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# Facing the State: Everyday Interactions throughout Regime Change: Chile's State Milk 1954–2010

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*This article uses Chile's state milk program as a prism to map the trajectory of Chile's social state through three combinations of political, economic, and welfare regimes. It traces the informal strategies deployed by citizens and local service providers and presents a historical typology of these encounters between 1954 and 2010, examining what commodification and decommodification mean to families in their everyday lives and discussing the implications of these findings to the literature on welfare regimes. The most important finding of this article is that regime type shapes but does not determine levels of provision. Welfare provision occurs in everyday interactions between state workers and citizens, and changes in regime type are filtered through and resisted through practices and strategies deployed in face-to-face encounters between local state representatives and citizens. There is often a large gap between central policy and these informal institutions that are created in everyday on-the-ground encounters between local state workers and citizens. Therefore, a second main conclusion of this article is that the informal institutions created at the local provision level coexist, compete, and clash with formal rules. A third conclusion of this article is that, to some extent, people who are regulated by the state also have some capacity to regulate their exchanges with the state, and, at the same time, state workers who organize and are organized by the state to distribute resources exercise discretionary power when implementing social programs.*

## Introduction

Between the 1950s and 2010, Chilean political, economic, and welfare regimes have shifted radically: from a modernizing democracy to a brutal dictatorship and then back to a democratic regime; from an internal focus on substituting imports to an external concern with exports on the global market; from a state that slowly expands rights to one that radically curtails these and to a state torn between its concerns with maintaining efficiency and expanding rights. These changes have deeply altered the content of citizenship in Chile. Surprisingly, some aggregate-level welfare outcome indicators—such as infant mortality and malnutrition—do not reflect these disruptions.[1] Instead, the data show relatively continuous improvement, suggesting citizens continued to secure basic welfare services in periods of retrenchment, rollback, recession, and even brutal repression.

1. While in 1925, infant mortality was 237.5 (per 1,000), by 2010 this rate had dropped to 7.7 (less than 1 percent). Similarly, in the 1950s infant malnutrition was one of Chile's main health problems and 80 percent of pediatric beds in hospital wards were occupied by children under the age of two with severe malnutrition (Mönckeberg Barros 2003). Since then, indexes have decreased from 37 percent in 1960 to 2.9 percent in 2000 (Rojas Flores 2010: 731).

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The welfare literature doesn't have a good explanation for this. Contemporary dominant theories in the social sciences focus on formal institutions, discussing whether economics, politics, policy orientation, or a combination of these determine levels of welfare provision, which they define as a dependent variable. However, welfare provision occurs in on-the-ground encounters between state workers and citizens, and there is often a large gap between central policy and the informal institutions that coexist, compete, and clash with formal rules. Therefore, by focusing only on formal institutions, scholars have missed the informal on-the-ground practices that govern social welfare.

This article uses Chile's infant-maternal primary health care network as a prism to map the trajectory of Chile's social state throughout three combinations of political, economic, and welfare regimes. It traces the everyday strategies deployed by citizens and service providers at the local level and presents a historical typology of these informal institutions. Alongside formal institutions, these also determine service provision and shape what commodification and decommodification mean to families in their everyday lives—in this case, how families adapt to and resist dramatically different political, macroeconomic, and social provision systems. The next section briefly lays out state-of-the-art welfare literature and introduces the analytical approach. The following three sections present the empirical findings that are organized by political, economic, and social policy regime type. The article concludes by making the claim that, by focusing only on formal institutions, scholars have missed the informal on-the-ground practices that govern social welfare and proposes a research agenda for welfare studies that includes observations made at the implementation level.

## State of Welfare and Latin American Social Policy Studies

Dominant theories on welfare focus on whether economics, politics, policy orientation, or a combination of these determines levels of welfare provision, which they define as a dependent variable. For the most part, the welfare literature has focused on spending and program design and has constructed what both Pierson (2000) and Amenta (1993, 2003) agree to be a successful research agenda with significant advances both on the empirical side as well as theory building and testing. Early studies, referred to by Amenta as "effort researchers" given their focus on state outputs (1993), used social spending as a percentage of gross domestic product to assess levels of welfare. They did not specify the kind of citizen covered—public-sector workers, middle class, formal workers, urban poor, men, and/or women—or the quality or extent of this coverage. Esping-Andersen (1990) opened the Pandora's box of spending by creating a typology of advanced welfare states differentiated and assessed in terms of their degree of decommodification for individuals—defined as freedom from market exigencies and fluctuations. Building on his work, power resources and institutionalists have built multivariable causal accounts of welfare that examine the role of labor movements,

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political parties, and bureaucratic institutions in creating and shaping welfare regimes (Hicks 1999; Hicks and Kenworthy 2003; Hicks et al. 1995; Huber and Stephens 2001; Iversen 2001; Lister 2002; Lynch 2006; Pierson 1994, 2001).[2] Feminist critiques have stimulated a reinterpretation of the welfare state both as an outcome of particular societal arrangements and as an active promoter of these (Fraser 1996; Orloff 1993, 1996) and revamped Esping-Andersen's typology to include a gender perspective (Huber and Stephens 2001).

Analyses of Latin American social provision models have followed similar research strategies and the leftward turn at the beginning of twenty-first-century Latin American politics has been accompanied by a growing interest in Latin American social policies. This research agenda, while inconclusive as to whether the political changes also signify long-lasting transformations in the distribution of responsibility for providing welfare among state, families, and market,[3] has been extremely productive. Studies have included regional welfare typologies (Filgueira 2005; Martínez Franzoni 2008; Pribble 2013b); medium-n studies that attempt to explain interregional variation (Haggard and Kaufman 2008; Huber and Stephens 2001); calculations of the effects of political regimes and parties on welfare provision (Huber and Stephens 2012; Pribble 2013b); identifying and exploring the trajectory and architecture of noncore cases that are successful at providing well-being for citizens while facing globalization pressures (Martínez Franzoni and Sánchez-Ancochea 2016; Pribble 2013b; Sandbrook et al. 2006); work focused on waves of policy diffusion among and from noncore countries (Weyland 2004); and small-n comparative studies (Castiglioni 2005a, 2005b). There is also a growing body of research on Chile's welfare arrangements for women (Gideon 2006, 2012, 2015; Martínez Franzoni and Voorend 2012; Mooney 2009; Pribble 2006; Staab 2012, 2016).

