

Contextual Politics of Service Delivery Reforms: Lessons from Delhi, Mexico City and São Paulo Comparison

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1 Introduction

The idea that policies of structural adjustment have to give way to a second wave of reforms oriented towards upgrading the provision of public services, especially for the poor and neglected portions of the population, has become a consensus among policymakers in the major international and multilateral agencies.¹ Decentralisation, pluralisation of providers and user participation have been consensually pinpointed as the most appropriate measures to produce the desired effects. While official documents from these agencies specify with caution that no one single model will fit all and that different combinations of these measures should be utilised according to national specifications (World Bank 2003: 10–18; Ahmad *et al.* 2005; Slack 2007), little attention has been given to the contextual politics of service delivery reforms.²

Efforts to systematically compare three different national contexts – India, Mexico and Brazil – show an extraordinary variation as to the degree, interests involved and meaning of changes which, in theory, correspond to these countries' commitment to the service delivery reforms agenda.³ Said variation is closely linked to political–institutional contexts and the histories of conflict, dealings and cooperation by which these institutions – as well as the most relevant organised social interests in a determined area of public policy – have been constructed.⁴ However, consideration of the contextual politics and, consequently, the empiric variation in the world is relevant not for its diversity alone but for the similarities that this diversity reveals, pointing to underlying analytic dimensions which deserve careful attention.

A few analytic dimensions are crucial in understanding service delivery reforms in the contexts studied here: the historical timing of local reforms and international consensus, the baselines of different sectors targeted by the reforms processes, and the degree and institutional locus of local discretion in policy as they relate to the federative arrangement as well as to the design of the policies to be implemented. The relation between national and sub-national regimes, and the role of field experts in the construction of the agendas of winning reforms as well as those of the opposition have also been demonstrated to be crucial, as they show contrasting patterns in the politics of reform at national, state and municipal or local levels. However, due to space limitations for this article, only the first dimensions will be examined. As such, we will focus on cases of reform in the healthcare sector and, to a lesser extent, the main policies in the social service sector – namely, the direct cash transfer programme in Mexico (Oportunidades) and the Public Distribution System in India (PDS).⁵ This article will examine the consequences of these cases in terms of their analytic implications in understanding the reforms.⁶

In India, Brazil and Mexico, the healthcare and social services sectors have been undergoing reform processes since the early 1990s, according to moderate estimations. Only in the latter case did the timing of the reforms coincide with a general perception that the healthcare sector was going through a financing crisis and, as a consequence, the federal administration adopted the most orthodox agenda. However, given the state of consolidation and development of sectorial baselines, the orthodox agenda clashed with corporate groups within the sector, and thus the

reform became irregular and came to a halt. In Brazil, the discrepancy was the highest, and a lack of international consensus combined with an urgency for measures to resolve financial crisis favoured processes of institutional innovation. However paradoxical it may seem, these processes combined circumstantial affinities between the military government – with its tendency to administrative rationalisation and capacity to impose losses – and the *Sanitarista* movement, engaged in the democratisation and universalisation of healthcare. In India, the crisis took place only a few years before the start of the reforms. This fact reinforced the traditional emphasis that the healthcare system tended to place on family planning, largely supported by international financial sources. While social actors tend to concentrate themselves on programmes in this strategic policy field, the reforms of the 1990s aimed to address the fragmentation and underdevelopment of the system. It did so in two different ways: by setting up economic regulations and by encouraging a concentration of private providers (capital), so as to enhance the complexity of the services offered by the market.

The federative arrangements in the three countries differ considerably, conferring greater attributions and capacities for bargaining and decision making upon the different levels of government. On the other hand, in national reform policies, the degrees and institutional loci of discretion at the local level vary in relation to each sector and its most relevant actors, but also depending on how they are embedded in federative arrangements. In India, despite the slow growth of local government bodies, its attributions are still limited and its weight inexpressive in the dispute for agenda and implementation of reform policies, while states enjoy notable autonomy, limiting the union's capacity to the use of fairly inductive strategies. In Brazil, recognition of municipalities as autonomous members of the federative pact has changed the federal government's capacities to negotiate the implementation of policy. This has paradoxically led national political leaders to adopt centralised strategies of direct budgetary transfers to municipalities in order to cultivate their adhesion to federal policy preferences. Mexico occupies an intermediate position. On the one hand, municipalities enjoy a constitutionally autonomous status and attributions but they are subordinate to the states; on the other hand, bargaining for the definition and implementation of reforms occurs

between the federal and state governments. Still, given the strong centralism in the Mexican federative arrangement, traditionally, the states have diverged from the centre less than in India.

