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SOCIAL POLICY INTERVENTIONS AND HEALTH

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Among the poorest nations, economic development is critically important for health (Preston 1976). In these nations, income provides a means to purchase food, cleaner water, and basic medicines. By overcoming hunger and infectious disease, a nation can greatly reduce mortality, especially among children. This probably explains why small changes in national per capita gross domestic product are associated with large increases in life expectancy in the poorest nations. However, once a nation's gross national income exceeds about US $5,000 per capita (adjusting for purchasing power parity), the relationship between income and life expectancy becomes less straightforward. In richer nations, social services – such as schools, health, transit, and safety net programmes – probably matter more for health (Schoeni *et al.* 2008). These services provide buffers that allow people to live in safer homes, be on safer roads, live with less stress, exercise more, and eat more healthfully.

In middle- and high-income nations, many of the social policy interventions that make the greatest impact on health lie outside the health care system (Muennig *et al.* 2010). Because middle-income nations are generally faced with the challenge of conquering chronic diseases rather than infectious diseases and hunger, many experts believe that we should again turn to structural, non-medical policies in the hope that we can realize similar success (Marmot and Wilkinson 2006; Schoeni *et al.* 2008).

These policies include enhancements to schooling or other social welfare programmes. One idea that has gained traction is to couple welfare payments to classroom attendance and receiving regular medical care, a concept known as conditional cash transfers (Adato *et al.* 2011; Cueto 2009; Fernald *et al.* 2008; Paes-Sousa *et al.* 2011). At first glance, social policies such as payments for primary school attendance may not seem as closely linked to health as clean water, but they may provide the next major boost to life expectancy among many nations tackling chronic diseases.

Such social policies can take very broad forms. Even democracy itself is thought to be lifesaving. The Nobel Prize-winning economist Amartya Sen declared that famine is rare in a functioning democracy because mass starvation is not good for anyone's political career (Sen 1999). Likewise, democracy provides a means for people to demand lifesaving programmes, such as better schools, roads, and access to medical care.

In this chapter, we discuss several prominent cases of social policy interventions at least partly aimed at improving health outcomes. We focus on conditional cash transfers, participatory budgeting, and governance and administrative innovations in Brazil,

comprehensive early childhood development services in the United Kingdom (UK), and changes to the built environment in New York and San Francisco. We weigh the evidence on the impact of these interventions and the conditions in which they work best, and we conclude with some potential lessons for practice and research.

A rise in targeted social policy interventions

Innovative social policy reforms have proliferated and gained prominence in public policy debates since the 1990s. Latin American cases have dominated many of these debates for several reasons. First, many of the largest economies in the region – Brazil, Argentina, and Chile, for example – returned to democratic governance after military dictatorships (Shifter 2009: 55). Second, the structural adjustment crises of the 1980s that ravaged South America highlighted the importance of sustainable social programmes to policymakers. Third, some economists had previously conceptualized social programmes as arising from economic growth rather than contributors to economic growth, but prevailing opinions began to recognize the importance of both pathways (Bloom *et al.* 2004; Sachs 2002; Waitzkin 2003). Fourth, there was growing awareness that steep wealth inequalities could lead to civil unrest (Blattman and Miguel 2010; Collier *et al.* 2003). Finally, the rise of China led to a demand-driven commodity boom that benefited Latin America economically, opening the door to more expensive, innovative social programmes (Nelson 2011).

Of course, this is not to say that innovative policy interventions are not happening elsewhere. Indeed, we reference cases from other low- and middle-income countries, such as India, and from industrialized nations such as the UK.

Conditional cash transfers

Child-centred conditional cash transfers (CCTs) attempt to simultaneously promote poverty alleviation and civic responsibility in the short term and investment in human capital in the longer term. In CCT programmes, families receive monthly cash payments if they meet certain behavioural criteria, such as sending their primary school-age children to school on more than 85 per cent of school days, complying with prenatal visits to clinics, and having their children receive recommended vaccinations.