In the previously mentioned literature, the outcome variable—social policy—is measured as a function of its formal institutions: spending, coverage, and program design. This focus has the benefit of permitting intercountry comparisons. However, not all state social spending is directly translated into services. For example, there is usually higher spending during periods of structural adjustment (financing the administrative costs of the reform) and both Gideon (2015: 8) and Nelson (2007: 80) point to the lack of direct correlation between higher spending and more equitable or improved services. To avoid problems with using spending data, some analyses focus on a bundle of policy outcomes measured in terms of health, pension, and education indicators (Glatzer and Rueschemeyer 2005; Pribble 2013b). In the case of

2. The varieties of capitalism literature contribute to this debate by adding a focus on the interests of employers and complementarities between business and large welfare states in what they call coordinated market economies (Estevez-Abe et al. 2001; Hicks and Kenworthy 2003).

3. For example, of this debate, at the 2013 Latin American Studies Association meeting social policy experts in Latin America debates Pribble argued that some countries were approaching a new model they defined as "basic universalism," Filgueira described this new model as an "opportunity foregone," and Kaufman posited that changes had occurred but that these were not concurrent with the regime type posited. See Filgueira (2013), Huber (2013), Kaufman (2013), and Pribble (2013a).

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Chile, these studies bundle together the effects of contributory and noncontributory programs, individual capitalization programs and solidaristic arrangements, targeted and or short-term programs, therefore not distinguishing between services that are guaranteed as social rights from those that happen to be available through temporary state programs or affordable on the market.

In addition, program implementation is rarely considered relevant in political science or sociological accounts.[4] In received theories, policy implementation is assumed to follow a rational-bureaucratic model roughly synonymous to formal rules and therefore not closely examined.[5] Divergences from formal rules are thought to be of minor importance in strong states, of greater importance in what the literature deems as failed states or gray areas of governance,[6] and, for the most part, due to isolated events of corruption or clientelism. Public servants' compliance is attributed either to the fact that it does not occur to actors to *not* comply, or given the role of "sanctions and monitoring" (Mahoney and Thelen 2010: 10). Citizens are conceived of as service recipients who passively comply, opt out, or on rare occasions engage in "open defiance," "voice options,"[7] or protest. The work of Martínez Franzoni (2008) presents an innovation to this literature by recognizing the active participation of families in attaining provision through a diverse array of vicarious or paralegal means. However, her conclusions are drawn mainly from aggregate-level spending data and therefore do not reflect these variations in modes of attaining services. In this way, the reigning approach does not reflect variations in on-the-ground service provision and might mask clientelistic or discriminatory distribution practices. The relationships between providers and recipients—be these antagonistic or based on shared goals—are largely ignored and whether services are provided with dignity or with attitudes of disgust[8] is considered unimportant for the larger welfare narrative.

## Formal and Informal Institutions

In this article, I trace shifts in provision by focusing on a single program through three different political economic and welfare regime combinations to diagram the long-term trajectory of the Chilean social state.[9] This article pairs formal program rules and everyday practices, weaving ground-level observations of program

4. Anthropologist Inhorn conducts a meta-analysis of ethnographies of women's health emphasizing the cruciality of capturing the everyday experiences in this health policy arena (2006).

5. In the words of Mahoney and Thelen: "[I]n some versions of sociological institutionalism,… rules and practices are considered to be synonymous with each other" (2010: 10).

6. "Grey areas of governance," as in O'Donnell (1993).

7. *Exit* and *voice* as used by Hirschman (1970).

8. For more on politics of disgust see Hancock (2004).

9. This approach follows the lead of Lynn Haney, who traces shifts in welfare arrangements through three generations of single mothers in Hungary (2002).

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implementation with interviews to top-level decision makers and testimonies from local service providers and beneficiaries. It offers thick descriptions and a typology of everyday citizen-state[10] interactions across three periods. I focus on the interface level that is everyday encounters between citizens and public-service providers. In my findings, service providers and recipients were neither obedient nor passive, would instigate counterparts to bend formal program rules, and found creative ways to assure services through changing contextual conditions. The everyday strategies are similar to what James Scott (1985: xvi–xvii) describes as "everyday resistance" (1985) defined as "low profile techniques" that "make use of implicit understandings and informal networks" and require "little or no coordination or planning."

It is sustained here that the everyday strategies to extract services from the state described in this article have significant material ramifications on the allocation of state resources and ultimately on infant-maternal macrohealth indicators.[11] They are not due to weak institutions or clientelistic practices and were not performed out of "neglect"[12] nor "habit."[13] Instead, they are best understood as *informal institutions.* There is a recent focus in political science of so-called informal institutions defined by Helmke and Levitsky as "socially shared rules, usually unwritten that are created, communicated and enforced outside of officially sanctioned channels" (2004: 727). For example, Waylen's edited book (2016) draws on new institutionalist and feminist institutional literature to examine the informal aspects of institutions during Chile's Bachelet presidency, focusing primarily on the practices among power holders at the central level. They are differentiated from "behavioral regularities" in that they violate a rule, creating external sanction and involving shared expectations (Helmke and Levitsky 2004: 727–28). While Waylen and colleagues focus on the political institutions, I propose extending this conceptualization to the welfare and service provision context and echoing the conclusions of both Tsai (2006) and Grzymala-Busse (2010). I close by suggesting that informal institutions can be partial determinants of both policy outputs and outcomes.[14]

10. The state is conceptualized as a layered entity in which policy outcomes are caused by combinations of top-down and bottom-up processes and in which service delivery is negotiated in encounters at the local level.

11. The idea that a series of uncoordinated small events have significant ramifications is not unique to this analysis. For example, for James Scott (1985) these "individual acts" "make an utter shambles of the policies dreamed up by their would-be superiors in the capital" (xvi–xvii) and can account for "limited state capacity of third world states" and the fall of the Confederacy (xvi–xvii, 30–31). In Mahoney and Thelen's analysis, "soft gaps in interpretation"—"open to contestation by actors with divergent interests" can have "profound consequences for resource allocations and substantive outcome" (2010: 11).

12. In Mahoney and Thelen's words, this "gap between the rules and their instantiation is not driven by neglect" but instead "produced by actors who actively exploit the inherent ambiguities of institutions" (2010: 17–18).

