The Changing Shapes of Latin American Welfare States

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Summary and Keywords

Latin American welfare states have undergone major changes over the past half century. As of 1980, there were only a handful of countries (Argentina, Brazil, Chile, Costa Rica, and Uruguay) with social policy regimes that covered more than half of their population with some kind of safety net to insure adequate care during their old age and that provided adequate healthcare services. With few exceptions, access to social protection and to healthcare in these countries and others was based on formal employment and contributions from employees and employers. There were very few programs, and those few were poorly funded, for those without formal sector jobs and their dependents. The debt crisis and the ensuing neoliberal reforms then damaged the welfare state in all countries, including these leading nations. Deindustrialization, shrinking of the public sector, and cuts in public expenditures reduced both coverage and quality of transfers and services. Poverty and inequality rose, and the welfare state did little to ameliorate these trends.

With the turn of the century, the economic and political situation changed significantly. The commodity boom eased fiscal pressures and made resources available for an increase in public social expenditure. Democracy was more consolidated in the region and civil society had recovered from repression. Left-wing parties began to win elections and take advantage of the fiscal room which allowed for the building of redistributive social programs. The most significant innovation has been expansion of coverage to people in the informal sector and to people with insufficient histories of contributions to social insurance schemes. The overwhelming majority of Latin Americans now have the right to some kind of cash assistance at some point in their lives and to healthcare provided by their governments. In many cases, there have also been real improvements in the generosity of cash assistance, particularly in the case of non-contributory pensions, and in the quality of healthcare services. However, the least progress has been made toward equity. With very few exceptions, new non-contributory programs were added to the traditional contributory ones; severe inequalities continue to exist in the quality of services provided through the new and the traditional programs.

Keywords: welfare state, social policy, social security, redistribution, pensions, healthcare, left governments, Latin American politics

Do Latin American countries even have a welfare state? If one conceptualizes the welfare state in a strictly value-free technical manner as the totality of cash transfers to individuals and households and the provision of free or subsidized social services by the state-then they certainly do. However, in political discussion the term has a value component. That component suggests that welfare states improve the lives of at least a majority, if not all, of their citizens. Accordingly, many scholars have been hesitant to apply the concept to Latin America.

Most of the literature on Latin America in the 20th century referred to social security or social policy or the social state, not welfare state policies (Borzutzky, 2002; Filgueira, 1995; Mesa-Lago, 1978; Papadopulos, 1992), and much of it continues to use this terminology (Martínez Franzoni & Sánchez-Ancochea, 2016). In fact, inclusion of Latin America in the comparative welfare state literature is a relatively recent phenomenon (Esping-Andersen, 1996; Filgueira & Filgueira, 2002; Garritzman, Häusermann, & Palier, FORTHCOMING; Haggard & Kaufman, 2008; Huber & Bogliaccini, 2010; Huber & Stephens, 2012). There are good reasons for these conceptual preferences. Certainly, before 2010 there were only a handful of countries to which the value-laden conceptualization of a welfare state could have been usefully applied. However, in the first decade and a half of the 21st century, these leading countries significantly improved their welfare states and another group of countries made major strides toward building them as well.

Generous and redistributive welfare states take a long time to build and require a favorable constellation of power in the society. In the context of the advanced democracies, the peak years of welfare state construction were the 30 years of high economic growth, or the Golden Age, after World War II. The most generous and redistributive welfare states were built in countries where unions and left parties were very strong (Esping-Andersen, 1990; Huber & Stephens, 2001). The most recent growth and improvement phase in Latin America lasted barely more than a decade. After 2012, economic growth slowed and Brazil, for instance, suffered a deep recession. Moreover, the political winds turned and in some countries the left governments that had led the way to welfare state improvement were replaced by the right. The question is whether the steps toward improvements of the welfare state have generated a constituency strong enough to resist rollbacks and whether pro-welfare state forces remain mobilized enough to push governments without a value commitment to equity to take further steps toward improvements.

This article will review the main phases of welfare state development in Latin America. It will focus on the changing characteristics of welfare states in different countries over time. It will explore the macro-economic and political conditions that gave rise to different kinds of welfare state policies. It will also link welfare state efforts to changing levels of poverty and inequality. Finally, it will discuss current conditions and provide some assessments of the future of Latin American welfare states.