For instance, Brazil's Bolsa Família began in rural areas, when local governments simultaneously extended after-school programmes and paid families with 5- to 16-year-old children to keep them in school all day, rather than have them work in degrading or hazardous conditions. Other components of Bolsa Família ask that pregnant women attend prenatal medical check-ups, complete immunizations for their children, and breastfeed. In Mexico, additional food cash transfers are given after families attend nutrition seminars.

Mexico's Oportunidades programme (formerly known as Progresa, and the first nation-wide programme of this kind) and Brazil's Bolsa Família are among the largest and most well-known CCT programmes. Bolsa Família alone reached 11 million families, or 46 million people, in 2006 (Lindert *et al.* 2006; Soares *et al.* 2010), affecting 100 per cent of Brazil's poor and 25 per cent of the entire population at the time. Other countries with CCTs include Bolivia, Colombia, Jamaica, and Nicaragua (Lund *et al.* 2010; Soares *et al.* 2009).

Currently, in Bolsa Família, poor families receive monthly benefits of 140 reals (US $88.60), plus 32 reals per child aged 15 or younger for up to three children. For teenagers aged 16 to 17, families receive 32 reals (US $21) a month for up to two teenagers. Families with incomes below the extreme poverty line receive additional cash transfers of 70 reals (US $44.30). Thus, a very poor family with three children and two teenagers would receive 242 reals (US $153) (Soares 2011). As a point of comparison, the current minimum wage is 545 reals a month (US $344).

These programmes have yielded some impressive outcomes. After the implementation of Bolsa Família, Brazil's poverty rate fell from 39 per cent in 2001 to 25 per cent in 2009 – the lowest rate in decades – and overall income inequalities also fell (ECLAC 2010). Secondary school enrolment increased by 13 per cent, from 69 per cent in 2000 to 82 per cent in 2008 (Loyka 2011). A growing number of Asian, African, and North American governments have followed suit (Schubert and Slater 2006). The CCT programmes' key features appear to be their eligibility rules, coordination with supply-side increases in funding of public services, and administrative structures and transparency.

Eligibility and conditionalities

The programmes' eligibility rules are tied to certain conditions. First, all eligible families must be poor. Brazil's Bolsa Família considers only household income in determining eligibility. This is challenging because many beneficiaries work in the informal sector, so they do not report their income to the government. In Mexico and Chile, social workers use an index to determine eligibility (Soares *et al.* 2009). Chile's Solidario programme is aimed at the indigent, the poorest 225,000 families in the nation.

Solidario builds upon the premise that many indigent families do not access public services partly because they face discrimination, lack information, and lack a sense of agency; social workers can help to remedy this by relying more on judgement than workers in Mexico. However, eligibility requirements, including possession of birth certificates, proof of citizenship, marriage certificates and divorce decrees, employment-related requirements, and unemployment affidavits, can increase barriers to access. These barriers to entry often come with high opportunity costs and have been more common in more recent programmes, such as one in the Western Cape in South Africa (Lund *et al.* 2010).

In 2009, Bolsa Família revised its coverage target from 11.1 million to 12.9 million families, despite the fact that poverty rates had fallen. In doing so, it expanded the programme's eligibility criteria and working definition of poverty: a family was poor even if its income exceeded thresholds as long as its income was volatile and risked falling below the poverty threshold in a two-year period (Soares 2011).

Access to social services

In Brazil, if families do not meet conditionalities – the things they are required to do to receive benefits – they go through five stages of warnings and suspensions before benefits cease. Even then, under-16-year-old children are not affected, and the warnings trigger a social worker visit to such families. For example, if a 16-year-old has partly missed school because he/she was caring for a younger sibling after their mother got a

new job, the social worker helps the family attain alternate childcare. The programme emphasizes opportunities for greater well-being, rather than punitive measures for poor performance.

Mexico's CCTs operate similarly to Brazil's and Chile's, though they give more generous conditional scholarships to upper secondary school students. As a point of comparison, the CCT ceiling for a very poor family with two teenagers was US $239 in Mexico in 2007, US $91 (adjusting for purchasing power parity) in Brazil in 2003, and just US $33 in Chile in 2003 (Soares *et al.* 2009).