13. For discussion of habitual paths in a path-dependent framework, see Sarigil (2015).

14. Tsai (2006) and Grzymala-Busse (2010) make similar arguments of reciprocal causation between formal and informal (adaptive) institutions.

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## Research Findings

It is particularly relevant to discuss the Chilean case given that the developmental path has been radically discontinuous in terms of regime type, economic model, and ideologies governing social provision. This is sometimes referred to in the literature as Chilean exceptionalism: Generous though segmented welfare programs were introduced early on (Arellano 1985; Filgueira 2005), extreme neoliberalism was adopted in the 1980s, and democratization did not produce policy reversals. Furthermore, Chile's long reputation for having low levels of corruption, having little clientelism, and keeping good statistical records makes it the country "most likely" to conform to a rational-bureaucratic model of policy making and implementation.[15] Within Chile, I focus on what I consider the population "most likely" to have positive experiences interacting with public-service providers: urban working-to-middle-class neighborhoods that are neither wealthy enough to opt out of public services nor poor enough to be marginalized by the public apparatus. Interviewed families were often part of the rural-to-urban migration of the 1930 through 1960s.[16] While the oldest family members recall their struggle for formal incorporation—achieving legal ownership of land, mobilizing for the extension of electric and water supply grids, and the creation of neighborhood clinics—their grandchildren became first-generation college graduates with middle-class expectations. While the grandchildren experienced severe economic difficulties during the recessions of the 1980s, they now fit neatly into Chile's national progress narrative.[17]

Chile's state milk program, known as the National Program for Complementary Foodstuffs (PNAC) was initiated in 1954 and distributes milk to families at neighborhood primary health care clinics (*consultorios*) in exchange for keeping up to date with a preventative health care program. Families are eligible for aid from pregnancy until children turn six years old and associated preventative services include nutritional monitoring and vaccines, evolving alongside national health needs.[18] The PNAC program and the primary health care network that supports it have had substantial continuity across regime changes. Even as politics, economics, and most other welfare policies were retrenched in the 1980s, this significant portion of the welfare state—which is extended throughout the country and has almost-universal coverage—has survived. Through this program, up to four generations of Chilean families have come into periodic contact with local public-service providers for a significant period of their family life cycle, making it an ideal site at which to make observations in such distinct periods and regime types. In this article, the

15. For a good discussion of case selection in small-n and case studies, see George and Bennett (2005).

16. Basically, the wealthiest and poorest 10 percent of Chileans.

17. These communities do not deal with the racial discrimination prevalent in state relations with indigenous communities (Richards 2004, 2013) or encounter the class-based or urban-rural/ center-periphery inequalities that often are most pronounced at the ground level of policy implementation.

18. For example, in the late 1960s these included home visits where health care workers were mostly concerned with teaching sanitary puericulture techniques. Today's PNAC beneficiaries receive mobiles and pedagogical toys and are instructed on early stimulation.

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implementation of the PNAC functions as a natural experiment where formal rules are held relatively constant to observe changes in the citizen-state interactions that result from this program.

To increase comparative leverage, the analyzed program is briefly contrasted here with the pension sector. These two policy arenas, which in practice function as the bookends of the life cycle, experienced mostly change (pension) and continuity (infant nutrition), respectively, and are also the most and least studied. The standard view on Chile is often based around shifts in Chile's pension model[19] and much of know about Latin America is often implicitly modeled around the Chilean case (Gideon 2015: 46). On the other side of the spectrum, the analysis of the infant nutrition program reveals an extensive welfare state, which for the most part has been overlooked in the welfare literature. Table 1 summarizes the findings of this article. The first three columns provide information on the formal institutions. In the welfare literature these are independent variables and policy outcomes (column 4) constitute the dependent variable.[20] The fifth column in this table describes state-citizen interactions—or the informal institutions—that the rest of this article will focus on. The pension sector confirms hypotheses about formal institutions dictating policy outcomes and the pension regime was substantially changed with each regime combo. However, in the case of the infant-maternal health services analyzed here, theories that predict welfare outcomes based on politics, economics, and policy orientation accurately predict welfare outcomes in one case, miss the mark in another, and have partial success at predicting outcomes in the third regime combination.

The next three sections provide a ground-level examination of each combination of political, economic, and social policy regimes that is based on interviews with high-level politicians and Ministry of Health professionals and on testimonies from providers and recipients at two Santiago neighborhood health clinics.[21]

19. For a detailed analysis of the "Chilean model" of pensions see Brooks (2004, 2007), Borzutzky (2002), Castiglioni (2005a, 2005b), Ewig and Kay (2011), and Madrid (2003).

20. In the policy literature, formal rules are often considered independent variables, and policy outcomes measured in terms of indexes of effectiveness and efficiency considered dependent variables. A policy feedback cycle is expected to maintain policies that meet their goals and create the demand for change in the contrary case.

21. Field research was between 2011 and 2013. During this time, I conducted more than 75 interviews and examined primary and secondary sources. A first round of interviews included key experts—mostly doctors who advocated for infant nutrition programs from positions as elected officials or from research centers and Ministry of Health authorities between 1950 and 2010. These allowed me to identify specific Santiago clinics that might best provide a full narrative of the city and period. Criteria for selecting these was that they be long-standing in neighborhoods whose inhabitants were neither wealthy enough to opt out of the PNAC program nor poor enough to qualify for narrowly targeted means-tested programs and were in different city quadrants. Site-intensive data-collection techniques included interviews with service providers, interviews with families, group interviews, and ethnographic and participant observation. The original research plan repeated this process in a clinic located in each quadrant of the capital. However, the second site added little novel information. Therefore, my research was more succinct in the remaining quadrants interviewing key informants (doctors, politicians, and policy implementers). For the most part, the transcripts echoed experiences of the first two sites.

