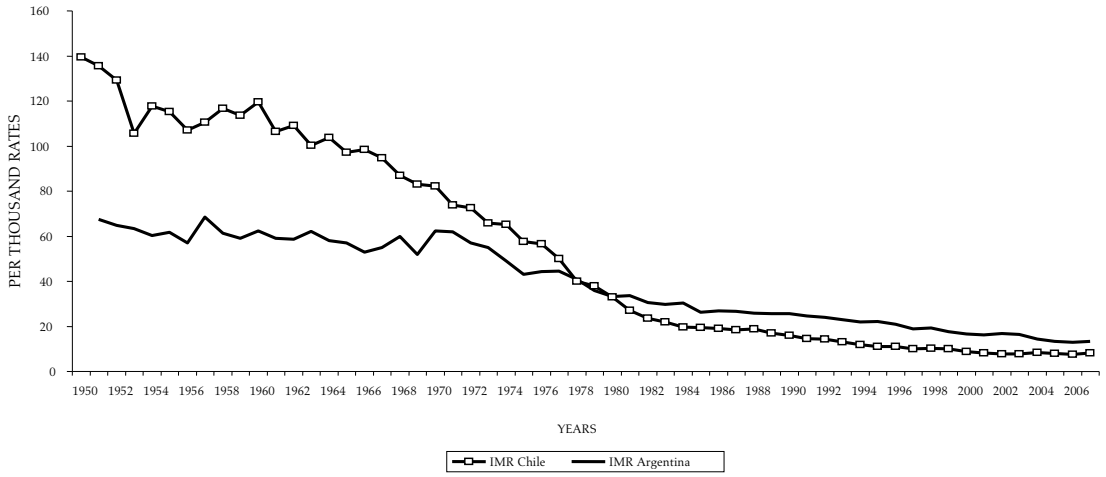
In this article, I examine Argentina's and Chile's national MCHPs from their origins as maternalistic provisions in the 1930s and their expansion as national programs during the 1950s and 1960s, to their transformations resulting from the implementation of market liberalisation reforms in the 1980s and 1990s. I argue that despite implementing

[2] The definition of appropriate tasks is specific to national contexts, history, and timing. Effectiveness refers to the appropriateness of efforts to produce the predefined goals; efficiency refers to time and resources to produce a given outcome; sustainability refers to continuous and long-term programme performance and perdurability (1, p. 6).

[3] Strategic capacities involve knowledge, skills, leadership, and human resources for guiding national and sub-national policy agendas. Operational capacities include programme and policy design, monitoring, assessment, and adapting implementation and management to specific contexts (1, p. 77).

[4] MMRs should be taken with caution: under-recording results from unreported deaths associated to illegal abortions. UNICEF's tables differentiate countries' official records from 'adjusted' values (UNICEF estimates after including underreported maternal deaths). For Argentina, MMR for 2000-2006 is 0.39 (official records) while UNICEF adjusted value for 2005 is 0.77 per thousand live births. For Chile, more reliable information indicates average MMRs (2000-2006) equal to 0.17 and 0.16 per thousand live births respectively (10). For exhaustive comparisons of bio-demographic and socioeconomic indicators, see (8).

Table 1. Historical Evolution Infant Mortality Rates. Aregntina and Chile 1950-2007



relatively similar policy lines in both cases –e.g. universalistic social provisions until the 1970s/1980s and targeting programmes in the 1980s/1990s-, Argentina and Chile contrasting long-term historical and institutional features (state capacities, policy coordination, integration and continuity) account for most of the variation in the process of implementing reform and the socioeconomic impact of social policies. Argentina's long-term political instability and weak institutional capacities to formulate and implement continuous social protection programmes contributed to a relatively poor performance in improving maternal and child health, despite maintaining consistently high levels of social expenditures.[5]

In the analysis of these divergent paths, I apply an integrative theoretical framework combining Carmelo Mesa-Lago's structural force framework and Theda Skocpol's polity-centred structure. Only by integrating both theories can we understand how political factors such as political contexts and state institutions produce divergent paths in social policy implementation, despite their initial similar departure points.

To understand the origins and transformations of MCHPs in Argentina and Chile I first present a historical path analysis of social policy experience in both countries up to the end of the 1990s. The periods are as follows: *pre-universalistic* programmes up to the 1940s; *universalistic* programmes up to the 1970s; *assistentialist* & *hybrid* programmes from the mid-1970s in Chile and late-1980s in Argentina; and *integrative* programmes in the 1990s in Chile and at the turn of the 20th century in Argentina.

Subsequently, I provide a description of the central characteristics and the transformations of national MCHPs in Argentina and Chile. For Argentina, two programmes are examined: the classical Infant-Maternity Programme (*Programa de Salud Materna y Perinatal*, hereafter PMI), and the more recent programme applied in the 1990s along prevailing international social policy guidelines, the Maternal and Child Health and Nutrition Programme (*Programa*

[5] This emphasis on concrete programme implementation differs from typical studies either focusing on policy adoption and legislative debates or socio-economic determinants of health from quantitative cross-national perspectives.

Materno Infantil y Nutrición, PROMIN). For the Chilean case, I study the long-lasting Maternal Child Health Programme (*Programa Nacional de Alimentación Complementaria*, PNAC).

I then compare the implementation of these MCHPs while identifying gaps associated to programmes' design and institutional capacities for both countries. I first map the organisations performing programmatic tasks; second, I analyse specific programmatic goals according to available institutional capacities; finally, I identify capacity gaps that may hinder programmatic results. I conclude with a comparative assessment of MCHP in Argentina and Chile.

General Characteristics of MCHPs and Theoretical Framework

MCHNPs central goal is to improve health and nutritional levels by reducing the levels of malnutrition in mothers, pregnant women and infants, via the distribution of free milk and, in some cases, formula. This free provision functions as the excuse to monitor beneficiaries' health, by forcing them to participate in periodic health examinations and to receive vaccinations.