Chile's Solidario programme may seem stingy at first glance. However, it combines CCTs with unconditional family subsidies for the very poor, potable water subsidies (in a country where water provision is privatized in many areas), disability and pension subsidies, and greater access to social services. Chile's Solidario attempts to tackle social exclusion by mandating that social workers collaborate with families to develop action plans for access to employment and domestic violence programmes that may fall outside the parameters of bigger CCT programmes. The amount of the CCT is calculated to ensure that the families can afford a certain basket of goods, amenities, and services below which they would be considered socially excluded. The CCT amount decreases and then ceases over a two-year period. Families are then given a graduation bonus and preferential treatment in accessing social services for another three years.

Transparent administration

Brazil's Bolsa Família was able to achieve notable outcomes because it learned from its mistakes. For instance, its 2003 food subsidy programme quickly lost support because it was seen as too bureaucratic; beneficiaries had to provide proof of their purchases to local managers, leading to barriers to access and heavy administrative costs. As a result, the Brazilian government unified all welfare programmes under Bolsa Família and encouraged civil society to participate (De Janvry *et al.* 2006). The government also coordinated the programme with the Departments of Education and Health (Lindert *et al.* 2006).

The central government now bypasses the country's 27 governors and the legislative branch, working with executive branch agencies and municipal agencies instead. Municipal governments must register families and transfer data to individual ministries (such as that of education). A fully updated and accurate registry earns the town a high 'decentralized management index' score, which then translates into more funds from the central government each month. The local government has general guidelines but considerable discretion on how to spend this money. This way, the national government ensures cooperation by simultaneously mandating responsibilities and providing incentives and funding to municipal governments.

In many traditional welfare programmes, street-level bureaucrats and social workers perform surveillance over beneficiaries, but there is little bottom-up or peer accountability. In contrast, the money in Bolsa Família is given directly to the households via 'Citizen Cards' mailed to each residence. Families use the Citizen Card as they would any debit card, withdrawing money at any ATM belonging to Caixa Econômica Federal, a government-owned savings bank. Further, an online portal publishes names of all persons enrolled in the programme and their CCT amounts. The federal government

also launched a single household database to combine all beneficiary databases for all social programmes, including gas, electricity, and food subsidies, Bolsa Família, and youth employment (De la Brière and Lindert 2003).

Outcomes

The amounts transferred to each family are quite modest, totalling extremely small amounts of the GDP in Chile to roughly 0.5 per cent of total GDP in Brazil and Mexico. Nevertheless, these programmes have reduced income inequalities in all three countries (Soares *et al.* 2009). This suggests that when CCT programmes achieve both good targeting and scale, they can be cost-effective poverty eradication policies.

While Brazil's Bolsa Família lowered child labour rates, it *raised* adult labour force participation rates, especially among women (Soares *et al.* 2010). This counters arguments by some critics, including the Brazilian Catholic Church, that the subsidies act as handouts that 'disincentivize' work. It remains unclear the extent to which adults are partly making up for the pay their children no longer earn.

As discussed above, better education translates into greater abilities to earn a living, make choices that yield longer-term benefits, and be informed citizens. Bolsa Família made the greatest difference for students in north-eastern Brazil (the country's poorest region), older students aged between 15 and 17, and girls. Female beneficiary students aged 15 to 17 in north-eastern Brazil were 28 per cent more likely to stay in school (Soares 2011).

In Mexico, Oportunidades increased school enrolment and lowered dropout rates, but it also lowered academic performance because low-achieving students became more likely to stay in school (Soares *et al.* 2010). It is hoped that these students still accrue many of the labour market benefits of having a high school degree, but it remains unclear whether the poorer performers are impacting the performance of the other students.

Hopefully, these changes improve health outcomes in the longer term, promote greater social cohesion and socioeconomic security, and reduce material deprivation. In terms of more immediate health outcomes, newborns of beneficiary pregnant women in Oportunidates were 14 per cent more likely to experience longer gestations (fewer premature births), and beneficiary children were 39 per cent more likely to avoid malnutrition and achieve normal body mass index scores (Soares 2011). Nutritional supplements are sometimes shared by everyone in the household, possibly diminishing returns to children under five (Lund *et al.* 2010). This contrasts with the experiences of Mexico and Colombia, where all beneficiaries under the age of two became significantly less likely to suffer from stunting (Soares *et al.* 2010). It is unclear exactly what local circumstances – advice on preventing malnutrition, monitoring by health clinicians, governance, culture, and so on – made the difference.