**TABLE 1.** *Political, economic, and welfare regimes: Formal policy and informal institutions*

| *Political Regime* | *Economic Regime* | *Welfare Regime* | *Formal Policy Outcome* | | *Everyday Interactions* |
|---|---|---|---|---|---|
| Democratic (progressively inclusive) | Import-Substitution-Industrialization | Gradually expanding, layering of rights | Pension | Progressive **extension** to occupationally stratified groups | **Brokerage** for rights-based entitlements |
| | | | Infant nutrition | **Universal** | **Top-down outreach** |
| Authoritarian | Neoliberal | Radical retrenchment | Pension | **Privatization** | Mandatory **marketization** |
| | | | Infant nutrition | **Universal**, thwarted attempts at retrenchment | **Plug through** (continuity) with silent **resistance** and **bypassing formal mandates** |
| Democratic (reformed center-leftist) | Tinkered neoliberalism | Expanding, layering of public spending alongside market provision | Pension | 1990–2007: **Liminal improvement** transfer sums; 2008: PBS—**Basic universalism** | 1990–2008: **Frustration** and dissuasion; 2008: basic universalism **payments** |
| | | | Infant nutrition | **Universal**, thwarted attempts at retrenchment | **Continuity, bypassing formal guidelines** to avoid targeting, segmented **exit** |

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## Outreach, Recruitment, and Empathy, 1954–73

While the most adequate categorization for Chile's early-twentieth-century political regime might be that of an oligarchy with competitive elections, from the 1930s on, there was a strong democratizing impetus and voting rights were gradually extended to women (suffrage in local and national elections in 1935 and 1949 respectively), finally becoming universal in time for the 1971 election.[22] During this period, the extension of state services took the form to an uneven process of accretion producing a fragmented and corporatist model that gathered speed during the progressive presidency of a Christian Democrat (1964–70), hit a climax during a brief socialist experiment (1971–73), and came to an abrupt end with the 1973 military coup. In terms of the economic model, efforts at state-led development focused on exporting natural resources (nitrate and copper) and on import substitution industrialization to supplement trade on a depressed global economy.

For this period, models of welfare provision accurately predict outcome and infant-maternal services were in fact expanded. While similar charitable and targeted initiatives preceded the PNAC, this benefit became universal in 1954.[23] Extension of services was particularly accelerated during the 1960s in tandem with the construction of neighborhood clinics across the country and the quantity of milk distributed during this period spiked: from 5 million kg per year in 1955, doubling to 10 million in 1964, and doubling again to 20 million in 1968 (Jímenez de la Jara 2009: 105).

On the ground level, recruiting PNAC beneficiaries was a laborious process and neighborhood clinic workers acted as a foot army walking door to door through working-class neighborhoods establishing relationships with mothers of infants on a one-to-one basis. According to testimonies of clinic workers and families, the nature of these home visits was very different from today's context where interactions are governed by strict guidelines, program target goals, and time constraints. Instead, clinic workers had significant autonomy and actions were loosely oriented toward the goal of convincing mothers to bring children to the clinic for regular checkups, transmitting modern puericulture techniques, and more generally organizing the central themes of Frei's Promoción Popular program.[24] Based on testimonies from clinic users and service providers it appears that for the most part while families—and in general mothers—received "educational information" readily, they also put their own concerns on the table. This resulted in interactions defined by Illanes as a policy guided by norms of "negotiated conditionality" (2007: 306–7). With time, and only after repeated face-to-face encounters, these same negotiated interactions were transported to local clinics and through them the policies designed by doctors

22. For description on modes of incorporation of popular sectors see Collier and Collier (1991) and for good discussion of development of Chilean political party system see Scully (1992).

23. A more extensive review of the antecedents and 1954–71 implementation of the PNAC program can be found in Goldsmith Weil (2017a).

24. Frei's presidency included an element of ground-level mobilization known as *promoción popular* (popular advancement) aimed for the "incorporation of the people," linking citizens to the state through specific neighborhood-based state agencies (Mooney 2009: 75–76).

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at the central level were adapted to local realities. By the early 1970s, attending local clinics had become a regular part of family's life.

## Plugging through and Bypassing the Rules, 1973–89

The September 11, 1973 military coup d'état brought an end to the process of state expansion. Between 1973 and 1989, Chile was ruled by an authoritarian dictatorship firmly committed to liberalizing economic trade and reducing state interventions according to neoliberal doctrine. The economy went through two major recessions, and social services were significantly retrenched. The pension and health systems[25] were privatized, and in the pension sector there was a mass exodus from public services. In this context, infant-maternal programs stand out as a "policy of exception" in that they were not only improved but also coverage was extended. This section briefly reviews the literature on welfare provision during Chile's dictatorship and reconstructs ground-level encounters describing everyday strategies to secure state services.

Despite worsening economic conditions, retrenching and deteriorating services, and a repressive political environment, some macroeconomic indicators such as infant malnutrition and infant mortality continued to improve between 1973 and 1989. One explanation offered to this statistical puzzle is that citizens' *exit*[26] from the public sector, purchasing services on the private health market or creating informal parastate structures[27] through which to organize, create, attain, and distribute resources.[28] This narrative is not sustained by numerical evidence.[29] Other authors attribute statistics to the fact that health programs targeted at women and infants were both maintained and improved in a context of massive public health cutbacks (Racynski and Oyarzo 1981) and ponder over what Dreze and Sen refer to

25. The military regime implemented major cutbacks and institutional reforms to Chile's *Servicio Nacional de Salud* (National Health Service, SNS). Per capita public health expenditures dropped from $28 (1973) to $11 (1989) (Collins and Lear 1995: 7–9). A private system ISAPRE (Institutes for Provisional Health) was created with the intent of replacing the SNS. Primary health clinics were decentralized to the municipal level.

26. Given the brutality of the regime, the *voice* option was limited and further on in this article referred to as what I call "muted voice."

27. Such as neighborhood initiatives, NGO-run clinics, and religious or charitable institutions.

28. For example, in Martínez Franzoni's examination of the historical trajectory of four Latin American countries, she offers a path-dependent explanation in which during the service extension of the pre-authoritarian era, citizens learned to value these kinds of services and therefore when faced with retrenchment will find ways to secure these through nonstate providers (NGO or private) or familial strategies (which include having women and the young join the workforce) (2008). Racynski offers a similar account (1991).

29. Racynski estimates that NGOs aggregately covered less than 10 percent of the urban poor in Santiago in 1984 (1991: 41) and, in practice, the newly formed private insurance system did not replace the National Health Service (Haggard and Kaufman 2008: 109). By 1990 only 15 percent of the population was affiliated with the private insurance system (ISAPRE) while 70 percent was enrolled in the public sector and 13.7 percent enrolled in neither (Gideon 2015: 76).