Argentina and Chile share a long tradition of social policy implementation: together with Uruguay, they pioneered the development of social protection programmes in Latin America. In both countries, the creation and implementation of national MCHNPs have roots in specific state initiatives during the rise of the welfare state in the 1930s. In addition to their early introduction and the launching of "Mother and Child" Laws, both countries expanded social protection programmes along universalistic principles and later transformed programmatic delivery from universal to targeted approaches during structural reforms under neo-liberal auspices in the 1980s and 1990s[6]. These non-contributory programmes followed a social assistance rather than a social insurance model. After their original legislative foundations, however, the long-term performance and impact of these MCHNPs took on divergent paths in each country.

In the analysis of these divergent paths, I use both Carmelo Mesa-Lago's structural force framework and Theda Skocpol's polity-centred structure. Mesa-Lago gives a central role to pressure groups (PG) in explaining the introduction and evolution of social programmes in Latin America (with specific emphasis to social security systems). His explanatory framework includes the role and the bargaining power of the PG, the nature and role of the state, and the interaction between the PG and state structures (11, 12). Other scholars point to the clientelistic relationship among the populist state, political constituencies, and organised social sectors, a relationship not explicitly theorised by Mesa-Lago (13-15)[7]. Remarkably, this research focuses on traditionally defined pressure groups —political parties, corporations, trade unions— neglecting the influence of women's organisations and feminist groups (19). It also leaves out institutional factors and historical traditions influencing the implementation and administration of social policy.

Skocpol's framework —focusing on self-reinforcing or positive feedback processes— attempts to provide a more complex, middle-range integrative model to account for the me-

[6] "Universalism" here refers to the rhetoric organising the expansion of social protection (mainly along principles of social insurance) covering the formal sector, and education and health programmes for the population, regardless of contributions corresponding to a social security scheme.

[7] The expansion of social security policies developed in a piecemeal form as special benefits for certain sectors of the working class. For critical perspectives building on Mesa Lago's and reconceptualising welfare state regimes for Latin America and the historical development of the social state, see (16-18).

chanisms operating at the intersection of state structures and social relations (20)[8]. Her path-dependent argument highlights the relevance of specific patterns of sequence and timing. In this model similar departing conditions can produce divergent paths, a range of social outcomes and a wide spectrum of resulting social outcomes that, in turn, cause even large consequences. Moreover, central to this framework are specific courses of action that, once introduced, are difficult to reverse and critical "junctures" delineating basic social outcomes (16, 21-23). Path dependence depicts "historical sequences in which contingent events set into motion institutional patterns or event chains that have deterministic properties" (24, 25)[9].

Elsewhere, I have developed an integrative framework combining Mesa-Lago's and Skocpol's models (8)[10]. Whereas both frameworks provide good theoretical insights for understanding the original formation and implementation of social policies, neither of these explanations account for the variations on policy paths in Argentina's and Chile's MCHNPs. Only by integrating both theories can we understand how political factors such as political contexts and state institutions produce divergent paths in social policy implementation, despite their initial similar departure points[11].

This article addresses the relevance of the long-term and continuous implementation of public policy provisions regarding maternal and child health. Nevertheless, it should be emphasised that alternative socio-economic indicators (e. g. general infrastructure, rural poverty and female literacy rates, income inequality) cannot exclusively account for IMRs' divergent paths between Argentina and Chile. To the contrary, in the long term Chile shows lower levels relative to Argentina in most indicators (8). James McGuire's exhaustive research on infant-mortality decline combining qualitative historical comparisons with cross-national analyses from 1960 to 2005 complements my framework. McGuire's emphasis on the relevance of government programs offering relatively inexpensive basic health care provisions without rejecting different variations of the "wealthier is healthier" hypotheses concludes that neither fast economic growth nor falling income inequality necessarily guarantee a rapid reduction of IMRs but "the effective provision of basic social services to the poor can lead to sharp declines of infant mortality, even in the face of dramatic failures on the economic front" (9)[12].

To understand the historical origins and transformations of MCHNPs in both countries, I frame the specific analysis of MCHNPs within different periods of social policy implementation during the twentieth century.

Historical Paths

A periodisation of social policy experience in Argentina and Chile up to the end of the 1990s is useful for understanding the origins

[8] For Skocpol, policies are both the result of state structures and organisational capacities, and products of political forces (not inevitable results of social conflict).

[9] Some authors prefer "political realignments" to "critical junctures" (26).

[10] Unless otherwise indicated, empirical references and statements are based on this source.

[11] Among these factors are the political power of pressure groups; links between pressure groups and state agencies; state institutional features (strength, relative autonomy, and administrative capacities); and policy feedback effects (capturing the dynamics of this process) (8, 9, 26).

[12] These hypotheses link economic development with bio-demographic indicators (among independent variables are GDP per capita, Income Inequality, Fertility Rate, Population Density, Urbanisation, Share of Population over 65 years of age, Family Planning Effort, Urban Water Supply, Literacy Rates) (9).

and transformations of MCHNPs: 1) *pre-universalistic* programmes (up to the mid- to late 1930s in Argentina and to the 1940s in Chile); 2) *universalistic* programmes (up to the 1970s); 3) *assistentialist* & *hybrid* programmes (from the mid-1970s in Chile and the late-1980s and the 1990s in Argentina); and 4) *integrative* programmes (in the 1990s in Chile, as part of the return to democracy, and later in Argentina, after the crisis of neo-liberal reforms by the turn of the century) (9, 27-29).

Pre-universalistic programmes were characterised by a multiplicity of philanthropic organisations bringing social assistance to the population and, later on, by a transition towards direct state intervention in the development, implementation, and administration of social provisions.

Argentina and Chile both have a tradition of health and nutritional programmes for mothers and infants, including initiatives started at the beginning of the century for mothers unable to breast-feed and malnourished preschoolers. Prior to the mid-1920s, these infant-maternity programmes were mostly provided by philanthropic organisations, the Catholic Church, and mutual-aid societies, as were institutionalised MCHNPs at the national level (30, 31). In both countries, The Sociedad de Damas de Beneficencia (SB) —a private charitable organisation— was in charge of administering most social assistance initiatives (32-35)[13].

In Argentina, numerous organisations and agencies, a lack of uniformity of efforts to protect infant-maternal health, and disconnection among services created a need for a unified, centralised office to provide general guidelines and coordination of infant-maternal health services (36, 37)[14].