There were also some notable failures. For instance, Bolsa Família's cash payments for vaccinations among children did not seem to improve immunization rates, possibly because vaccination services were not available in some localities. In contrast, immunizations rose dramatically in Colombia and Mexico, where payments were only made within localities that actually offered such services. In Ecuador, the first few years of CCTs were actually unconditional in municipalities where adequate services provision and monitoring had not yet been set up (Soares *et al.* 2010).

Remaining problems

These promising but mixed results hint at several important issues. First, payments only work when quality services are available. For example, payments for school attendance, the cornerstone of Latin American CCT programmes, would not make a difference in educational achievement in South Africa, where 8-year-olds achieve an astounding 98 per cent average attendance rate (Lund *et al.* 2010). However, in Kenya, where attendance is low, covering the cost of a school uniform increased attendance by 6.4 per cent and reduced dropout rates and teenage pregnancy rates among girls (Glennerster and Kremer 2011; Kremer *et al.* 2004).

Opportunity NYC, the New York City programme that ran from 2007 to 2010, focused on education, health, and work CCTs. In the randomized control trial, beneficiary families received an average of US $3,000 a year, and CCTs decreased poverty by 8 per cent and extreme poverty by almost half. Programmes that linked poor families to existing institutions and provided intensive guidance were quite successful. The most dramatic health outcome lay in a 10 per cent increase in dental visits to two per year. Still, other outcomes were small; beneficiaries were 2 per cent more likely to hold health insurance (from unusually high baseline rates) and 3 per cent more likely to have been treated for a medical condition (Riccio 2010). This is probably related to the higher baseline rate of health insurance in both groups.

Second, governments recognize that the poverty lines do not accurately differentiate the poor from the non-poor. This is a problem that led to public scrutiny of Brazil's Bolsa Família. In 2011, President Dilma Rousseff announced a new 'Brazil without Misery' programme aimed at eliminating indigent poverty by 2014. This will resemble Chile's Solidario programme, developing more comprehensive action plans for the poorest. Ideally, this would expand the pool of beneficiaries to further move Brazil toward a society with a guaranteed basic income.

Third, policymakers are uncertain about the full range of desirable habits that can or should be shaped via conditionalities. Newer proposed conditionalities to tie cash payments to school achievement scores have been controversial. Mandatory 'volunteering' in the community has also been attempted; however, not only is mandatory volunteering oxymoronic, it risks stigmatizing welfare beneficiaries and real volunteers alike.

Such political questions plagued Opportunity NYC as well, which was criticized by conservatives for 'bribing' poor people to do what they should do anyway. Liberals also criticized it for attempting to correct individuals' 'poor values' in a 'culture of poverty' without adequately addressing larger structural inequalities. Student beneficiaries were 15 per cent more likely to have attendance rates of 95 per cent or better, but conditionalities tied to outcomes (such as high achievement scores), rather than participation in activities, yielded few results. In one case, thousands of students protested a dearth of college preparatory and Advanced Placement (AP) classes even as programmes offered US $1,000 bonuses to Latino or Black students who scored perfectly on AP exams (Su 2010). Few single mothers in the programme were able to maintain a job and attend a skills-building course, despite the US $3,000 bonus. Childcare problems, the Great Recession, high unemployment, and the lack of suitable courses were all notable problems. In other cases, full-time workers who met all conditionalities were still unable to raise themselves out of poverty, for their jobs did not pay living wages (Goldstein 2009; Riccio 2010).

Finally, political and social context also matters. Conditionalities that help adolescents stay in school rather than work full-time in hazardous conditions might be more appropriate in Brazil than in the United States (US), where students are more likely to drop out for different reasons. A programme that gave mothers in Rajasthan, India a kilogram of lentils each time their children received vaccines raised immunization rates from 5 per cent to 38 per cent (Glennerster and Kremer 2011), but these conditional lentil transfers would hardly work in other middle-income countries. (For one, in our humble opinion, American lentil soup is much less tasty than Indian daal.)