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as "the intriguing question of why a government that had no hesitation in resorting to the most brutal political repression to protect the privileges of the dominant classes was so interested in looking after child health and extreme poverty" (Dreze and Sen 1989: 230). McGuire presents an inventory of five potential explanations to this puzzle that include international reputation, protest deterrence, state paternalism, market failure, and technocratic leadership (2010: 114–17).[30]

The fact that during the dictatorship citizens continued to interact with state services in a quotidian way has remained largely understudied and the contents of these everyday interactions not explored in the policy and welfare literature. After the military coup, the dynamics at neighborhood health clinics dramatically changed: from lively sites—full of popular promotion programs, which were an integral part of the community that performed services both on and off site—to a barricaded closed site with a hierarchical structure and a culture of fear and silence. In the words of Dr. Patricio Hevia: "During the military dictatorship, there was no community outreach, no home visits, none of those things.… they prohibited all community-oriented actions."[31] Military officials provided constant surveillance: One Macul clinic nurse recalls: "We had very few resources and we couldn't say anything.… the clinic was surrounded by soldiers with war paint on their faces. They would check people's documents at the entrance and exit,… they kept us surrounded."[32] Medical teams were disbanded with activists singled out and removed,[33] personnel shuffled to different clinics, and regime supporters and military-medical officials placed in clinic positions.[34] In addition to these measures of intimidation, ambitious family-planning programs were cut, clinic workers lost some of their benefits,[35] and there were freezing hires and emergency labor program participants used to fill gaps.[36]

30. While these are not mutually exclusive, I tend to find the first is an unplanned outcome that was later instrumentalized and have argued elsewhere that international reputation only became relevant to the military cupola after the failure to retrench and the last explanation not relevant in this case given the Chicago Boys did not support PNAC maintenance, preferring means-tested programs (Goldsmith Weil 2017b).

31. Leading public health specialist in the preauthoritarian period, political exile during the dictatorship, and now the founder and head of the *Unidad Patrimonio Cultural de la Salud* (Unit of Cultural Patrimony of Health) (2011), author interview, Santiago, October 11.

32. Macul clinic worker #4 (2011), author interview, Santiago, November 22.

33. Leftist doctors were imprisoned in a designated detention center set up by the Ministry of Health. See "Chile is arresting prominent doctors connected with Allende government," New York Times, January 13, 1974.

34. For example, one Recoleta midwife recalls "that the directors of the clinic during the dictatorship were uniformed. They would come to work with their military uniforms. They would wear helmets with their campaign uniforms on. And the director kept a replica of Pinochet's bust on his desk." Recoleta clinic worker #8 (2011), author interview, Recoleta Santiago, October 25.

35. Decentralization created a decline in working conditions for clinic health care professionals who lost their status as central government employees and, with that, job security, opportunities for career advancement, and benefits (Kubal 2006: 116).

36. The use of emergency labor programs *Programa de Empleo Mínimo* (Minimal Employment Program, PEM) and *Programa de Ocupación para Jefes de Hogar* (Occupation Program for heads of household, POJH) to staff neighborhood clinics was a widespread practice. Through this program,

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In conjunction, this created a context of silence. In the words of a Macul clinic nurse: "In simple terms, I did not know who my colleagues were.… In that time, we were all more silent."[37] This "silence" affected the quality of services.[38] Empathy with families now became an almost secret affair, carefully guarded from the military presence. As one Recoleta paramedic (1966–2010) explained:

> Ties had to be built [in privacy], in the medical box, by the act of touching—placing a hand on someone when giving instructions. That is what I did, what I was like; I don't know what my colleagues did.[39]

Despite often violent treatment and worsening conditions at local primary health clinics, citizens continued to "plug through" showing up at neighborhood clinics regularly. In my interviews to service providers and citizens, I identified three different types of bottom-up strategies exercised at the local level to attain provision despite adversarial conditions. These include funneling state resources to and from resistance movements, finding creative ways to exercise political voice in a repressive context, and finding alternate uses for state-provided milk. The next three paragraphs provide examples of these strategies enacted in everyday encounters.

At the Recoleta clinic, resources were funneled *into* and *from* resistance organizations. Citizens would routinely pick up their PNAC milk, cross the street, and leave it on the steps of the church. From here, it would be taken to an organization working against the dictatorship, therefore, effectively using public resources to protest the government. This practice, which was elegantly described by prominent activist nun and founder of religious-run primary clinic[40] as one in which "[p]eople would bring milk from the clinic when they did not need it or it was not good for them, as a way to give a fraternal hand"[41] was widespread and came up frequently in group and individual interviews in Recoleta.[42] At the same time, resources from antidictatorship organizations were also funneled *into* the clinic. The military dictatorship had implemented "an ambiguous reproductive rights regime."[43] As a way

described by one witness of the time as "organized exploitation," workers received approximately one-third of a minimum wage (Ruiz Tagle and Urmeneta 1984: 16, 108, 118, 124). The working underclass created by PEM became a stable part of a public institution's social pyramid during the authoritarian period, which had repercussions on public services, life within these organizations, and for formally employed public servants.

37. Macul clinic worker #4 (2011), author interview, Santiago, November 22.

38. Recoleta clinic worker #11 (2011), author interview, Santiago, October 17.

39. Ibid.

40. http://www.fundacioncristovive.cl/que-hacemos/salud-familiar/, accessed March 2015.

41. Sister Karoline Mayer (2013), author interview, Recoleta Santiago, February 5.

42. For example, a 47-year-old mother of four and longtime clinic user explains: "Across the street from that [Recoleta clinic] there was the clinic that Mother Karoline ran and people would go drop off their milk there and she would distribute it to poorer or needier people." Recoleta clinic users' group interview #1 (2012), Santiago, December 6.

43. The military dictatorship effectively ended the ambitious family planning programs of the 1960s and neighborhood clinics went from sites for community family planning to be dedicated almost exclusively to infant-maternal care. However, these rules were not always abided at the ground level. For

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to wiggle outside the confines of this mandate, public health workers at the Recoleta clinic would smuggle intrauterine devices (IUDs) donated by international solidarity groups into the public clinic, and health workers found ways to offer and place them in patients without the knowledge of military directives and guards.