Changing Welfare State Efforts and Levels of Poverty and Inequality

Over the past half century, one can identify three clearly distinct phases in the development of Latin American welfare states or—more modestly and for most countries, more accurately—social policy regimes. The first phase occurred roughly throughout the 1960s and 1970s and saw the growth of social insurance covering employees in the formal economy, specifically the public sector and the growing industrial sector. The second phase covered the lost decade of the 1980s and the heydays of neoliberalism in the 1990s. This period was one of retrenchment, with declining expenditures and coverage, resulting from the economic crisis and deindustrialization. The third phase began after the turn of the century and saw a recuperation of the role of the state, with an improvement of benefits in the social safety net and of the quality of healthcare services as well as an extension of coverage to previously excluded groups.

Table 1. Social Expenditure (Social Protection, Education, Health) in Latin America 1980–2015(Percentage of GDP)

	1980	1990	2000	2010	2015
Argentina	12.2	15.4	20.1	25.8[A]	27.8
Brazil	8.4	18.1	12.2	24.7[A]	23.9
Chile	15.2	11.7	13.7	14.3	15.4[C]
Costa Rica	15.5	16	15.4	20.4	21.1
Uruguay	14.2	16.7	21.6	21.9	24.6
Mexico	6.7	9.2	10.7	9.6	10.2
Panama	11.6	13.1	14.1	7.7[B]	6.3
Venezuela	7.1	6.5	–	16.7[A]	11.0
Bolivia	5.6	6.2	11.8	12.2	18.4
Colombia	7	6.8	11.7	13.1	18.6
Ecuador	9.6	6.8	3.9	7.9	7.9[C]
Paraguay	3.5	2.5	7.3	13	12.0[C]

Peru	4.1	4.5	9.8	8.2	10.6
Dominican Republic	5.2	2.6	5.6	6.1	7.6[C]
El Salvador	5.5	3.3	6.2	12.2	12.0[C]
Guatemala	3.6	3.3	4.4	6.2	5.4[C]
Honduras	5.9	7.5	9.2	11.8	8.5[C]
Nicaragua	9.3	13.2	7.0	11.1[A]	8.1[C]

Note. Huber and Stephens dataset, Social Investment portal in Latin America and the Caribbean; MEF Uruguay

([a]) 2009,

([b]) 2008,

([c]) Central government only.

On the eve of the debt crisis of the early 1980s that marked the end of the import substitution industrialization period, social expenditure on social protection, health, and education combined had reached a high of between 14.2 and 15.5% of GDP (gross domestic product) in the countries with the strongest welfare state efforts (Costa Rica, Chile, and Uruguay). However, it remained at a low between 3.5 and 4.1% of GDP in the countries with the weakest efforts (Paraguay, Guatemala, and Peru). A decade later, both the spread and the rankings of countries remained similar overall, with the following exceptions: Brazil joined the top group whereas Chile fell behind, and the Dominican Republic and El Salvador joined the bottom group. The weighted average for the region in 1990 was 13.8% of the GDP (Economic Commission for Latin America and the Caribbean, 2014). Another decade later, that average had risen just slightly to 15% of GDP. Thus, throughout the two decades of economic crisis and neoliberal reform, there was little to no progress overall in welfare state effort despite greatly increasing need caused by the economic crisis.

To the extent that there was any progress, it was in the legal bases for later expansion of social policy, in the development of preventive and primary healthcare for the poor, and in some education initiatives. The Brazilian Constitution of 1988 guaranteed a number of social rights, the realization of which required funding that was made available after 2000. Costa Rica and Argentina introduced innovations with low-cost initiatives in healthcare while Brazil and Argentina significantly increased enrollment in primary and secondary education.

It was the decade of rapid economic growth from 2002 to 2012 that saw a significant increase in welfare state effort, bringing the average expenditure on social protection, health, and education to 19.1% of GDP. As Table 1 shows, this average masked tremendous variation. The leading countries (Argentina, Brazil, Costa Rica, and Uruguay) had increased their social expenditures to between 20 and 26% of GDP, whereas the lowest spenders (Dominican Republic, Guatemala, Ecuador, Panama, and Peru) had increased theirs only to between 6 and 8%. After 2012, the increase in social spending slowed; in a few cases social spending became stagnant or even declined slightly, which aligned with the slowing of economic growth.

As important as the changes in spending levels were, the changes in the allocation of the expenditures were even more critical. As this article will explain, after two decades of attempts to privatize much of social protection, enhance private sector participation in health and education, and focus public sector efforts very narrowly on emergency assistance to the poorest groups, many governments reinforced the role of the state in the 21st century. Networks of social protection and social services offered to large and previously excluded groups were expanded. These efforts were particularly strong under left governments. A few countries (Argentina, Brazil, Bolivia, Costa Rica, and Panama) had already begun to invest heavily in education in the mid-1990s, allocating between 4 and 5% of GDP. This put them in a better position to deal with skill-biased changes and moderate the increase in the education wage premium in the labor market after 2000.