The transition that began in the 1920s and 1930s was marked by a plethora of social initiatives and legislative proposals. In Chile, President Alessandri's social policies faced strong opposition in the Senate, and passed only at the end of his presidential term. Thus, Chile's social policies became the earliest of its kind in Latin America[15].

During the second half of the 1930s, both Chile and Argentina approved protective legislation for mothers and children. In Argentina, The Mother and Child's Bill (1936) created a new Bureau of Maternity and Childhood (hereafter the Bureau), under the supervision of the National Department of Hygiene (Law 12,341/1936). As was anticipated by the law, the Bureau enacted the first National Infant-Maternity Programme to protect infants throughout the nation in 1937. All the activities developed by the Bureau were centralised (40). The Programme was consolidated into the Federal Ministry of Health in 1946, thus facilitating a tendency towards more universal coverage. For the next 40 years, the programme maintained its institutional structure and design, although its resources (technical and budgetary) suffered periodic reductions as the

[13] In Chile, the SB administered the network of public hospitals until the creation of the "Seguro Nacional de Salud" in 1952.

[14] Among philanthropic organisations in Argentina were the SB (created in 1823), the Sociedad de Damas de Caridad, the Patronato de la Infancia (1912), and the Asistencia Pública (1883). Geographical dispersion and regional disparities characterise social provisions up to this date.

[15] The Mandatory Insurance Fund (Caja del Seguro Obrero Obligatorio, Law 4,054) contemplated prenatal and infant care benefits and milk distribution for female workers and their children up to eight months of age (32, 38). The Social Security Service Legislation (Law 4,054/1924) provided a breast-feeding subsidy to female industrial workers (32, 39). Other social policy initiatives were the creation of the Ministry of Hygiene, Assistance and Social Welfare, and the Worker's Social Provision Fund, all passed in 1924.

country experienced chronic political instability, and recurrent economic and fiscal crisis of the state (8, 40)[16].

A precursor of PNAC, the "Mother and Child Law" (Law 6,236/1937) formally began Chile's tradition of MCHNPs (42). The law, with its central goals of protecting pregnant women and children and preventing malnutrition, extended prenatal and infant care and milk distribution benefits to children up to two years of age and workers" spouses (12, 34, 36, 43). Despite not providing widespread coverage (the law benefited approximately five percent of the population) it was an important step extending the state's participation in women's and children's health and nutrition (38)[17].

Universalistic programmes are characterised by the organisation of the welfare state along a traditional social insurance plan, with the State taking on the multiple roles of financier, direct producer, and manager of social services[18]. Universal programmes (e. g., public health care and public education systems, social security, family allowances, maternity benefits, etc.) unified pre-existing and fragmented partial services for the whole population.

In 1952, the creation of Chile's National Health Service (*SNS*, Law 10,383), represented a new stage towards the provision of universal health services in Chile. The most relevant public health reform until the mid-1970s, the SNS unified multiple pre-existing, health provisions and public services, and was the first nationwide organisation of health care and prevention in Chile.

Two years later, social programmes were organised around the Maternal and Perinatal Programme, the Children and Adolescents' Health Programme, and the PNAC. With a basic goal of diminishing IMRs, these programmes' provided periodic check-ups for women before, during and after delivery, children's check-ups; diagnosis and prevention of sicknesses in mothers and infants; vaccinations; health and nutritional education for mothers; programs encouraging breast-feeding, responsible parenting and birth control; and nutritional interventions. All the programmes were well coordinated and integrated. Despite political changes, the programmes have been characterised by historical continuity.

PNAC was organised at the national level to unify the multiplicity of milk and infant maternity provisions while dropping the social security requirement for programme beneficiaries. Among PNAC's general characteristics was the universalistic provision of benefits with a strong emphasis on preventive and curative care (in this order) of mothers and infants, articulating food distribution with health care actions (34).

During the 1960s and early 1970s, Argentina's national policy guidelines emphasised integration and coordination with other social programmes while maintaining similar maternal and child health and nutrition goals. During 1963-66, changes at the PMI were short on effective, long-term implementation[19]. In 1973, a new National Maternal and Child Plan —part of the government's triennial plan— attempted to create day-care centres, requiring signed agre-

[16] According to Susana Belmartino, effective state-run health policies actually decreased (41).

[17] In 1942 the government created the General Office for the Protection of Infants and Teenagers (*PROTINFA*), providing coverage to marginal groups: uninsured, indigent children, and pregnant women (34, 43).

[18] Even from a critical view regarding the "welfare state' in Latin America, it is recognised that for pioneer countries pertaining to the stratified universalism type (Argentina, Chile and Uruguay) this is an appropriate term to be applied up to the 1970s (16).

[19] Law 12.341/36 was never fully accomplished, programmatic reforms and increasing budget allocations were required (44).

ements between federal and provincial before providing PMI technical assistance. The same year a specific institutionalised sub-programme began to distribute powdered milk to the provinces (45, 46). In 1980, a supplementary feeding sub-programme was put in place; it has provided funds to the provinces since 1981.

Assistentialist & *hybrid* programmes were characterised by new strategies for social policy implementation, with implicit and explicit neo-liberal ideologies underlining reform. Privatisation, decentralisation, and selectivity (targeting) of social provisions were the new principles for social policy in accordance to neo-liberal ideology (47).

In Chile, an authoritarian political state organised assistentialist programmes along the principles of subsidiarity and a break with the pre-existing model of social and macroeconomic policy. During the military government (1973-1990), the reduction in public fiscal and social expenditures and the redistribution of public social expenditures among and within specific programs combined with public policy along "state subsidiarity" principles, moving away from previously traditional universal policies (48).

MCHNPs became the first priority within the national health policy. Despite shrinking public expenditures, the budget allocated to obstetric and paediatric care in public hospitals increased (48). At the same time, the government improved existing programmes and applied new complementary nutritional schemes to malnourished children. One of the main characteristics of these programmes was their interrelation and the "waterfall" effect that they generated[20]. Between the mid-1970s and the mid-1980s, the government modified several programmes. The PNAC underwent several internal transformations related to both the selection of beneficiaries and administration. Most important was a stricter targeting of policies to benefit the extreme poor. In addition, during the 1980s the programme strongly focused on the curative aspect, thus diminishing its historical preventive component.