Some citizens actively resisted retrenchment of services through what I call "muted voice,"[44] referring to unplanned acts of defiance implemented at the ground level. In 1985, the regime tried to cut back the program replacing milk distribution with rice. Without prior coordination, citizens took these bags of rice and split them open, spilling the rice at clinic doors, within sight of the clinic personnel and military guards. These "silent acts" of protest were replicated at neighborhood clinics across the country and were so widespread that within days of implementing the replacement, Pinochet personally decreed milk distribution be reinstated.[45]

Finally, citizens made alternate use of what were perceived as low-quality clinic food products (thus converting them into resources with value for the family). Here, I use the case of Fortesán—a product made from a mix of soy and dairy products[46]—to highlight the differences between top-level perceptions and mandates and ground-level practices. By official accounts, low-cost Fortesán had low solubility and acceptability and was therefore a failed experiment (Gobierno de Chile 2005: 67–72). In the words of Dr. Hector Aliaga, in charge of the PNAC at the time, "Fortesán was like a block of stone or cement" and it "had no acceptance rate" amongst beneficiaries.[47] Dr. Fernando Mönckeberg Barros[48]—well-known advocate for programs that combat infant malnutrition—remembers Fortesán as being commonly sold on the black market.

> [T]he milk in the first years [after 1973] was dramatic. The mother would receive a package of 3 kg of milk and Fortesán … and on her way

example, longtime Recoleta paramedic, activist, and community resident explains: "The military doctors tended to not put them [IUDs] in and the other ones did. However, there were no rules about it." Recoleta clinic worker #1 (2011), author interview, Santiago, October 18. For more on what is referred to here as an "ambiguous reproductive rights" see pages 142–45 in Mooney (2009).

44. The idea of muted voice bears some semblance to James Scott's notions of partial transcripts, referring to the unedited transcripts of elites and subordinated classes. These are usually hidden from each other and only come into direct confrontation during moments of crisis. Both are necessary to revel the "full transcript" of class relations (1985: 284–89). Instances of "muted voice" are outbursts of these hidden transcripts and while usually the product of a spontaneous defiance, they result from a process of slow accumulation of frustration.

45. For more on this incident, see Goldsmith Weil (2017b).

46. It was developed by the team of Dr. Fernando Mönckeberg at the National Institute for Food Technologies (INTA) (Gobierno de Chile 2005: 67–72).

47. (2011), author interview, Santiago, December 26. Mönckeberg was a main advocate for the maintenance of the PNAC program throughout the military years. He founded the institutions that accompanied state-led efforts at decreasing infant malnutrition throughout the 1980s—the INTA, *National Council for Food and Nutrition* (CONPAN), and *Corporation for Infant Nutrition* (CONIN)—and vehemently fought against all attempts at cutbacks.

48. (2011), author interview, Santiago, November 17.

> out she would sell it. For three full years, they would be selling the milk [every month].[49]

At the local level, clinic workers would help families find ways to make "use" of these products. Not preparing state milks according to instructions was not merely an issue of domestic mismanagement as the top authorities believed but also, as in the case of Fortesán,[50] a coping strategy sometimes learned at the clinic. For example, one paramedic would teach beneficiaries not to dissolve Fortesán as the instructions state but instead to get around its low solubility with alternate uses: "Sometimes some really bad milks came in … and people didn't want it. So we would teach them to make desserts with that milk … to make little dessert balls of Fortesán."[51]

The different narratives of local provision presented in this section illustrate the ways in which policy implementation occurred independent of formal mandates. The micro-episodes of solidarity[52] in conjunction with low *Instituciones de Salud Previsional* (ISAPRE) enrollment rates reveal a state that rather than retrenched is ubiquitous in the health sector—even in the everyday working of resistance organizations. By the end of the military regime, PNAC was accompanied by a series of targeted programs,[53] the quality of state-distributed milk was greatly improved,[54] and PNAC coverage increased from an estimated 72 percent in 1975 to 80 percent in 1987,[55] with the number of children younger than six years old under surveillance in Ministry of Health establishments rising from 1,015,000 in 1975 to 1,258,200 in 1985.[56] Therefore, despite the political situation that led citizens to retreat from the state whenever possible, in the area of infant-maternal health and nutrition programs, citizens continued to "plug through" by finding creative ways to continue extracting resources and services from local state offices despite the repressive and adversarial context—a practice that continues beyond the dictatorship.

49. The idea of clinic users "selling" state milk came up often in my interviews with PNAC administrators and politicians concerned with deuniversalizing the program or assuring what they refer to as "efficiency." It did not, however come up in ground-level interviews and, while I was able to confirm that clinic milk is available on the black market, I suspect that it is overdimensioned in the narratives and imaginary of neoliberal policy makers.

50. Fortesán is still so prominent in the popular imagination that in a recent TV show depicting a family during the period, it is mentioned jokingly (and the audience is assumed to remember it) (Los 80: season 2). When I showed a picture of an advertisement of it to a group interview consisting of eight women who were mothers of young children and PNAC beneficiaries in the 1980s, it spurred a long conversation in which they shared their memories of how delicious it was. Recoleta clinic users interview #1 (2012), author interview, December 6.

51. (2011), author interview, Santiago, September 27.

52. It should be noted that paralegal strategies were not only deployed in a context of regime opposition but also one of regime supporters. Proregime clinic workers also found ways to secure preferential services to families with whom they shared a political affinity. Ruiz Tagle and Urmeneta provide a good example of how PEM and POJH workers received privileged access to health entitlements (1984).

53. Specifics on these programs in Foxley and Racynski (1984: 123).

54. Under the guidance of Mönckeberg, CONPAN created a state brand, *Purita*, also commercialized in supermarkets and, from then on, all clinic food products delivered with the *Purita* label.

55. 1975: INE and Ministry of Health, Anuario de Recursos y Atenciones de Salud, in Racynski (1991: 36); 1987 in Castañeda (1990, 1992: 111).