In this way, the direct cash transfer programme, *Oportunidades*, in Mexico, was purposely designed from the centre to avoid any intermediation between beneficiaries and the state, but the attempt, revealing as it is, showed itself to be unviable and allowed for the political use of the programme by intermediaries both old and new. The implementation of healthcare reform in Brazil and, more specifically, the construction of a national and universal basic healthcare system, resorted to a strategy (*Programa de Saúde da Família* or Family Health Program, PSF) defined in a highly centralised way, decentralised to the local level for its execution. In India, states with universal food distribution programmes opposed the targeting of PDS, and the local government bodies do not seem to have taken on a relevant role in visibility or assisting the complaints of the population victimised by the grain distributors.

2 Two crucial dimensions of analysis

There are two dimensions of analysis which have enormous relevance in understanding the reach and effectiveness of service delivery reforms which have not received systematic attention: (1) the historical timing of reforms and sectorial baselines, and (2) the degree and institutional locus of local discretion in policy. These dimensions clearly reference contextual politics and comprehend certain conditional factors of the reforms, which prompt a surprising variation of combinations in which decentralisation, pluralisation and participation are allied in the process of service provision reforms, producing diverse results. This variation indicates vulnerable points in the presumptions of the reforms in question (see Joshi, this *IDS Bulletin*), as well as serious gaps in the understanding of the reform process itself.

2.1 Historical timing of reforms and sectorial baselines

The idea of a second wave of reforms is indeed suggestive, since the ocean metaphor refers to the exhausted effects of a first set of reforms, as well as the vigorous advance of a new consensus spreading out to various latitudes. Yet, with an attentive eye on both the historical timing of the reforms and the sectorial baselines that condition them, one can see an extraordinary variation in both the possible

choices and the real adopted proposals. This variation indicates a low adherence of the standard international accounts of service delivery reforms to the real world. In national literatures, one may also find a curious phenomenon, an embodiment of these undifferentiated narratives that cast the reforms of recent years in a negative light, classifying their true intentions ('neoliberal'). Still, the changes in each context obey complex processes with dynamics of their own which, although affected considerably by emerging international consensus, preceded the second wave of reforms.

Vast reform processes usually bring together vast consensus about the diagnosis and the solutions and some kind of trigger or alarm arising from the performance of the sector in question. That is, the problem to be taken into account is often implied under 'crisis'. It is possible, however, that both components do not coincide, whether in the form of general consensus without crises or vice versa. This analytical distinction becomes relevant when considering that the presence of strong international consensus in respect of how a determined sector, for example healthcare, should be reformed, constricts the space for innovation and possible options for intra-national actors. Inversely, the need to confront sectorial crises which, by definition, momentarily puts the *status quo* in check, without the configuration of solid consensus, leaves room for a bargaining process between the relevant sectorial actors. Where there are no sectorial actors with the capacity to introduce reforms to alter the *status quo*, the *status quo* tends to fall back into place easily. This will be seen shortly, while in India and Brazil, the financial crises in the healthcare systems occurred before the emergence and/or consolidation of the first and second waves of state reforms. In Mexico's case, the consensus preceded the crisis. On the other hand, the significance of the crisis and the measures are apt to be decanted into a viable consensus depend considerably on sectorial baselines.