In Argentina, after the crisis of the social protection networks during the late 1970s and early 1980's, numerous attempts to reform social policy marked the beginning of a period of hybrid programmes. In 1984, under a new democratic government, the PMI was reformulated following the Bureau's guidelines.

Neo-liberalism underlined multiple attempts at implementing reform and became a central component of social policy during the 1990s. Neo-liberal tendencies, however, coexisted with the pre-existing universalistic model. A combination of remnants of the traditional welfare state and new targeting criteria dominated the design, administration and implementation of social policy at the federal level during the entire decade. The state financed, designed, and implemented pre-existing universal programmes within a context of budgetary and long-lasting administrative deficiencies, thus generating a process of de-financing of public social provisions (e. g., public education and health care sectors). These traditional programmes coexisted not only with privatised ones such as the pension system, but also with newly targeted, anti-poverty initiatives to assist vulnerable groups.

By the early 1990s, PMI's general guidelines remained almost untouched. Moreover, information for evaluating both the efficiency of programme expenditures and the efficacy of undertaken activities was totally lacking (40). Between 1991 and 1992, the federal govern-

[20] "Cascada" is Raczynski's term. Three universal MCHNPs covered about 95 percent of pregnant women and children: Programa de Control de la Embarazada, Programa del Control del Niño Sano, and PNAC.

ment ordered a study to overview the health and nutritional conditions of mothers and infants and, indirectly, to evaluate the PMI. The final report —written mainly by Unicef experts— provided a baseline for the emergence of a new MCHNP. The new programme, named the Maternal and Child Health and Nutrition Programme (Promin) constituted a new infant-maternity programme designed according to modern criteria for implementing social provisions: targeting, decentralisation, community participation, and integration both within the health care sector and among social sectors. With relatively strong financial capacities provided through multilateral lending —when compared to the PMI— Promin was the government's flagship initiative towards the transformation of both primary health care and federal social programmes as a whole.

Nonetheless, Promin did not replace the PMI; both programmes stood apart within the orbit of the Federal Ministry of Health. Financed by external multilateral organisations (the World Bank and the Inter-American Development Bank), the new programme had a time frame limited to ten years[21]. Programmatic shifts severely affected service provision and criteria for determining the population to be covered. With a strong and definitive emphasis on strict targeting criteria, the programme only benefited mothers, pregnant women and children experiencing "structural poverty". Also, there was a shift from direct curative and preventive care of the targeted population to the provision of basic infrastructure (e. g., building small preventive and primary care clinics,) that changed the basic configuration of MCHNPs.

Lastly, *integrative* programmes are characterised by a redefinition of the state which regains a fundamental role —though not divorced from the participation of the private sector— as social policy provider.

In Chile, there was both continuity and change in terms of public policy when compared to the previous authoritarian government (27, 28)[22]. Integrative social programmes started in 1990. Despite the continuation of the overall general policies of market liberalisation, the new democratic government promoted "growing with equity" reforms implementing social programmes to cope with the social costs of prior structural adjustment. Social policy was different from 1970s' expansionist periods: social programmes were fiscally grounded, without interfering with the process of continuous growth and macroeconomic equilibrium (51).

During 1990, the Chilean state ratified the International Convention of Children's Rights. As a direct consequence, the government enacted the Plan Nacional de la Infancia. One of the main goals of this programme was decentralisation along with persistent targeting as an instrument for programme implementation. In addition, adjustments were made in order to preserve continuity in programmes already in place (Maternal and Perinatal Programme, the Programme for Infants and Adolescents, and PNAC).

Since the mid-1990s, social policy researchers and public health experts in Chile have voiced some concern about the status of MCHNPs. Changes in the epidemiological and nutritional structure of the Chilean population requiring a different public policy strategy with regard to health care and prevention, ca-

[21] Multilateral financing accounted for about 60 to 70 percent of Promin's total budget. Its ending date was extended twice to facilitate the implementation of the Health Emergency Plan after the crisis in 2001-2002: until 31 Dec 2004, and, later, until 31 Dec 2005 (49).

[22] Filgueira characterises Chile during this period as "universalistic liberal residual regime" (16). For analyses on new forms of social assistance and income transfer programs in Latin America, see (50).

lling into question the validity of the original programmatic goals of PNAC (52, 53).

In Argentina, after the 2001 crisis of neoliberal reforms, emergency plans targeted at vulnerable groups were designed to cope with and/or prevent further deterioration of social indicators. New social policy initiatives have moved towards a more integrative model, combining targeted and more universalistic strategies.

MCHNPs: Institutional Capacities and Recent Transformations in Comparative Perspective

For a comparative analysis of MCHNPs' institutional capacities, I first mapped the organisations performing programmatic tasks; second, I analysed specific programmatic goals according to available institutional capacities; finally, I identified capacity gaps that may hinder programmatic results[23]. Related to these gaps, I evaluated two adjustment criteria to respond to these gaps: a) the adjustment of programmatic goals to existing capacities —a qualitative change when compared to original programmatic aims—; and b) the actions targeted at capacity building facilitating the effective fulfilment of original programmatic goals. Finally, I analysed an additional alternative where neither of the previous alternatives is attempted, resulting in failure to attain both long-term programmatic goals and medium to long-term programme effectiveness.

a. Institutional Context and Political Tradition

Both the PMI and PNAC are long-lasting social programmes. Argentina's PMI originated in 1937 (nationwide in 1943). 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 passage of the Mother and Child Law, and its further consolidation as a national public health care programme in 1954 Chile has provided efficient coverage levels for mothers and children. In contrast with Argentina's PMI, PNAC officers have consistently capitalised on the programme's activities, experience, and work in primary health care accumulated over the years to improve maternal and child health and nutrition.