56. INE, Ministry of Health documents collected in Racynski (1991: 36).

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## Democratic, Leftist, and Still Bypassing the Rules, 1990–2010

Between 1990 and 2010, Chile was governed by presidents of a center-left coalition committed to expand social services and rights while fomenting competitive conditions for trade on international markets and assuring government spending was both efficient and had visible results. Even though beginning in the early 1990s, social spending increased in terms of policy outcomes, most of the social spending was framed in what can be called an essentially *market-based* logic where the responsibility of the state as a provider of welfare was subordinated to its role as protector of *fair* market conditions. This was translated into temporary subsidies to families, training programs in market-friendly skills, or transfers to the private sector for services provided. This tension created a disjuncture between a rights-based rhetoric and limited welfare expansion and resulted in a constellation of ground-level encounters between state workers and citizens. While attempts at deuniversalizing the state milk program were abruptly halted by the threat of a political scandals and media uproar, the posttransition socialist governments (2000–10) implemented a series of "technical adjustments" that, taken together, constitute an attempt to retrench the program without the political costs of changing legislation. At the local level, citizens and providers coordinated to counter these attempts at de facto targeting by strategically scripting encounters to meet eligibility criteria and engaging in diverse paralegal strategies including finding alternate uses of clinic milks, intrafamilial dispersion, intracommunity redistribution, and funneling resources. This section briefly summarizes the literature on the social program of the *Concertación*, describes changes and continuities in the PNAC program rules, and moves on to describe the ground-level strategies to secure state milk.

In the welfare literature, there seems to be a consensus that, for the most part, the spending of the 1990s in Chile did not reverse the neoliberal reforms. Political scientists have attempted to explain the *Concertación*'s insistence on gradual change and commitment to not challenging basic neoliberal tenets by focusing on the institutional (Borzutzky 2002; Siavelis 2006, 2009; Taylor 2004), actor-centered (Davila 2005; Ewig and Kay 2011), or authoritarian legacies. Ewig and Kay (2011) highlight the lock-in effect of the increased power of business and capital interests in social provision, and Staab concludes that, from a gender perspective, "market reforms layered new gender inequalities on to the already existing legacies of maternalism and male-breadwinner bias" (2012: 303). Whether the spending of the Lagos 2000–6 and Bachelet 2006–10 presidencies reverses the model is an open debate:[57] For example, while Pribble (2013b) categorizes 2000–10 Chile as moving toward what she defines as "basic universalism," Farias (2014) questions this categorization.

57. For more on this debate, see the edited volume of Borzutzky and Weeks (2010), which provides a sector-by-sector analysis of the tensions created by the *Concertación*'s simultaneous commitment to broad-based *consensus* (and conflict aversion) and its attempts to respond to increasing bottom-up demands for more progressive policy.

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At the ground level, as in the previous period, policy outputs at the local level occurred somewhat independent of formal mandates. Unlike in the previous period, where providers broke the rules because of what they consider a "bad government," here contestation is due to the idea that program rules are "mistaken" and sometimes guided by the idea that other program rules would most help the center-leftist presidency meet its stated goals. The case of the introduction of a new milk product and the ground-level strategies to resist, reuse, and avoid it serve as a lens through which to observe the informal strategies deployed at the local level to resist this change. In 2008, *Leche Purita Mamá*, a fortified milk product designed to provide benefits for infants when consumed by pregnant and nursing mothers, was introduced.[58] In practice, *Purita Mamá* tasted and smelled bad and gave women acid reflux. While it was presented as a milk that would "deepen equal opportunities," government evaluations tended to focus on economic efficiency over equality. Ministry of Health officials pointed to its unfavorable organoleptic qualities (foul taste) was understood as a positive was externality given that it lowers rates of what they refer to as intrafamily dilution[59] and would therefore deter citizens in higher income levels milk pickups (Contreras et al. 2011: 318), in this way creating a de facto targeting of the program without the political cost of formal retrenchment. Dr. Eduardo Atalah,[60] one of the proponents of the *Purita Mamá* and author if its two evaluations, explains in a 2011 interview: "The advantage of the *Purita Mamá* is that there is some self-targeting. The distribution has gone down a little. The proportion of milk pick-ups amongst recipients with private insurance has gone down."[61]

58. *Leche Purita Mamá* was engineered as a product fortified with omega acid designed for consumption by this target group (pregnant and nursing mothers). It had less fat, had reduced lactose, and was fortified with ten vitamins and minerals considered essential for infant development (Contreras et al. 2011: 313). For more on the technical analysis that led to the introduction of this product, see Mardones et al. (2008) and Mardones and Zamora (1990).

59. An analysis of the research and government surveys regarding the introduction of this product reveals that Minsal authorities were aware of its problems and, while making some adjustments, also tried to downplay its alleged bad taste and smell shifting the blame of its low acceptance rates to recipients who were allegedly preparing it incorrectly. According to a national survey, it initially had high rates of rejection with 81.4 percent of recipients emphasizing its sharp odor and vanilla taste (Contreras et al. 2011: 313–14, 317). The results of this pilot study led to a change in its organoleptic characteristics and the Minsal began to distribute the new *Purita Mamá Modificada* (modified *Purita Mamá*) in October 2009 (ibid.). One year after the introduction of this new product, the Minsal conducted a survey to assess the level of acceptability and consumption of the modified *Purita Mamá* milk and found that 50 percent still found to have an overbearing odor and 82.2 percent still claimed it had a strange taste (Contreras et al. 2011: 313–16, 318). Differences in acceptability were attributed to higher dropout in treatment groups, which is in turn attributed to the standard research process of informed consent (Atalah et al. 2008), and, in a second analysis, the authors sought to explain this negative assessment using domestic mismanagement and claiming that mothers did not prepare the milk as instructed either overconcentrating (50.8 percent) or overdiluting it (Contreras et al. 2011).

60. President of the Chilean Association for Nutrition in two period and for the Latin American Association for Nutrition (2007–9) (2011) author interview, Santiago, December 28.

61. (2011), author interview, Santiago, December 28.