South African welfare programmes have a history of using so-called 'conditions' that are not easily monitored and act as normative injunctions, i.e. that the child must be 'properly' clothed. At the same time, these welfare benefits are often meagre, so that parents struggle to meet conditions. Further, past conditionalities demanded that families participated in 'livelihood activities' in neighbourhoods where such projects did not exist (Lund *et al.* 2010).

Getting at education early

Sizeable income-related gaps in cognitive development are often present in children even before they attend school (Hart and Risley 1992). Children from poorer families tend to enter kindergarten far behind their peers with respect to vocabulary and math skills, making it much more difficult to catch up. This gap appears to be primarily attributable to changeable factors, such as maternal health and parenting styles (Waldfogel and Washbrook 2011). One idea, then, is for governments to enhance these skills for the very poorest children, and to help parents (for instance, those with two jobs) cope with the demands of parenting.

There is evidence that such programmes not only improve earnings once the children grow up, but also reduce criminal behaviour, improve health, and reduce the use of social services (Belfield *et al.* 2006; Muennig *et al.* 2009; Muennig *et al.* 2011). In fact, in the US, one programme was shown in a small randomized trial to produce a net benefit of US $1 million dollars over the lifetime of every child in the experimental group.

Sure Start Children's Centres in the UK attempt to address health disparities by offering services aimed at young children and their families. It has some similarities to Ontario's Early Years Plan in Canada and Head Start in the US. However, Sure Start is more comprehensive than Head Start. In addition to creating children's centres, the British government more generally revamped social service programmes to (1) make work pay; (2) raise incomes for families with children; and (3) invest in children's services (Waldfogel 2010).

The first component of the UK programmes, making work pay, consisted of establishing a national minimum wage and rendering tax rates more progressive by lower payroll tax rates for low-income earners. It also established a Working Families Tax Credit. This is similar to the Earned Income Tax Credit in the US, which provides income supplementation for workers in low-wage jobs. The second component of the anti-poverty strategy expands on this family-based supplemental income approach by increasing New Child Tax Credits, grants to children under ten years, and other child benefits. There were also reductions in primary school class sizes, increases in education spending, and an increase in the minimum school-leaving age from 16 to 18. The most prominent aspect of the campaign probably lay in the Sure Start Children's Centres (Waldfogel 2010).

Between 2002 and 2004, the UK opened 500 Children's Centres serving around 800 children each. These centres ran independently of local governments and received funds so rapidly that only 9 per cent of 1999 moneys were spent that year. In 2005, control of the Centres was transferred from central to local governments (Melhuish *et al.* 2010).

Between 1999 and 2008, the UK experienced a 50 per cent drop in children's poverty. Health outcomes associated with the programmes included improved mental health and school performance among adolescents in single-parent households, a dramatic increase in the consumption of fresh fruits, and decreased spending on tobacco and alcohol by parents (Waldfogel 2010). The implementation of these social programmes was also associated with increased numeracy and literacy among children. Interestingly, outcomes for parenting behaviour, especially in dealing with children's noncompliance, violence, and aggression, were positive and statistically significant in more strictly implemented settings, such as randomized control trials in Wales (Hutchings *et al.* 2007). Outcomes overall were modest or negligible in 2005 but more pronounced in 2008, suggesting that Sure Start programmes improved over time (Mackenbach 2010; Melhuish *et al.* 2010). Though they appeared to be largely successful, the British government announced an end to many of these programmes and reductions in others due to massive deficits from the Great Recession (Ramesh and Gentleman 2011).