Promin, in turn, started in 1993 in response to the critical situation regarding maternal and child health and nutrition at the national level (critical despite the existence of the long-lasting PMI). Promin satisfies new, modern neo-liberal criteria for social policy implementation, propitiated worldwide by stick-wielding financial International Governmental Organisations during the 1990s.

b. Goals, Design, and Institutional Capacities

Improving overall maternal and child health and nutrition is the long-term goal of both the Chilean and Argentine MCHNPs. Indicators of such improvement are the reduction of maternal and child rates of mortality and morbidity, a result of improved primary health care and education.

Argentina's PMI and Chile's PNAC designed their programmes based on the free distribution of milk to attract potential beneficiaries —pregnant women, nursing mothers, and children— and maintain their continuous

[23] Among the main indicators for assessing institutional capacity are the identification of tasks; appropriateness of actions; available and efficient utilisation of resources; and the sustainability of actions over time (1).

participation. According to officers' accounts and documents, the main goal was to attract potential beneficiaries to health care centres in order to provide adequate and continuous levels of primary health care and nutrition services.

A comparison of the discourse and actions of the two institutions shows some interesting contrasts. An analysis of programme reports, audits, external monitoring and evaluations, and the long-term historic evolution of basic maternal and child health indicators, demonstrate that Chile's PNAC has kept health care and nutrition transformations as key programmatic goals, effectively subordinating milk distribution to primary health care aims. In addition, health and nutritional education for mothers and pregnant women constitute a central feature of the programme. Such initiatives together with the extensive use of midwives for nationwide prenatal care constitute fundamental pillars of the programme, and help explain its long-term success.

In Argentina's PMI, milk distribution appears as the fundamental, organising component. This may not be the result of explicit policy decisions, but rather the unintended consequence of several factors, such as the federal organisation of the programme, the low capacity of the Central Programme administration to monitor and control programme implementation at local levels, recurrent budgetary cuts, and de-financing. The overall result is embodied in the programme beneficiaries knowing of the programme as the "milk programme", implicitly assigning a social assistance connotation, and not, as in the case of Chile's, as a health and nutrition programme for mothers and children involving, in this case, a "social citizenship" connotation (8).

Promin's goal of improving basic life quality indicators for the structural poor came about through the strengthening of institutions associated with maternal and child health, nutrition and development. Promin implemented its goal via health care and child development centres, training activities, and technical assistance to local subprojects[24].

Finally, the type of health care provision illustrates an important difference between Argentine and Chilean programmes: whereas in Argentina general health and infant-maternity care are organised according to the "spontaneous" demand of the population within the health care network, in Chile they are also organised according to the development of explicit extramural activities to reach the most vulnerable sectors of the population[25]. In Argentina, the absence of extramural activities designed to reach potential beneficiaries relates to lower levels of programme effectiveness, coverage, and improvement of long-term maternal and child health and nutritional care.

In traditional MCHNPs such as the PMI and PNAC, programmatic design was historically organised on universalistic foundations. Programme provisions are seen as "citizens" rights' and are delivered to all mothers and children participating in the public health care network, regardless of socioeconomic and/or work status[26]. These programmes, however, have implicit self-selection mechanisms (self-exclusion): programme activities operate within public health care network, where assis-

[24] Changes in Promin's goals are a direct result from the *ex-ante* evaluation of maternal and child health conditions.

[25] Contrasting to Argentina's public health care sector organisation, Chile combines this type of attention with a network of health care and social services' professionals (e. g. midwives) representing a more aggressive outreach and follow-up of the population in need.

[26] For citizens' expectations and increasing demands for public provisions, see (9).

tance is delivered to the population with high levels of socioeconomic needs[27].

In the case of the PMI, explicit targeting procedures for selecting beneficiaries were introduced during the 1990s not as the result of a national policy strategy but rather a consequence of the relatively low quantities of milk distributed that, in turn, generated local, spontaneous, and non-regulated strategies within provincial MCHNPs[28].

The Chilean PNAC introduced targeting strategies during the 1980s along with more general neo-liberal reforms of public policy. The universal component, however, coexisted with this new targeted component, the latter receiving relatively higher levels of financial resources according to the internal composition of PNAC's budget. These changes were supported by specific nutritional studies to define the targeting population. Initial diagnosis, policy designs, and the identification of vulnerable groups were starting points to apply targeting instruments (6, 52, 56). In striking contrast, in Argentina targeting reforms during the 1990s were implemented without specific baseline studies of children's and mothers' health and nutritional deficiencies[29]. By mid- to late 1990s, while external PNAC evaluations led to the implementation of deeper targeting mechanisms to increase programme efficiency while lowering costs, there was strong support for maintaining the universal component among the population. A combination of universal and targeting elements is still characteristic of PNAC's design; for example, the nutritional supply for vulnerable groups is higher than the one distributed to the general population[30].

Within Promin, geographical and demographic targeting mechanisms were included in the original design. One mechanism was based on regions with populations with unsatisfied basic needs (according to socioeconomic information provided by general census data); the other benefited mothers, pregnant women, and children up to five years of age[31]. In addition to these fundamental targeting elements, there were some "unintended" universal effects. Such universal effects result from the fact that strengthening institutions indirectly benefits the whole population participating in the public health care network.

b.a. Coverage

PMI's Coverage in Argentina has been relatively low when compared to expected coverage goals. Even after ten years of proclaimed "aggressive" changes to increase efficiency, programme coverage remains relatively low and is well below expected goals (on average, around 35 percent). The importance of the milk distribution component and the extreme dependency on this factor for effective

[27] Some potential beneficiaries participating in periodic health care checkups opted for not claiming the milk that was assigned to them (54).

[28] Federal General Auditing Bureau's (AGN) audits to provincial MCHNPs documented irregular situations: reduced milk ratios to be allocated (when compared to national or provincial norms); implicit selection of effective beneficiaries (performed by medical and non-medical personnel at public health care facilities); heterogeneous provincial targeting criteria to distribute milk according to local jurisdictions, etc. (55).

[29] Absence of *ex-ante* nutritional diagnosis generated serious problems: baseline measurements of socioeconomic and health conditions are required for effective targeting and to evaluating programme's impact.

[30] Targeting mechanisms were adequate: almost 90 percent of the two lower quintiles of the population were reached by PNAC, see (57).