India's healthcare sector has been historically fragmented and marked by peculiarly low levels of universalisation. The formal workforce is at a level close to 10 per cent, drastically delimiting maximum coverage under the social security system (Nundy 2007). Even the organisation of healthcare services for this portion of the workforce presents fragmentations from functional corporations within the public service – railroad workers, the army, and various segments of

the public service sector possess their own healthcare systems. The uninsured population is attended to by a series of medical institutions that go from hospitals and public healthcare facilities to polyclinics and public dispensaries; part of which ascribe to other systems of medicines – most notably Ayurveda, Yoga, Unani, Siddha and homeopathy. Still, healthcare expenses are mostly private or paid by families, in that throughout the country, 73.5 per cent of total healthcare spending is paid for from the population's pockets. In the case of New Delhi, the population pays for 56.41 per cent out of their own pockets (Jalal and Nundy 2006).

The financial crisis that the healthcare sector faced in the 1980s reinforced one characteristic that has been distinctive since the late 1960s – namely, a strong emphasis on family planning. Propelled by international donors and entities (both national and international) dedicated to reproductive health, the healthcare agenda came to move subtly from birth-rate reduction to reproductive rights and options, and from family planning to family welfare and, more recently, health and family welfare, but preserving the same emphasis (Narayanan 2006). In this way, the response to the crisis in the 1980s was driven by the donors' agenda towards family welfare. Further, given the disproportionate amount of resources available for family welfare, which in a certain dimension end up financing the entire public medical system, a part of the social actors and most relevant disputes in the area have been directed precisely towards the field of reproductive health. The consensus of the 1990s, centred on the structural adjustment of the state,⁷ arrived after the financial crisis and confronted a healthcare sector whose fragmentation confers upon the idea of privatisation a primordial meaning of concentration of capital, economic regulation and market construction, rather than one of privatisation as a retraction of the state. In a similar sense, later precepts like the pluralisation of providers lose meaning if placed in this context or characterised by these sectorial baselines. In fact, the policies of reform have resorted to public financial support, fiscal incentives, subsidies and other stimuli for the creation of the market, in particular the offer for much more complex services – hospitals.

It is not possible to formulate a general characterisation of the Brazilian healthcare system that outlines a pertinent description of the past 50 years, due to the intense process of institutional reform that occurred from the 1970s on, passing from

the healthcare model consecrated in the 1988 constitution – the Single Healthcare System (Sistema Único de Saúde, SUS) and through successive steps and disputes which led to SUS regulation, implementation and operative institutional specification. In the 1960s, at the time of the coup which installed a military dictatorship (1964–84), the public healthcare system still presented three distinct features: (1) institutional fragmentation for the population covered by collective healthcare services, as the Institutes of Retirement and Pensions were created within the corporate logic of the 1930s, providing different independent services to different professional categories; (2) dependence on the private sector contracted to attend the insured population, i.e. those subscribing to the social security system; and (3) the massive presence of philanthropic institutions in attendance of the open public or noninsured population (Dowbor 2007). Despite criticisms and common complaints in the literature that analysed transformations in healthcare over this period, processes of unification, amplification and bureaucratic–administrative rationalisation of the system were urged during the dictatorship. In this way, by the start of the 1970s social security comprised 80 per cent of the economically active population (Dowbor, this *IDS Bulletin*). In later years, thanks to the ‘Healthcare Chapter’ approved by the Constitutional Assembly, and a strategy of extraordinarily centralised implementation, healthcare reform was actualised, that included the neglected poor population, in national unification and the universalisation of a basic healthcare system.

How is it possible that the configuration of the healthcare system has changed in such an accentuated manner, imposing losses upon corporate and economic actors? Everything seems to point to a favourable confluence of factors. First, the sectorial baselines at the start of 1960s defined two relevant actors – the private medical–hospital sector, which held together the infrastructure and contained a considerable capacity for attendance, and the corporations, which were dedicated to serving a relatively limited set of professional categories. The dictatorship imposed the overthrow of the latter set of actors and initially favoured the former by means of a unification model which relied on the public healthcare sector’s hiring of private services. Second, the financial crisis in the healthcare sector erupted in 1979, placing suspicion on the principal beneficiary of the *status quo* – the medical private sector. It is