During the decade of the debt crisis, levels of poverty rose from an average of 40% of the population below the ECLAC national poverty level in 1980 to 48% in 1990, declining only to 44% by 2002. During these two decades, the welfare state did very little to slow the rise of these levels. It was the period of economic growth and stepped-up social protection efforts that reduced aggregate poverty levels to 28% in 2013 (Economic Commission for Latin America and the Caribbean, 2014). Again, these averages hide great variation (Table 2). ECLAC (Economic Commission for Latin America and the Caribbean) calculations for the period 2008–2013 show that in most countries, growth effects were clearly stronger than distribution effects in lowering poverty. However, distribution effects did make a contribution, and in Uruguay, Brazil, and Mexico the distribution effects were as strong as or stronger than the growth effects (ECLAC, 2014).

Table 2. Poverty Levels in Latin America 1990–2016 (Percentage of the Population)

	1980	2000	2012	2014
Argentina	12.2[A, B]	23.7[A, F]	4.3[A]	–
Brazil	48.0	37.5[F]	18.6	16.5
Chile	38.6	21.7[F]	10.9[H]	7.8[I]
Costa Rica	26.3	20.3[F]	17.8[G]	18.6[J]
Uruguay	17.9	9.4[F]	6.1	4.5
Mexico	47.7[C]	46.9[F]	37.1	41.2
Panama	31.0[A, C]	19.5[A, F]	24.0[H]	21.4[J]
Venezuela	39.8	49.4[F]	25.4	32.1
Bolivia	52.6c[D]	60.6[F]	36.3[H]	32.7[I]
Colombia	52.5[C]	49.7f[G]	32.9[G]	28.6
Ecuador	62.1[B]	63.5[A, F]	32.4a[H]	31.0[A]
Paraguay	43.2[E]	59.0[F]	47.3	42.3

Peru	47.5[D]	54.7f[G]	25.8[G]	22.7[J]
Dominican Republic	–	47.1[F]	41.2	37.2
El Salvador	54.2[C]	49.8[F]	45.3	41.6
Guatemala	69.4[C]	61.1[F]	54.8[H]	67.7
Honduras	80.8	79.7[F]	69.2[H]	74.3[I]
Nicaragua	73.6[C]	69.4[F]	58.3[H]	–

Note. From ECLAC (2014) for the 1990, 2000, and 2012 series; ECLAC (2015) for the 2014 series.

([a]) Urban areas,

([b]) Greater Buenos Aires,

([c]) 1989, except in the cases of Panama (1991), Colombia (1994), Peru (1997), El Salvador (1995), and Nicaragua (1993),

([d]) Eight departmental capitals plus the city of El Alto,

([e]) Metropolitan area of Asunción,

([f]) 1999, except in the cases of Chile (1998), Mexico (1998), Colombia (2002), Peru (2001), Dominican Republic (2002), Guatemala (1998), and Nicaragua (2001),

([g]) Figures not comparable with those of previous years,

([h]) 2011, except in the case of Guatemala (2006), Honduras (2010), and Nicaragua (2009),

([i]) 2013,

([j]) Figures not comparable with those of previous years.

Inequality shows a similar pattern. Historically, very high levels of inequality rose even more during the debt crisis, with the Gini rising as high as .63 in Brazil, between .58 and .62 in Colombia, Guatemala, Honduras, and Nicaragua, and .55 in Chile in 1990. The lowest levels were found in Costa Rica with .44, Venezuela with .47, and Uruguay with .49 (ECLAC, 2014). During the decade of renewed economic growth and neoliberal reforms in the 1990s, levels of inequality inched up even higher in 8 of the 18 countries, while remaining largely stable or declining only marginally in the others. Parallel to the change in poverty levels, inequality began to decline markedly after 2002, with an improvement in the Gini of .08 or more in Argentina, Bolivia, Ecuador, El Salvador, Guatemala, Paraguay, Peru, and Uruguay (Table 3). In Argentina, Bolivia, Brazil, and Uruguay, the investment in education and the expansion of social safety nets, which began in the 1990s, contributed significantly to this decline.