[31] Original census data at PROMIN's launching dated from 1980, adjusted on the basis of Permanent Household Surveys (EPH, INDEC). The information available at the time had some problems for effective targeting (it did neither provide up-to-date screening of groups under socio-economic needs nor coverage to regions for areas not surveyed by the EPH, e.g. rural sections).

participation in the PMI contribute to these low rates. It should be noted that the coverage figures are only indirect estimates, since there are neither accurate nor exhaustive records of programme beneficiaries at the national level. This problem, in turn, limits the programme's ability to estimate effective coverage levels.

Promin, in turn, has relatively higher coverage rates than the traditional PMI. Coverage rates, however, vary according to jurisdictions and sub-programmes. In addition, because of the differential activities pursued by Promin —more complex actions beyond distributing milk, e. g., infrastructural works, technical assistance and training— measurement of coverage rates, especially consolidated data at the national level, are more difficult to gather (8).

In contrast to the Argentine situation, Chile's PNAC offers a record of continuous high coverage rates, even when controlling for both socioeconomic status and age groups (average rates around 70 to 80 percent) (57). According to 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 (6, 52, 56). 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 recipients, even across socioeconomic groups.

b.b. Monitoring and Information Systems

Information systems and monitoring capacities of social programmes show noticeable contrasts between the two countries. Up to at least the mid-1990s, the Argentine PMI lacked mechanisms for monitoring and controlling in terms of efficacy, efficiency and impact of its activities and goals: only PMI's financial audits at selected provincial and national levels were available at that time.

Although initially contradicting traditional managing procedures as implemented locally, modern Promin applied some monitoring mechanisms. Contradictions between traditional and new procedures produced difficulties in coordinating innovative programme management at provincial and federal levels. One of the main components of Promin was the organisation and implementation of a programme information system to systematise comparable information from MCHNPs across jurisdictions[32]. Again, Chile's PNAC differed from Argentina's MCHNPs. An information system, periodically updated, was organised during the mid- to late 1970s as a result of the "urge" to implementing targeting mechanisms towards the most vulnerable groups. The PNAC's unitary political organisation facilitated data collection and monitoring procedures at the same as higher degrees of coordination and centralisation improved the levels of coverage and programme monitoring. Again, the Chilean system contrasts with that of Argentina, where, during the 1990s, information on potential beneficiaries required for the implementation of targeting mechanisms was scarce, when not chaotic.

b.c. Constituencies

MCHNPs constituencies are, by definition, mostly composed of women —as mothers and future mothers— and children. Contrary to the

[32] According to contemporary programme reports and evaluations, difficulties resulted from extreme disaggregated-level information (county and municipal) on programme's evolution, implementation and impact, requiring aggregated provincial and federal level information. Audits signaled the persistence of unconsolidated indicators for evaluating programme implementation and effectiveness (58,59).

inherent characteristics of most recent conditional cash-transfer programs (CCTPs), women should not compensate the state in exchange for benefits provided[33]. Even though, theoretically, fathers can go to primary health care facilities to participate in MCHNPs, underlying maternalistic assumptions —and, in fact, the great proportion of effective participation— centre on women's role as mothers as key agents involved in MCHNPs. Neo-liberal practices such as targeting serve to further reduce women's roles as mothers to the strictest biological sense. Rather than having access to health care or nutrition programmes as part of a universal welfare system, women only have access to programmes through their biological role as mother. Mothers, not women, use medical and nutritional programmes.

There is a contrast between the characteristics of MCHNPs' beneficiaries in both countries. In Argentina, PMI beneficiaries do not comprise a strong constituency with specific expectations and demands. Furthermore, beneficiaries know the programme as the "milk programme" and do not even recognise the curative and preventive health care component, which is purportedly the fundamental pillar and goal of the PMI (8). According to specific case studies, potential beneficiaries restricted their use of primary health care centres beyond the required monthly visit to withdraw milk and receive some prenatal monitoring. Also, audits of provincial MCHNPs performed between 1994 and 1997 —a period characterised by frequent delays in the transfer of federal funds and, subsequently, numerous irregularities concerning milk purchases and distribution— highlighted a reduced participation in periodic primary health checkups when milk was not available for distribution (55).

Despite the relatively new nature of Promin, it seemed to be better known among its beneficiaries. Perhaps, this is because Promin is perceived as a more efficient social programme, even though such a perception varies according to jurisdictions and sub-programmes. The decentralised nature of the programme combined with the federal organisation of Argentina's public policy give rise to heterogeneous programme implementation by specific jurisdictions.[34] Promin seemed to be better and more extensively known among programme officers than among potential beneficiaries.

For Chile's PNAC, the situation is very different. Potential and effective programme beneficiaries constitute a strong constituency, resulting from the long, continuous historical tradition of PNAC and the primary health care programme for mothers and children. Pregnant women, nursing mothers, and mothers consider MCHNPs benefits to be "citizens' rights", and not mere palliative services, as may have traditionally been the case in Argentina. By the late 1990s (ca. 1997 and late 1998), when several officers at the National Ministry of Health considered operating structural changes in PNAC (after almost 50 years), mothers mobilised to oppose the changes. Such changes were, according to PNAC's constituencies, against their long-entrenched citizens" rights to maternal, and child health and nutritional benefits (8).

[33] Gender implications of CCTPs centre the debate at the "liberalising/empowering" potential vs. the "re-traditionalising/reinforcing" gender roles involved in conditionality for keeping programme status (60,61).

[34] We need to consider this information with caution. Research on popular perceptions of social services pursued in 1999 documented extremely high levels of ignorance of federal social programmes: about 71 percent of the surveyed poor population did not know about any federal social programme for which they might become beneficiaries. Among these, 89 percent ignored what PROMIN was (62).

b.d. Impact

In Argentina, the absence of baseline information to implement and evaluate MCHNPs' impact and targeting procedures is a central problem, not only for these two social programmes but for social policy in general. In this case, overlapping competitive programmes with high levels of heterogeneity both at provincial and local levels make all implementation, regulation and monitoring very difficult. The relative success of Promin to organise procedures and some monitoring activities (though impact studies were still lacking), reflects the way that International Multilateral Organisations can support a central state with traditionally weak administrative and institutional capacities.