Innovations in the built environment

Health insurance status appears to play little role in explaining the massive health disparities according to race, education, income, and region within non-poor societies (Muennig *et al.* 2010). For example, Asian-American women in Bergen County, New Jersey in the US live to an average of 91 years, while Native American men in the Dakotas live to an average of 58 years – a 33-year gap in life expectancy. These differences largely persist after holding constant health insurance status and excluding HIV and homicide. Further, the ten leading risk factors for poor health outcomes in the US (smoking, obesity, high blood pressure, illicit drug use, unsafe sex, etc.) cumulatively only account for 30 per cent of disease among men in the US (Murray *et al.* 2006), and do not appear to explain international changes in life expectancy over time (Muennig and Glied 2010). In response, an increasing number of city planners see that public transit, housing, economic development legislation, zoning, and other aspects of the built environment help to determine how, and how long, residents live.

For instance, New York City embarked upon a multi-pronged approach of giving away free bicycling gear (lights, helmets, and maps), promoting bicycling through advertising, and building (or painting green) 390 miles of new bicycle lanes between 2002 and 2010. By 2011, the number of commuter bicyclists in New York City had risen by 62 per cent since 2008 and 262 per cent since 2000 (O'Grady 2011). While progress was sometimes slowed by a lack of community input, resulting in backlash, the overwhelming majority of new bicycle lanes have been implemented without incident and widely adopted by local residents.

Nevertheless, New York remains behind cities such as Barcelona, Spain; Paris, France; London, England; and for that matter, Curitiba, Brazil; and Hangzhou, China, in promoting transportation alternatives to cars. In those cities, individuals who cannot afford to buy a bicycle (or worry about it getting stolen) can still cheaply rent bicycles at stations conveniently located at public transit stations. Congestion pricing also heavily

taxes cars. Both citywide changes, especially in zoning and the promotion of mixed-use and dense areas, and individual-based incentive programmes appear to be essential in encouraging population-wide lifestyle changes (Appleyard *et al.* 2007; Goldman and Gorham 2006).

San Francisco has attempted to tackle health disparities by changing the built environment in other ways (City and County of San Francisco 2010). In the mid to late 1990s, the Bay Area experienced a housing boom because of Silicon Valley and Internet-related industry. The housing pressures persisted even during the economic recession of the 2000s. In response, community organizations struggled to address persistent health disparities (especially in conditions such as asthma and lead poisoning) caused by unsafe housing, proximity to toxic industrial spaces and hazardous land use, and lack of access to public transit, amenities, and good jobs. By 2001, the city had begun to use Health Impact Assessments (HIAs) of proposed built environment developments such as new condominium towers at Rincon Hill, an intra-urban freeway in the Excelsior neighbourhood, and redevelopment of two federal public housing sites. Whenever possible, the Department of Public Health attempted to mandate HIAs alongside the government's or private developer's more typical cost–benefit analyses and environmental impact assessments (Corburn 2009).

In 2004, the city worked to consolidate lessons from different HIAs. It forwarded a Strategic Plan to tackle four priority social determinants: (1) low socioeconomic status; (2) social isolation; (3) institutional racism (including racial disparities regarding the locations of sewage treatment plants, hazardous lots, amenities like public parks and well-funded schools, and well-stocked produce suppliers); and (4) transportation. By 2007, they had developed the Healthy Development Measurement Tool, a comprehensive evaluation metric for all cities and neighbourhoods to use themselves in considering health needs in urban development. The tool includes six key elements, 28 objectives, and 125 indicators. For example, the 'Healthy Economy' key element has four objectives, such as 'Increase high-quality employment opportunities for local residents'. This particular objective has four indicators, including 'jobs paying wages greater than or equal to the self-sufficiency wage'. Each of these indicators then comes with a table on the exact local 'self-sufficiency wages', as well as how they were calculated, so that policymakers in other cities can calculate their own.

Innovations in administration and governance

As the Bolsa Família case suggests, good governance is an integral component of many innovative social policy interventions. Indeed, there has also been a growth in experimental governance structures in the past two decades (De Sousa Santos 2005; Fung *et al.* 2003). Here, we briefly discuss two governance cases: Ceará state in Brazil, where the state government bolstered a preventive care programme by bypassing local governments and strengthening civil society instead; and the city of Porto Alegre, Brazil, where city residents decide annual city budgets themselves, instead of leaving them up to elected city officials.