Table 3. Inequality Levels in Latin America 1990–2016 (Gini Index)

	1980	2002	2012	2016
Argentina	0.501[B]	0.468[F]	0.389	0.392
Brazil	0.627	0.569	0.523	0.511[I]
Chile	0.554	0.508f	0.469[G]	0.453[I]
Costa Rica	0.438	0.498	0.502[H]	0.500[H]
Uruguay	0.492[A]	0.474[A]	0.388	0.391
Mexico	0.536[C]	0.508	0.499	0.504
Panama	0.530[A]	0.571[F]	0.528[G]	0.513
Venezuela	0.471	0.420	0.385	0.378[I]
Bolivia	0.537[D]	0.611	0.471[G]	0.453[I]
Colombia	0.601[C]	0.567	0.539	0.521
Ecuador	0.461[A]	0.537[F]	0.463	0.445
Paraguay	0.447[E]	0.583	0.489	0.497

Peru	0.532[C]	0.565	0.457	0.452
Dominican Republic	–	0.513	0.469	0.470
El Salvador	0.507[C]	0.540[F]	0.454[G]	0.421
Guatemala	0.582[C]	0.636[F]	0.535[G]	–
Honduras	0.615	0.554[F]	0.515[G]	0.480
Nicaragua	0.582[C]	0.568[F]	0.495[G]	–

Note.ECLAC (2014) for the 1990 series; ECLAC (2018) for the 2000, 2010, and 2016 series.

([a]) Urban areas,

([b]) Greater Buenos Aires,

([c]) 1989, except in the cases of Colombia (1994), Peru (1997), El Salvador (1995), and Nicaragua (1993),

([d]) Eight main cities plus El Alto,

([e]) Asunción metropolitan area,

([f]) 2001, except in the cases of Argentina (2003), Chile (2003), and Guatemala (2000),

([g]) 2011, except in the cases of El Salvador (2013), Guatemala (2014), Honduras (2013), and Nicaragua (2014),

([h]) Figures not comparable with those of previous years,

([i]) 2015, except in the case of Venezuela (2014).

Development of the Welfare State in the Import Substitution Industrialization Period

With the exception of Uruguay and Chile, where social security schemes covering diverse groups beyond the military and high-level civil servants had been established by the mid-1920s, most countries established social insurance schemes covering only white- and blue-collar workers for their old age and for healthcare during and after World War II in tandem with efforts at import substitution industrialization (ISI) (Filgueira, 2005; Mesa-Lago, 1978; Papadopulos, 1992). Accordingly, coverage reflected the share of the economically active population in industrial employment. By 1980, only Argentina, Brazil, Chile, Costa Rica, and Uruguay had reached pension and/or sickness coverage for more than 60% of their population; industrial employment had reached 28.5% or more in Argentina, Chile, and Uruguay (Huber & Stephens, 2012: 78; Mesa-Lago, 1994: 22). Brazil's coverage was high despite an industrial employment level of only 20% because the military government had passed a rural non-contributory scheme with minimal benefit levels. Costa Rica remained way ahead of countries with similar levels of industrialization and GDP per capita because of its long history of democracy and frequent rule by a party committed to equity. Mexico, Panama, and Venezuela covered between 40% and half of their populations, with industrial employment at 24–25% in Mexico and Venezuela, but only 9% in Panama, an anomaly which may best be explained by the employment in the Canal Zone. Colombia, Guatemala, and Peru covered between 30 and 40% while the rest of the countries covered 20% or less of their populations, with levels of industrial employment below 20%.

Linking social security coverage levels to levels of industrial employment does not establish any automatic or functional relationships. Rather, the growth of industry changed power relations in that there was a new numerically strong group of industrial workers that could organize in unions and be politically mobilized by political parties or populist authoritarian leaders (Segura-Ubiergo, 2007). Mobilization by left-of-center parties in a democratic context led to significant coverage expansion in Chile, Costa Rica, and Uruguay; mobilization and cooptation by populist leaders did the same in Argentina and Brazil (Huber & Stephens, 2012). Venezuela and Mexico followed the same types of patterns but with less intensity. Union militancy pushed governments of different stripes in democratic and authoritarian regimes toward expansion of social protection (Dion, 2010).

The dominant pattern of welfare state construction followed what the comparative welfare state literature calls the conservative-corporatist (Esping-Andersen, 1990) or Bismarckian (Palier & Martin, 2008) model, that is, insurance based on employment. Typically, employees and employers made contributions based on the payroll, and employees and the state contributed to the pension funds of public employees. Different schemes covered different groups, such as the military, higher-level civil servants, public employees, and white-collar and blue-collar employees in the private sector. Prior to the military governments of the 1970s imposing some streamlining, in some countries (Chile and

Uruguay, most notably) fragmentation was much more extreme, with different schemes for different categories of employees in different sectors (Castiglioni, 2005). Such fragmentation entailed not only inefficiencies in administration but great inequality in benefits. People without jobs in the formal economic sector were covered as dependents of people with such jobs at best, and without any protection at all at worst. There were very few non-contributory schemes; benefits in these schemes were very low and availability often depended on annual budgets, resulting in long waiting lists (Pribble, 2010, 2013). In short, Latin American welfare states as of 1980 could accurately be described as dual or exclusionary (Filgueira, 2005), truncated or conservative/informal (Barrientos, 2009), or incomplete and inegalitarian—far from universalistic.