Despite strong investment in 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— were still pending in 2002, almost ten years after Promin's debut. The lack of an adequate knowledge of the nutritional status of the population at the national level meant there was no baseline to measure the overall impact of MCHNPs' reforms during the 1990s. The fact that a national nutritional survey was still lacking by the time of Promin's completion embodied the problems associated with the implementation of long-term social policy initiatives requiring state capacities and financial resources.

In Chile, PNAC's evaluation studies show long-term positive impacts of the programme. In addition, the availability of periodic studies allows for long-term comparisons 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. During the late 1990s, 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 recommendations effectively implemented by 1999 were the transformations of the traditional characteristics of PNAC according to the new nutritional characteristics of the Chilean population (6, 52, 56).

c. Macro-Institutional Level Gaps

c.a. Political and Institutional Organisation

Argentina's Federal organisation requires a decentralised execution of federal social programmes, including MCHNPs. At the national level, the Bureau provides general programmatic guidelines, norms and regulations, financial resources (transfers to provinces of funds for purchasing milk), some supplies, and technical assistance. Agreements between the national level and provinces provide the general framework for state-level implementation of the programme. Provinces effectively implement MCHNPs across their jurisdictions. By the early 1990s, the PMI did not include any specific mechanism to control programme implementation at local levels. Since 1996, several attempts and initiatives to increase local programme regulation resulted in some improved controlling capacity of the Bureau, though its monitoring capacity, however, remained low during most of the decade.

Through the signing of agreements between the Central Programmatic Unit (UCP) and specific local subprojects, Promin provided stronger guidelines for overall programme implementation, strategies, and targeting criteria. Nonetheless, local jurisdictions were in charge of designing their own subprojects according to specific local needs and criteria. According to a

study of Promin (ca. 2002), UCP's organisation and everyday activities (programme design and implementation) were relatively autonomous, independent from immediate political conflict. Social and political conflicts at provincial levels, however, affected all public policy provincial activities, including Promin's subprojects (63).

The effective implementation of Promin's goals has been neither smooth nor easy. In fact, pervasive traditional procedures developed by provincial units as well as local political changes and discontinuities have worked against efficient programme implementation within a decentralised organisation. This situation is not characteristic of Promin, but of social policy organisations in Argentina in general.

Chile's unitary political organisation requires and results in a strongly centralised model for social policy provisions. The national level —for MCHNPs, the National Ministry of Health— assumed the overall design, general and specific guidelines, regulation, implementation, and the provision of financial and technical resources for PNAC[35]. In the Chilean case, the highly centralised nature of the state and its specific programmes allows for a solid design and implementation of targeting mechanisms, homogeneous delivery of services and benefits, standardisation of procedures, and close monitoring of programmes' activities. Despite some decentralisation during the 1990s, there were no deep transformations on the centralised and unitary tendencies organising policy design and implementation.

Although decentralisation has been favoured during the 1990s in both countries, implementation varied according to the specific institutional structures already in place. In Chile, a pre-existing unitary system allows for a national articulated system. In the Argentine case, a pre-existing federal system generates higher levels of mediation. In addition, compromises and a predominant fiscal logic for the allocation of funds to provinces weaken regulatory and monitoring capacities. Decentralisation in this case, hinders minimum levels of programme implementation according to the initial national norms and goals.

c.b. Inter-Institutional Coordination

Argentina's MCHNPs present low levels of integration and coordination both between different federal programmes and among national and provincial programmes. This phenomenon is not exclusive of these programmes, but of social protection programmes 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 programmes are documented on existing research (64, 65). This lack of integration and coordination occurs at all levels both within and among relevant social sectors, (e. g., health care, social assistance, and education programmes) and is a recurrent mark. In fact, we find documented evidence of PMIs' coordination problems in historical studies.

During the 1990s, official public policy emphasised the integration and coordination of social initiatives and programme action, especially *vis-à-vis* health and educational services. Nevertheless, at the level of concrete programme implementation, integral and coordinated programmes are very difficult to find in Argentina. The absence of integration among MCHNPs, constitutes one of the most visible

[35] Extreme centralisation even included nationally purchasing and storing powder milk and formula. Only by mid- to late 1980s, PNAC became financially decentralised. Such a process was very limited since milk purchases and storage remained all centralised activities.

structural deficiencies. At the provincial level, during the 1990s coordination between Promin and PMI also reflected heterogeneous situations, and depended more on local political and institutional conditions rather than on federal initiatives. This lack of effective integration for programme planning and design between these programs persisted during most of the decade: five years after the creation of Promin (1998), the Federal Ministry of Health finally organised a coordinating committee; more than seven years after the creation of Promin (under the new national administration, ca. 2000), the Federal Ministry of Health created a Unit to coordinate both sub-programmes and to promote policy integration for maternal and child health actions (66). The latter represents a political decision to support coordinating activities while also pointing to the political and institutional difficulties to effectively fulfilling Promin's goals. Effective unification of PMI and Promin in Argentina took place during Promin's final years (2002/2003), formally consolidating both into one national program *ca.* 2004/5 (49, 67).

In turn, Chile's MCHNPs have an integral, articulated design both within the health care sector and across social sectors (e. g., education). In addition, these are also articulated with equivalent health care and nutritional programmes for children at school age (Programa de Alimentación Escolar, PAE) facilitating a continuous provision of health care and nutrition services for the Chilean population. Analyses of PNAC's targeting effectiveness emphasise difficulties at identifying causal relationships between programme's activities and nutritional improvement: its close linkage with the primary health programme makes virtually impossible to fully separate what proportion of the impact is due to better nutrition and which one is due to improved access to the health care system (56).

d. Micro-Institutional Level Gaps

d.a. Financial Resources

Both traditional MCHNPs are fully financed through national funds. In contrast, Promin has mixed funding: a multilateral lending component —mainly the World Bank, providing the IDB and UNDP technical assistance— and a federal and provincial funds component. Resources within Promin are comparatively higher than those for the PMI.