important to remember that, at this time, neo-conservative experiments in the UK and the USA were taking their first steps and there was not yet an international consensus with respect to structural state reforms and even less in regard to precepts for orienting sectorial reforms. On the other hand, generations of doctors trained in social medicine – the *Sanitarista* movement – and often affiliated with clandestine organisations and leftist parties came to occupy positions in the public service sector that had been opened through the process of bureaucratic–administrative rationalisation. The *Sanitarista* movement ended up as an emerging protagonist endowed with a growing bargaining capacity and armed with its own agenda of reforms. Due to an auspicious environment for institutional innovation – crisis without consensus – the movement was able to ally with a military government which, besides having a high capacity for imposing losses, was looking to innovate and had an emerging need for an anti-*status quo* actor with competent knowledge. In fact, and as Dowbor has shown (this *IDS Bulletin*), the trajectory of the relationship between the military government and the *Sanitarista* movement is not just made up of conflict – it also includes a good measure of circumstantial affinities. The Constitutional Assembly provided an extraordinary opportunity to subordinate the intense bargaining process between the *Sanitarista* movement agenda and the large representatives of private medicine, producing an accommodation of interests which cleared the way for profound reform in building up a public system of basic healthcare, while preserving the role of the private sector for segments of the solvent population – in other words, those who can afford to pay for healthcare service, at times via the insurance market, at times via outpatient health services.

Differently from Brazil (where the formation of international consensus about state reform was extemporaneous and disconnected from the implemented healthcare reform) and, to a lesser extent, India, in Mexico the idea of crisis came in the 1980s as a diagnosis coupled with a package of structural adjustment; in other words, the consensus brought with it both ‘sickness’ and ‘remedy’, foretelling sectorial malfunctions which lacked previous social awareness. However, the adoption of the measures recommended by the diagnosis faced serious obstacles. The sectorial baselines present by far the most elevated degree of institutional

development and consolidation of the three countries under analysis. Curiously, said development and consolidation are related, in a parallel way, to the power and capacity for resistance of actors interested in defending the institutional structures that should be transformed. As in the other two contexts, the healthcare system in Mexico corresponds to the basic division between the insured population, or those covered by social security, and the open, uninsured population, though the proportions and range of corporations associated with these proportions are clearly distinct. The Mexican Institute for Social Security (Instituto Mexicano de Seguridad Social, IMSS) and the Social Security Institute for Civil Servants (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE) are the institutions that provide universal coverage for formal sector workers, servicing 50 per cent of the population. The other half of the population, including informal sector workers, are serviced by public healthcare under the jurisdiction of the Ministry of Health (Secretaría de Salud y Asistencia, SSA) (Blanco-Mancilla 2006). The private insurance market, the public corporations of medical attention by professional category and traditional medicine are, frankly, marginal.

IMSS and ISSSTE are prototypical institutions of the so-called 'social compromise' of the Mexican post-revolutionary state and, at the same time, corporations of notable political force inside the traditional power structure. Though weakened with the passing of time, both corporations succeeded in barring healthcare reform in aspects that would impose losses – notably those measures inclined toward the unification of the system, the privatisation of pensions systems and an increase in the Ministry of Health's power in the healthcare sector. The reform took place where it was possible to overcome resistance, i.e. in the realm of public healthcare services, marked by a clear subordination to the federal executive and where there were no organised corporate interests of considerable magnitude (Blanco-Mancilla 2006). Reform for the uninsured population proceeded through the decentralisation of coordination and financial responsibilities of the federal level to the state level, as well as a stimulation of diversification in financial sources. Even so, the reform was extremely partial and reached less than half of the Mexican states due to the confluence of contrary interests on the part of large healthcare corporations, the Labour

movement in alliance with them and various governors who were reluctant to assume previously federal functions that would have to be paid with state resources. In the mid-1990s, after the thorough restructuring of the post-revolutionary Mexican state and the decay of its sustaining bases – among them corporatism – the executive power made another attempt at reforms with more success, which included the privatisation of the pension system and full transference of ownership and administration of the Ministry of Health's organs to the states.