Economic Crisis and Neoliberalism

At the onset of the Latin American debt crisis, social security systems in the more advanced countries had matured and were facing financial problems. The ratio of contributors to beneficiaries was declining and reserve funds were inadequate for a number of reasons ranging from employer non-compliance with contribution requirements to diversion of resources for other purposes, as well as bouts of high inflation (Mesa-Lago, 1989). The debt crisis then brought fiscal insolvency of governments and the accumulation of pension debts, along with an erosion of the value of benefits due to hyperinflation. Moreover, the process of deindustrialization initiated by the rapid and forced opening of the ISI economies, along with the shrinking of the public sector in the wake of severe austerity policies, led to a significant decline of formal sector employment and thus of coverage by social security schemes. The austerity prescriptions of the International Monetary Fund (IMF) also forced cuts in benefits and severely damaged the quality of health services and of education. Deindustrialization in the context of austerity resulted in rising levels of poverty and inequality (Bogliaccini, 2013).

In the eyes of the IMF, social security schemes and other social expenditures constituted a heavy and unwarranted drain on government resources and therefore needed to be reformed and reduced. Particularly where pension expenditures were high, reform pressures were intense (Madrid, 2003). The preferred model for social security schemes was full or at least partial privatization, and for healthcare it was an expanded role for private insurance and providers. Chile under Pinochet was a trailblazer in completely privatizing its pension system, turning it into a system of forced savings with private pension administration firms. Bolivia, Mexico, El Salvador, and the Dominican Republic followed the Chilean model and put a fully funded private pension system in place of the previous pay-as-you-go public pension system. Peru and Colombia established a private parallel to the public system, and Argentina, Uruguay, Costa Rica, and Panama established mixed systems, with a basic public tier and a supplementary private tier (ECLAC, 2018; Mesa-Lago, 2008). In Argentina, Uruguay, and Costa Rica, resistance to privatization was intense, resulting in a mixed system.

Reforms in healthcare were less sweeping and more diverse, partly as a result of more diverse policy legacies and a more complex array of organized stakeholders (Kaufman & Nelson, 2004). In Argentina, for instance, unions administered the healthcare system that covered the bulk of the population and strongly resisted reforms. Elsewhere, IMF and World Bank pressures for expansion of the private sector's role were counterbalanced by pressures for expansion of cost-effective preventive and primary care. In Costa Rica, for instance, there was widespread resistance against World Bank proposals and instead the country strengthened the basic healthcare teams that came to serve as gatekeepers to the rest of the healthcare system (McGuire, 2010). Moreover, healthcare reforms were complicated by the trend to decentralization that shifted greater responsibilities for social services to subnational governments (Falleti, 2010; Niedzwiecki, 2018).

The steeply rising levels of poverty called for government action to meet the most basic needs of growing sectors of the population. The IMF and World Bank were concerned about reform backlash and provided some funds for emergency social assistance, particularly to the poorer countries of the region. However, these funds were narrowly targeted and typically of limited duration, so they did not provide the basis for a strengthening of the social safety net. Brazil is an important exception to the rule of prolonged austerity: The democratic constitution of 1988 contained provisions regarding social rights, among them the right to a benefit equal to one minimum wage for all poor, aged, and disabled persons. In 1991, enabling legislation was passed and benefits began to be disbursed (Weyland, 1996). However, social assistance for the working-age poor and their children remained highly limited everywhere; expenditures on social assistance remained on average well below 1% of GDP. Costa Rica was a partial exception due to a social assistance fund supported by payroll taxes that had been set up in the 1970s (Martínez Franzoni & Sánchez-Ancochea, 2016). In the overwhelming majority of countries, significant expansion of the social safety net did not occur until fiscal pressures had abated after the turn of the century.