In terms of cost assessment, in Argentina no studies evaluate MCHNPs according to cost/effectiveness during this period. Several factors partially explain this absence: recurrent oscillations regarding PMI's approved annual federal budgets; variations regarding the proportion of effectively allocated and spent budgets; and problems associated with estimations of effective programme beneficiaries. With respect to Promin, again there is no cost/efficiency study, although since 2000 the programme began a cost assessment analysis for specific local subprojects[36].

Some general studies on nutritional programmes document a cost of $ 0,50 Dollars per person/day, spent on federal nutritional programmes (65, 68). Based on this estimation, the annual per capita cost would equal approximately $182 Dollars.

For the Chilean case, accurate and periodic information on costs are available. PNAC's evaluation studies (1979 and 1995) include cost/effectiveness assessments, even though such evaluations require complex estimates (similar to the ones that would be required for Argentina's MCHNPs). Average PNAC per capita annual costs range from $21 to $41 do-

[36] For PROMIN, such an absence was justified by the complexity of the programme's activities: per capita annual costs were difficult to estimate. PNAC's, the indirect universal effects make cost estimations a more complex task (52, 57).

llars per capita in evaluations performed during the 1980s and early 1990s[37]. This amount is considerable lower than Argentina's approximations indicated above (even less than four times the Argentine). Contrasts in MCHNPs' cost-effectiveness represent an additional factor to Argentina's MCHNPs' low efficiency and institutional capacities.

Conclusions: Maternal and Child Health Programmes in Argentina and Chile

Argentina's IMRs have decreased over time. Infant-mortality declines, however, are lower than those for its neighbouring country, Chile, despite both nations having similar traditions of long-lasting MCHNPs. This situation can be explained in two different, though not mutually exclusive, ways. First, preventive and curative health policies implemented during the 1990s have neither been enough to compensate for nor to ameliorate the negative effects associated with increasing poverty levels and the "social costs" resulting from implementing neo-liberal reforms[38]. Second, the perennial lack of state capacity in social policy design and implementation compounds the poor results —relative to the high social expenditure levels— of the new social programmes put in place during the 1990s (69).

The overall success of Chile's PNAC is documented by 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, long-term continuity (despite governmental and political regime changes) and institutional capacity of the state to execute nationwide integral primary health care programmes.

The original, universal character of PNAC constituted a solid base for the implementation of target reforms in these social protection programmes during the 1980s. Such targeting, however, did not eliminate its universal component. PNAC became a mixed-type of programme, a "hybrid" form that combines universal and targeting components. This ideal mix constitutes one of the factors for the continuing improvements of MCHNPs.

As in other Latin American countries, one can observe changes in the epidemiological and nutritional structure of the Chilean population: obesity and overweight, two feeding- and nutritional-related disorders that affect children and elderly as well as the majority of the population require new public policy strategies for preventive and curative health. The success of the continuous and long-lasting infant-maternity policy —PNAC— and its articulation with health care programmes is central to explaining these changes, although it is not the only factor. PNAC's success, in fact, may be one of the reasons for modifying the traditional structure of this long-lasting, highly institutionalised nutritional programme. In Chile, public health care policy at the turn of the 21st century requires fundamental changes (e. g. Plan Auge) in order to address important problems beyond the compass of infant and maternal primary health care (6, 56, 70).

In contrast to Chile's uninterrupted and successful maternal, child health and nutritional policy implementation, Argentine policy presents a gloomy picture at the turn of the century. With similar nutritional and epidemiological changes, and despite extremely high

[37] Costs depend on sub-programme type (basic or fortified), and age group (56).

[38] A counterfactual exercise may attribute implementation of emergency programmes (from 2002 onwards) to the remedial effect avoiding further deterioration of socioeconomic indicators.

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.

Despite the increasing financial resources and the multiplicity of MCHNPs available, these programmes have not efficiently addressed maternal and child health. Proliferation, policy fragmentation, and the overlap and lack of coordination between programmes result in both under coverage and "leaks" in benefits. As a result people received similar benefits from several infant-maternity programmes. The inability of the Argentine programmes to record an accurate list of beneficiaries —systematically proclaimed by successive administrations— reflects insufficient administrative capacities, and deficient monitoring and coordination among them. Argentina shows increasing problems associated with the state's administrative and regulatory capacities to oversee the implementation of these programmes. These factors, in turn, generate higher levels of inefficiency.

The larger problem, however, resides not within the programme itself but at the core of the Argentine social policy network, expressing again one of the recurrent characteristics and failures of Argentine social policy: overlap, competition, and lack of coordination among social programmes both within social sectors at different levels, (e. g. national, state, and county) and between social sectors (e. g. interaction between health and education initiatives). A considerable overlapping of activities combined with the lack of coverage for a substantial sector of the population who are excluded from both programmes, demonstrates the low administrative capability and inefficiency of the Argentine state when implementation of social programmes is concerned.

In addition to traditional deficits of institutional capacities in Argentina, the new challenge for present and future MCHNPs is to address the "double burden" of malnutrition. A public policy approach must centre on how to articulate MCHNPs to address this burden, while improving program effectiveness and impact through existing and enhanced national and local institutional capacities. By the turn of the century, Argentina's crisis after a decade of reforms differs from Chile in terms of points of departures, legacies of social policy implementation and, overall, state capacities and autonomy. A combination of historically-weak state capacities, the persistence of the patronage system when implementing social assistance programs, and an under-funded state may be especially unable to provide the long-term public policy solutions required for this social and economic emergency, especially if gaps between institutional capacities and programmatic goals are not addressed.

After the socioeconomic crisis of 2002, the new Argentina scenario posed a challenge: how to provide ameliorative public policies? Emergency social programmes implemented from 2002 onwards attempt to deal with increasing poverty, unemployment, and further deterioration of the health status of the population. A novel, "ground-breaking" maternal and child health insurance plan —Plan Nacer— launched in 2003 claims to target problems related to maternal and child health and nutrition (71, 72). This new initiative involved similar programmatic goals as the ones targeted by long-lasting MCHNPs. Recent basic bio-demographic indicators show short-term improvements for Argentina. Nevertheless, conclusions on medium and long-term results of both maternal child health improvements and overall public policy implementation and institutional capacities require additional research and in-depth analyses of programmatic performance that are still to come.

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