2.2 Degree and institutional locus of local discretion in policy

Public sector reform processes imply both different degrees of discretion in local supervision and policy management and placing such discretion at different loci of the institutional structure responsible for operating policy. *Who, and under what circumstances is it possible to decide what, at what levels of government and in which organs of these levels?* This question has been revealed as crucial to understanding, in the reforms under analysis, not only the reach and actual consequences of participation and decentralisation reforms but also the strategic choices of social actors, including bureaucracies and local politicians. It is possible to territorially reduce the concentration of functions or responsibilities without altering the hierarchy or degree of centralisation in decision-making processes. It is also possible to increase capacities for spending and collection in sub-national and sub-administrative units but there is no direct proportion between an increase in spending power and autonomy in the allocation of new resources (Arretche 2006). Last but not least, it is possible to transfer decisive autonomy. There is no necessary or single relation between these three processes and they can be set in motion separately, individually or as a whole, gaining approval from the institutions of political representation which regulate the relationship between federative units and the union – as in the case of federalist countries considered in this article – or arising from within the bureaucratic structure of a determined sector or programme.

From a more general point of view, the distinctive features of the federative arrangements emerge as undeniable determinant factors in the meanings adopted by the decentralising and participatory reforms in each context. The Brazilian Constitution of 1988 defined states and municipalities as members of a federative pact, meaning that the latter are

constitutionally autonomous entities and not obligated to accept state decisions regarding policies affecting the municipality's population (Anastásia 2004). In Indian federalism, states enjoy a strong autonomy in relation to the federation (Bhattacharyya 2005). Though the constitutional amendments of 1992 had multiplied the number of local urban and rural bodies of government, their capacity to provide services and collect taxes is extremely limited (Rao 2002). The Mexican case differs from the two previous ones. Municipalities in Mexico are not only strongly subordinated to the state governments but, to a large extent, they are political-administrative jurisdictions which overrun or do not correspond to the 'natural' limits of specific urban settlements – as illustrated by the discrepancy in the number of inhabitants per municipality in Brazil (33,000) and in Mexico (42,000).⁶ In fact, Mexican federalism is well known for an accentuated concentration of power at the union level (Aguilar Villanueva 1996).

Roughly put, municipality, state and federation appear in the three contexts having politically different capacities, indicating that the municipal level of government in Brazil, the state level in India, and the federal level in Mexico, occupy privileged bargaining positions in the definition of policy. However, the sector reforms of public service delivery are of national character, meaning that they are implemented from general agreements made among the elites that govern at the federal level, which, from the perspective of the centre, present the challenge of coordinating sub-national units. In other words, given an agenda of reforms or a set of national policies, the federation should find the mechanisms capable of obtaining or forcing cooperation from states and municipalities. As shown below, the federal arrangements hold decisive weight in the way in which reforms are designed and, more specifically, in the institutional degree and locus of local discretion in the formulation and implementation of policy. Resorting to a certain simplification of the argument, it is possible to affirm that in Mexico negotiation occasionally occurs between federation and states but, whenever possible, the former simply imposes itself, eliminating the costs associated with the latter's agreement and intervention. In Brazil, bargaining occurs directly between the federal level and municipalities, eluding the bureaucratic and political structures of mediation and bargaining at the state level. In India, state

autonomy is so robust that, on the one hand, states possess their own set of reforms and, on the other, federal reforms are limited and markedly inductive.

However, as for the designing of direct cash transfer and basic healthcare reforms, the degree of municipal discretion, just as the institutional niche in which it lies, concentrates the decision-making capacity in determined actors and organs, conferring upon them political protagonism and making them the object of strategic action by other social actors. This has relevant consequences: when the participatory component of the reforms – via councils, commissions, assemblies, etc. – does not coincide with the institutional locus of discretion, it is plausible that the effects of public oversight attributed to participation will tend to be lesser.