Post-2000 Innovation

With the turn of the century, democracy was more consolidated in the region and fiscal pressures decreased. Left-wing parties began to win elections and form governments that enjoyed more fiscal room for action and less fear of political backlash (Huber & Stephens, 2012; Levitsky & Roberts, 2011). Some of these parties had proven that they were able to govern at the subnational level (Socialist Party and Party for Democracy in Chile, Broad Front in Uruguay, Peronist Party in Argentina, Workers' Party in Brazil). In addition, organized civil society began to push for changes after recovering from the repression suffered during the bureaucratic authoritarian regimes and the economic hardship that the debt crisis had brought (Silva, 2009). Finally, deindustrialization had spread economic insecurity and created a larger coalition of citizens favoring non-contributory programs and ready to support left governments in their efforts to build such programs (Carnes &

Mares, 2014). The rapid economic growth experienced between 2002 and 2012 allowed for spending on social protection, health, and education to increase, as shown in Table 1.

In this context, several countries saw significant expansion of the social safety net along with an improvement of benefits. A renewed role of the state was responsible for the expansion of social protection networks and social services to large segments of the population that had previously been excluded. Progress toward universalism, however, conceptualized as universal coverage with generous and equitable transfers and services (Martínez Franzoni & Sánchez- Ancochea, 2016), has varied across the region. A few countries implemented comprehensive reforms whereas most countries expanded coverage but kept unequal benefits for the different segments of the population (Hunter & Sugiyama, 2009). In terms of the expansion of formal coverage, there has been great progress, although with variation across countries. By 2008, workers' affiliation to the contributory pension systems was as high as 67.4% in Uruguay and 65.8% in Argentina, whereas it was only 8.9% in Paraguay and 13.1% in Bolivia (ECLAC, 2018). Moreover, in many countries, there was an expansion of benefits to informal workers. By 2010, non-contributory pensions for people 65 years and older outside the formal economy reached 97% in Argentina, 79% in Brazil, and 55% in Chile (ECLAC, 2018). The generosity of social benefits provided also varied, not only across countries but also within them across their populations.

Left governments accomplished larger coverage of the population and/or offered more generous benefits and spent more on social programs (Huber, Mustillo, & Stephens, 2008). The role of strong left-wing parties in government in expanding and improving social benefits was particularly relevant in Argentina, Brazil, Bolivia, Chile, and Uruguay. In other countries, such as Mexico, Colombia, and Peru, center and right-wing parties also expanded formal coverage, particularly in healthcare (Ewig, 2016), but funding for these programs remained low and thus de facto access did not keep pace with formal coverage (Ponce de Leon, 2018). Among left parties, those with closer ties to their organized social bases, such as unions, presided over bolder reform efforts than parties with a more professional-electoral character and a leadership that kept its distance from civil society, as exemplified by the contrast between the left in Uruguay and Chile (Pribble, 2013). Also, a mobilized civil society could push a variety of governments to improve benefits (Niedzwiecki, 2014) or be an important ally of left governments in passing redistributive programs, as happened with the Renta Dignidad in Bolivia (Anria & Niedzwiecki, 2016). An important development of the new century was the establishment of Conditional Cash Transfer (CCT) programs, probably the most widespread type of new program in the region. CCTs have great variation in coverage and generosity.

Uruguay had one of the most sweeping reforms toward universalism. The *Frente Amplio* (FA) reformed Uruguay's healthcare system in 2005, with the introduction of the state as the single payer and the creation of a unified fund that covers income and health risks (Pribble, 2013). In Chile, the *Concertación* implemented a partial reform of the healthcare system in 2002, Plan AUGE. AUGE brought an important expansion of benefits, achieving equality with guaranteed treatment for a specific set of illnesses. The *Partido Justicialista*

(PJ) in Argentina made the pension system public again, getting rid of the private tier and greatly expanding coverage (Arza, 2009; Niedzwiecki, 2014), whereas Chile reformed the fully privatized pension system by introducing a supplementary non-contributory public scheme with universalistic coverage. Bolivia introduced a public citizenship pension for anybody over 60 years old who is not in receipt of any social security or other state-financed pension. Only marginal reforms to the privileged pension schemes took place in Brazil, despite repeated attempts under different governments. However, the benefit levels in the non-contributory system were increased significantly under Lula, as they are tied to the minimum wage. Mexico and Peru also enacted healthcare reforms seeking to accomplish universalistic insurance coverage. But these reforms did not guarantee stable funding or a plan for infrastructure development, which hindered their progress in making access to services a reality (Ponce de Leon, 2018).