In 1987, the Ceará state government launched a new health worker programme that managed to lower infant mortality by 36 per cent, triple immunization rates, and almost quadruple the number of municipalities with nurse access – all in just five years, and all with low-paid, unskilled health workers. It managed to do so by coordinating health

worker salaries and the recruitment process via the state capital. This way, local mayors could not distribute these funds or jobs via their patronage networks. It also won over local nurses (the main point of resistance because their jobs were threatened by low-wage workers) by giving them considerable training and supervisory powers over these new health workers. Finally, it launched massive publicity campaigns that encouraged the community, including the many applicants who did not receive the jobs, to respect these new health worker public servants, and to hold them accountable via evaluations. All of the public servants felt both pressure to perform well and newfound prestige, despite their low pay. And they succeeded, often performing tasks beyond those formally prescribed. This case runs contrary to what decentralization and privatization proponents would have expected. The state government actually increased its involvement in public programmes, but it was able to reap some of the typical benefits of decentralization, such as knowledge of local contexts, by empowering local communities to hold civil servants accountable (Tendler 1997).

Another approach is to include public participation in developing local budgets. Porto Alegre began its first participatory budgeting process in 1989. Participatory budgeting is a process in which people within a community – rather than elite policymakers – help to determine how government funds are spent. In Porto Alegre, a city of roughly 1.5 million people, a disproportionate percentage of government funds historically went to middle- and upper-class neighbourhoods. This was true even as slums continued to lack access to potable water and other amenities.

The participatory budgeting process forced elected officials and roughly 50,000 residents to meet with one another and justify their budget priorities in public, deliberative assemblies. After hearing residents' concerns, delegates translated these concerns into specific programme and policy proposals. City officials, in turn, worked with these delegates to make the programmes and policies technically and financially feasible. The resulting budgets from this process are binding. After the process, the proportion of the city budget that went to poor districts and to basic public services rose dramatically (Baiocchi 2003).

Many of the middle- and upper-class residents who attended neighbourhood assemblies voted for projects in slum neighbourhoods rather than their own. As a result, sewer and electricity rates rose from 75 to 98 per cent, and the number of schools quadrupled. Health and education budgets increased from 13 to almost 40 per cent (Bhatnagar *et al.* 2003). An analysis of Brazil's 220 largest cities suggested that participatory budgeting is statistically significantly correlated with lower rates of extreme poverty (Boulding and Wampler 2010). Participatory budgeting has now spread to over 1,000 cities around the world – hundreds in Latin America and dozens in Europe, Africa, Asia, and North America. By building a more equitable distribution of lifesaving resources – such as water, sanitation, education, and public transit – it becomes possible to better tackle the health problems associated with poverty in such nations.

Concluding lessons

Social policy interventions are messy. However, tinkering with policies to make them better – as policymakers did with Bolsa Família, the Health Agent Programme in Ceará, and Sure Start in the UK – should not be viewed as a sign of dysfunction. In fact, the governments' responses to the criticisms ultimately rendered the programmes successful.

It is also important not to attempt to generalize successful programmes from one place across entirely different foreign contexts. Chile, Mexico, and Brazil all launched successful CCT programmes, but in very different ways: Brazil chose administrative decentralization and income as the sole criterion, Mexico chose centralization and a multidimentional poverty index, and Chile chose social worker empowerment and a multidimentional index (Soares *et al.* 2009). Real estate brokers' mantra of 'location, location, location' matters as much as in social policy as it does in housing markets.

Nevertheless, some themes emerge. In all of the successful cases, civil society and the state were mutually reinforcing rather than mutually exclusive. Decentralization only works if central governments have also worked to bypass corrupt networks in local governments, coordinated programmes, trained workers, and infused resources into the programmes. This increased funding might come about because of newly elected governments or systems of governance (like participatory budgeting), but it must be institutionalized in a transparent manner.

Structural approaches work best when they combine environmental changes and increases in public services with individual and family-based programmes like conditional cash transfers. Poor people's risky behaviours might change, but it takes a long time (and many synergistic policies) to shape health outcomes in sustained ways. Still, these cases ultimately demonstrate that thoughtfully designed social policy interventions are worth a shot; when they do work, they tackle the root causes of health disparities in ways medical approaches cannot.

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