It is possible, though in an extremely synthetic mode, to show how the degree and institutional locus of discretion vary depending on how they are articulated to the profile of federative arrangements and to policy structure. In Brazil, sectorial reform policies in the post-transition context, notably the implementation of SUS, have heavily relied on conditional budgetary transferences as a mechanism to induce the municipalities to adopt federal policy preferences. The Family Health Programme (Programma Saúde da Família, PSF) was the federal strategy defined for the national implementation of SUS and, as in other cases, its adhesion is not only voluntary and applies to municipalities (overrunning the state level) alone, but it supposes subscription to a contract with the union by which municipalities integrally adopt the programme's framework and rules receiving federal transfers to the support of the programme (Dowbor 2007). In spite of considerable advances in fiscal decentralisation at the municipal level, local discretion is limited to – as in the fundamental characteristics of PSF – accepting or refusing the model defined by the central government. However, as PSF is a programme operated by the Municipal Ministry of Health's bureaucratic-administrative and professional structure of basic healthcare, other aspects of the programme, which are not a part of its framework or basic rules, become the object of local disputes: whether actors of the third sector could or could not be hired to administrate the programme in the city of São Paulo, whether it is necessary or not to introduce mechanisms of public oversight or, in a micro-level, in which areas of the city to invest more in the hiring of PSF teams.

Still, it is possible to operate programmes in an entirely centralised manner, reducing local discretion of policy management to the minimum. Despite its ample coverage and social capillarity, the evolution of the programmes of direct cash transfers in Mexico is emblematic in this respect. Due to strong criticism of the political use of the Solidarity programme under the administration of president Salinas de Gortari, an elimination of all intermediation between state and beneficiaries was incorporated as a fundamental feature of the Oportunidades programme's structure. Each of the stages in the programme's implementation process, including rolling registration for beneficiaries, was defined and made operational at the federal level with intervention, when necessary, from outsourced services from large private firms rather than states or municipalities (Hevia 2007). Under such an institutional design, in which interest intermediation must be eliminated, there is only room for direct participation without representation and without mechanisms for aggregating opinions or preferences, which could foster collective or political agency. In a coherent way, participation in the Oportunidades programme remains restricted to a system of complaint-filing. As demonstrated by Hevia (this *IDS Bulletin*), in spite of the local capillarity of the Mexican State, formerly omnipresent, or perhaps due to the kind of partisan and corporate State capillarity, the intention of connecting the citizenry directly to the programme without intermediaries has been proven unviable and the attempt to 'protect' the citizenry from the voracity of corporate structures ineffective. Unallied and harmless users have had to confront old and new forms of political patronage. It is worth mentioning that in the design of the Bolsa Família programme, local discretion has been limited considerably, though not eliminated, being that the beneficiaries in each municipality are registered by their respective town halls. In fact, São Paulo's government programme, Minimum Income (Renda Mínima), shares with Oportunidades the aim of suppressing costs related to collective actors' intermediation (Houtzager, this *IDS Bulletin*). The modalities of collective action favoured by this kind of design, as seen in São Paulo, are opportunistic and have an eye on the inclusion of those linked to some associations in the register of beneficiaries.

While in India states and the union are co-responsible for the Targeted Public Distribution System (TPDS), the former set the pace and the best strategy for

confronting or adopting the strategy of targeting and reduction of subsidies urged by the federal government. In harmony with the differences between federative arrangements previously mentioned, this degree of autonomy for decision making at the state level can be currently seen in the protective and promotional social security programmes as a whole (Mehtta 2007). In fact, in the case of food security, the states that set up universal systems opposed themselves to the measures of the centre and, under federal level constraints, chose alternative paths. In Delhi, for instance, once the administrative criteria, which allow the division of the population into types of beneficiaries and non-beneficiaries, is defined according to poverty lines, the operation of the programme tends to make room for discretion. In this case, the shift to focalisation respected the usual local channels of distribution used by the PDS, namely, the fair price shops. These shops are largely controlled by small individual proprietors and authorised to sell grains and other goods inscribed in the PDS. Unintentionally, this design concentrated local discretion into the hands of small, individual store-owners who in turn used it to undermine the programme's objectives, diverting grains to a parallel market, forcing beneficiaries to buy the grains at higher prices and establishing an exploitative relationship with them (Pande 2007). Such an extreme pluralisation of providers generated collective reactions which allowed for the correction of some distortions and the introduction of a certain amount of local oversight over the providers themselves but, paradoxically, the motives which led to the rise in accountability have little or nothing to do with the precepts of service delivery reforms. The Right to Information Act, sanctioned by the legislature in 2001, permitted middle-class civil organisations to establish ties with demands of local largely neglected populations, redefining such demands as a part of a larger battle for State accountability and transparency (Pande, this *IDS Bulletin*).