These differences in effort are reflected in the redistributive effects of the totality of taxes, transfers, and services at the end of the first decade of the 21st century. After direct income taxes and government transfers, Argentina, Brazil, and Uruguay reduced their Gini by 6% or more with regard to market income, whereas Mexico, Bolivia, and Peru reduced theirs by 4.5% or less. If the value of subsidized goods and services in education, health, and housing, minus copayments and user fees, is taken into account, the differences widen: Argentina, Brazil, and Uruguay reduced their Gini by 20% or more, compared to 14% or less for the other three countries. The most dramatic difference is in poverty reduction through direct taxes and transfers: Uruguay, Argentina, and Brazil reduced the poverty rate defined by US$2.50 PPP/day by 71%, 58%, and 26%, respectively, whereas the corresponding reduction in Mexico, Bolivia, and Peru was 15%, 10%, and 7% (Lustig, Pessino, & Scott, 2014).

Another area in social policy schemes where there has been some moderate progress is gender equity. The non-contributory pension schemes include women in their own right, not as dependents of their husbands. In contributory pension schemes, Chile, Uruguay, and Bolivia introduced bonuses for each live-born child in recognition of maternity and unpaid care work (ECLAC, 2018). The CCT programs have put money in the hands of millions of mothers. These reforms as a whole have contributed to a process of women’s economic empowerment by giving women access to income of their own. The more fundamental dynamic in women’s economic empowerment, which began in the 1990s, was increasing women’s labor force participation, but social transfers were important for the poorer sectors (Filgueira & Martínez Franzoni, 2017). Left governments did not prioritize gender equality as they were reactive rather than proactive, reacting to feminist mobilization, but left governments and left competition did provide more support for policy initiatives promoting gender equity (Blofield, Ewig, & Piscopo, 2017). By prioritizing redistribution across class lines, left parties provided better services and transfers and targeted a broader base than non-left governments. This meant that poor women received more resources and services, which strengthened their economic autonomy (Filgueira & Martínez Franzoni, 2017).

Work-family conciliation policies have begun to attract attention as well. Maternity or paternity leave policies were expanded in many countries, though the latter have remained minimal (Blofield, 2016). Similarly, expansion of early childhood education and care has been on the agenda. Coverage has expanded most for the immediate pre-school age, but services are mostly part-time. Coverage for infants to 3-year-olds has remained more limited and of greatly varying quality, depending on the qualifications required of providers. Comparable figures on coverage and quality are lacking (Filgueira & Martínez Franzoni, 2017), but particularly ambitious plans were adopted by the left governments in Uruguay and Chile.

The efforts to expand healthcare and education spending, and particularly the expansion of CCT programs, have raised the question as to whether Latin American countries have joined the turn to social investment, or from redistribution to predistribution, a path charted by some of the most advanced welfare states in Europe (Chwalisz & Diamond, 2015; Hemerijck, 2017). The situation in Latin America is essentially different in that the safety nets for at least the lower two-thirds of the population are not nearly strong enough to allow for an effort in shifting away from them. Investment in education has not brought the desired effects in the context of high levels of poverty and inequality (Huber & Stephens, 2018). The CCTs are a step in the right direction in that they contribute to alleviating the severity of poverty and enhancing school attendance, but in many cases the investment that would be required to enhance the quality of education for students from poor families is not forthcoming (Huber, Dunn, & Stephens, 2018).

Turn to the Right

With the slowdown of economic growth in 2012, the increase in social spending also decelerated. In some cases, social expenditure became stagnant or even decreased, as did progress in reducing poverty and inequality (Tables 1, 2, and 3). This decade also brought an important political change in the region, the new electoral success of right-wing parties in countries like Chile (in 2010 and 2018), Argentina (in 2015), and Brazil (in 2018), and the consolidation of the right in countries like Colombia, Peru, and—up until the election of López-Obrador in 2018—Mexico. In the countries where the left governments had achieved the expansion of social safety nets, the right-wing candidates promised to protect such achievements during the electoral campaigns. Once in government the right generally kept their promises and maintained and, in a few cases even expanded, the benefits the previous governments had provided (Fairfield & Garay, 2017; Niedzwiecki & Pribble, 2017).

In contrast to the neoliberal reforms of the 1990s that sought to dismantle social security systems, the right did not attempt to privatize the systems, nor did they implement steep financial cuts. On the whole, a mixed picture has come into view, with a few rollbacks and a general maintenance or partial expansion of the benefits in place. In Chile, the government of Sebastián Piñera, leader of National Renovation, increased the number of illnesses covered by AUGE and expanded maternity leave, while at the same time strengthening

the role of the private sector. Mauricio Macri's administration in Argentina expanded CCTs, although the real value of the transfers decreased given a context of high inflation and the price increases in essential services. In Brazil, although Michel Temer's government increased the amount of the benefits provided via Bolsa Familia, the program experienced financial cuts and a significant purge of the rolls of families entitled to the benefit. Moreover, the Brazilian national healthcare system (SUS) experienced spending cuts (Martins, 2018). While there was some minor expansion, in none of these cases were there major policy innovations leading to the improvement of services (Etchemendy, 2017; Niedzwiecki & Pribble, 2017).

These actions on the part of right-wing governments can be explained as a result of two mechanisms. The first are policy feedback effects. Once welfare state programs with wide coverage are established, they become very popular and therefore it is politically very costly to cut them (Huber & Stephens, 2001; Pierson, 1996). Further expansion of benefits can also be explained with electoral competition for the votes of people in the informal sector and with pressures from mobilized popular groups (Fairfield & Garay, 2017; Garay, 2016; Niedzwiecki & Pribble, 2017).

The path taken in the countries where the right has maintained dominance appears similar, but the financial commitments have remained significantly below those of left governments. In Colombia, the 1993 healthcare reform that increased the population formally covered from less than 25% to over 86% by 2010 (Ewig, 2016) continued during the Santos administration, with formal protection reaching approximately 96% by 2016 (Lamprea & García, 2016). There was also expansion of coverage of non-contributory pensions. However, social expenditures in Colombia did not increase significantly until after 2010, after Santos fell out with his predecessor Uribe and became seriously involved in peace negotiations with the guerrillas (Table 1). In Mexico, although formal healthcare protection has also continued to grow, reaching 93% by 2016, public health expenditure has suffered minor reductions, and social spending as a whole has remained very low (Table 1). In Peru, similar to Mexico, the growth in formal coverage has been accompanied by reductions in public expenditure, and overall social expenditures in Peru remain very low (Table 1). One of the most pressing problems these three countries share is that the rapid expansion of formal protection has not been paralleled by material access to health services, particularly in the poorest regions and departments.

Conclusion

Latin American welfare states have undergone major changes over the past half century. As of 1980, there were only a handful of countries with social policy regimes that covered more than half of their population. Access to social protection and to healthcare in these countries was based on formal employment and contributions from employees and employers. There were very few and poorly funded programs for those without formal sector jobs and their dependents. After shrinking further in coverage and generosity in the last

two decades of the 20th century, Latin American welfare states have generally expanded in the 21st century.

The most significant innovation has been expansion of coverage to people in the informal sector and to people with insufficient histories of contributions to social insurance schemes. The overwhelming majority of Latin Americans now have the right to some kind of cash assistance at some point in their lives and to healthcare provided by their governments. In many cases, there have also been real improvements in the generosity of cash assistance, particularly in the case of non-contributory pensions, and in the quality of healthcare services. However, the least progress has been made toward equity. With very few exceptions, new non-contributory programs were added to the traditional contributory ones, and severe inequities continue to exist in the quality of services provided through the new and the traditional programs. The main exceptions here are Uruguay and Costa Rica, as the former unified payments to public and private healthcare providers and the latter maintained the unified public healthcare system. Significant progress was also made in Chile with guaranteed treatment for a specific set of illnesses and payment according to income. In the area of pensions, the greatest advances toward equity are the universalistic pension scheme in Bolivia and the supplementary public schemes in Chile.

So what are the obstacles in the way of achieving greater equity? In some countries, there would be some fiscal room to redistribute resources from privileged to general schemes. This applies to some of the privileged public sector pension schemes in Brazil, for instance, or to the private healthcare scheme in Chile. Both kinds of reforms have been tried but failed because of strong resistance from the beneficiaries of the privileged pension schemes in Brazil and from beneficiaries and private providers of healthcare and their right-wing party allies in Chile.

The other path to equity is via increased taxes and expenditures on the programs that are of lesser quality. There is significant room for maneuvering there, as Latin American countries continue to have lower tax revenue than countries at similar levels of economic development in other regions, with the exception of Brazil and Argentina, which stand out in terms of the total tax burden (Ondetti, 2015). In particular, income and property taxes continue to be very low in Latin America (Mahon, Bergman, & Arnson, 2015). However, the problem here is political resistance as well. In countries where a significant portion of the middle and upper-middle classes have opted for private health insurance and private education, these groups have little tolerance for tax increases to improve public education and health services. As Holland and Schneider (2017) aptly put it, improving equity in transfers and services requires a transition from the “easy” stage of redistribution to the “hard” stage. This transition, in turn, requires strong political coalitions based on strong political parties with a commitment to equity, capable of governing well, and of socializing significant sectors into the values of equity and solidarity. And here the scenario looks rather bleak, with the Chilean left parties being uprooted (Luna & Altman, 2011), the Workers’ Party in Brazil in crisis in the wake of corruption scandals, and party fragmentation proliferating in countries like Costa Rica.

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