3 Conclusions

Contextual politics caused considerable changes in the way that the most common recommendations from the second wave reforms have been implemented. National experiences have combined the *decentralisation* of provisioning and policymaking, *pluralisation* of service providers and users' *participation* in ways that challenge the usual classifications, requiring a more accurate analysis. This article has focused on two crucial analytic dimensions: the

historical timing of reforms and sectorial baselines, and the degree and institutional locus of local discretion in policy. Both are helpful in shedding light on the paths that the reform processes have taken in each country, though the same recommendations are common to all three cases.

Both analytic dimensions have different practical or normative consequences for policy design. While the former is posed as a starting point for the reform process – and in this sense is merely a piece of data – the degree of local discretion in policy is a political decision that is not only preterite but also related to the future and, consequently, admits for changes at least in its non-constitutional features, i.e. those related to policy design rather than the federative arrangement. As shown by the programmes Bolsa Família, Oportunidades and PSF, the drastic

reduction of local discretionary power is quite agreeable to the federal policy designers. However, this reduction unintentionally favours opportunistic actions on the part of local societal actors, and thus presents obstacles to the construction of stable public oversight in the long run. This matter is relevant when considering that measures of participation, decentralisation and pluralisation of providers are supposedly aimed at the promotion of social accountability in public services. Nonetheless, if the role of local government is limited to registering beneficiaries, as in the programmes of income transfer, the societal actors are likely to pressure the local bureaucracy and politicians for the inclusion of their members or publics as beneficiaries. It is an inexpensive way to ensure access to public benefits, but does not promote relationships that favour the improvement of accountability.

Notes

- 1 Besides the World Bank's well-known *World Development Report 2004: Making Services Work for Poor People*, see the International Monetary Fund's (IMF) September 2003 *Finance and Development Report* 40.3, in particular articles by Jeremy Clift, John Williamson, Guillermo Ortiz, Shantayanan Devarajan and Ritva Reinikka.
- 2 An interesting approach to contextual politics is Harris *et al.* (2004).
- 3 The results are registered in the research project 'Modes of Service Delivery, Collective Action, and Societal Regulation', conducted by IDS–DRC for the Future State in partnership with CEBRAP. For more on the project and other pertinent information, see www.ids.ac.uk/futurestate/research/Phase2/prog2/projects/modesofservdel.html.
- 4 See the polity approach (Houtzager 2003) and politics of institutionalisation (Gurza Lavalle 1998: 182–214).
- 5 Bolsa Família in Brazil is one of the best known examples of a direct cash transfer programme. Due to a limit in space and that, methodologically, the relation between the analytic dimension proposed and the reform policies analysed is of a descriptive nature, Bolsa Família and the Renda Mínima programme in São Paulo will be introduced solely as a counterpoint to the Oportunidades programme.
- 6 There is a copious amount of literature (both national and international) on the various subjects discussed in this article. Except when absolutely necessary, the references in this article allude to research results that have been established in various papers and research reports.
- 7 This article draws heavily on the project's findings, background papers and research reports (see note 3).
- 8 According to Instituto Brasileiro de Geografia e Estatística (IBGE) projections, Brazil had 186,000,000 inhabitants in 2006. In 2007, it totals 5,564 municipalities, with an average of 33,429.19 inhabitants/municipality. The equivalent statistics for Mexico in 2007, according to Instituto Nacional de Estadística Geografía e Informática (National Institute of Statistics, Geography and Informatics, INEGI), are: 103,263,388 inhabitants; 2,445 municipalities (42,234.51 inhabitants/municipality).

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