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Citizens reacted to the introduction of *Purita Mamá* by engaging in techniques of intrafamily dispersion, donating milk to political organizations, and scripting encounters with health providers to bypass the new product. In practice, these ground-level strategies manage to somewhat resist the intended socioeconomic targeting of Chile's state milk program. *Purita Mamá* created conflicts between top- and mid-level Ministry of Health professionals. For example, one Ministry of Health nutritionist developed a set of strategies and recipes to coax women to drink this (foul-tasting) milk, an experience she shared at a Minsal conference. After her presentation, she had an argument with a doctor who told her teaching recipients alternate preparations was an "incorrect" practice. She feels that distributing milk that makes pregnant women queasy is an incorrect practice and has continued bypassing the rules teaching women alternate preparations explaining "what I care about is that they drink the milk."[62]

While the ministry's obsession with reducing "intra-family dispersion" deepened,[63] it is based on my fieldwork, "sharing" (i.e., intrafamily dispersion) is the most common way to make use of all resources including clinic foodstuffs for families. For example, when I visited the house of one Recoleta, a multigenerational household containing three milk recipients—a senior citizen (Program for Complementary Foodstuff for Senior Citizens [PACAM][64] recipient), one child younger than six, and a breastfeeding mother—she explained that one of the children is eight years old and therefore is no longer a PNAC recipient. However, he is not fussy and will drink any milk:

> Whatever milk, you give him he will drink. Even that milk that they give mothers—that expecting mother one … I don't like it because it tastes acid to me, but he is fine with it.… His little sister will drink her grandmother's milk mixed with *Purita Cereal*, but she won't drink that "Future Mother" milk. She said it tasted weird and that was the end of it. I have to buy milk separately for her.[65]

This brief window into one family's consumption practice shows how clinic milk is seen as a useful resource for families. Even in the case that it is not consumed by the intended beneficiaries, the consumption of clinic milk by other family members frees resources for the family to purchase preferred products.

Other kinds of redistribution include intracommunity solidaristic arrangements. Some recipients only drink part of their ration and distribute the rest to those close to them in need. For example, one Recoleta resident and PACAM recipient shares her

62. (2011), author interview, Santiago, September 27.

63. He continues to defend the initiative explaining: "They like the other [milk] better, but they distribute it to the whole family." Dr. Eduardo Atalah (2011), author interview, Santiago, December 28.

64. The PACAM program was initiated in 1999. It is modeled after the PNAC and distributes powdered milk and other foodstuffs to senior citizens who keep up to date with a preventative health care program at local *consultorios.* Slots for this program are limited and it is much smaller than the PNAC.

65. Macul family #1 (2011), author interview, Santiago, November 29.

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rations with her brother and his family.[66] Another who struggles to make ends meet for basic needs explains that while her family doesn't like and will not drink clinic foodstuffs, she still picks them up and gives them to a neighbor:

> I pick them up, but give them away. An elderly lady across the street loves them..... She eats them when she doesn't have anything else to eat or when she is cold.[67]

Despite her own stretched economic and time resources, she still values being able to help her neighbor with this ration of state milk.

Other solidaristic redistribution arrangements are more institutionalized. As described previously, during the dictatorship milk flowed from the clinic to resistance organizations through churches and nongovernmental organizations (NGOs). In the democratic era, this practice of funneling state resources to political organizations continues and is sometimes organized within the clinic. In both clinics in which I conducted in-depth research, there were mechanisms for PNAC and PACAM recipients to pick up their milk and then drop it off at a different part of the clinic to be distributed to others. In Macul, citizens could leave their foodstuffs outside the office of a social worker who would then pass them on to families in need. In Recoleta, a midwife collects PNAC (mostly *Purita Mamá*) and PACAM foodstuffs to funnel to the indigenous Mapuche movements engaged in political struggle in the south of Chile.[68]

While some families responded to the introduction of what was considered a substandard product by ceasing to go to the clinic for milk pickups and medical checkups after 2008 which is evidenced in the marked increase in families that do not pick up milk:[69] others actively resist the change. In regular health checkups, mothers of infants in the *Purita Mamá* recipient age bracket claim to not breastfeed to bypass *Purita Mamá* and receive regular milk instead. Minsal nutritionist explains: "When they ask mothers if they are breastfeeding, these respond that they are not. So they give them *Purita*—the milk for children, and the mother drinks it. Women tip each other off on how to do this in clinic waiting rooms."[70] The knowledge on how to bypass formal policy and this undesired milk product is usually learned from family members or neighbors. However, when these mechanisms fail for individual beneficiaries, health providers will instruct women

66. Recoleta family #5 (2011), author interview, Santiago, December 1.

67. Recoleta family #3 (2011), author interview, Santiago, November 30.

68. Recoleta clinic worker #7 (2011), author interview, Santiago, October 25.

69. The household survey data (CASEN) provides evidence that points to the effective targeting among pregnant and nursing mothers that occurred with the introduction of this less desired milk product. Milk pickup for mothers with children in the age groups 0 through 12 months (numbers limited to those families with infants under six months old is not available) are lower in 2009 and 2011 than in previous years: 72.41 percent in 2009 and 62.92 percent in 2011 compared to an 84.22 percent average in the 1990–2007 period. Total averages for these years (children 0–6 years) are not lower, meaning there is a slight increase in other age groups during this period. Ministerio de Desarrollo Social (1990–2011).

70. Ministry of Health professional #1 (2011), author interview, Santiago, September 26–27.

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on the necessary scripts with which to fudge eligibility criteria and receive desired state products. Midwives will ask new mothers whether they tolerate clinic milk and, in cases in which they do not, suggest they tell the nutritionist they do not breastfeed.[71] In these interactions, service providers collude with service recipients to bypass formal policy and provide a service that is understood as an acquired right.

After 2008, citizens quickly learned to adjust their responses to health questions in such a way as to assure the distribution of a desired product. This apparently "small digression" where mothers routinely bypass policy changes and despite a government mandate to distribute *Leche Purita Mamá*, pregnant and nursing mothers continue to receive *Leche Purita Fortificada*; potentially distorts national statistics on breastfeeding. Dr. Mardones Santander—public health and nutrition expert—explains:

> This situation is so serious that many mothers who are breastfeeding say they are not to get *Purita* milk.… This means that the surveys on the duration of breastfeeding … are probably biased.[72]

In conjunction, the measures taken by Chile's leftist presidencies threatened the prestige of *Purita Mamá* milk, understood as "milk for Chileans," and potentially jeopardized the relationships between families and providers.[73] For the first time, in terms of effective coverage, there is a small decrease—in particular in the families with infants in the 0 to 6 months age group—in those who would receive the controversial *Purita Mamá* milk. In sum, in leftist-neoliberal Chile, on-the-ground state workers often behaved according to a narrative shared with elected government public discourse bypassing government policies, therefore "breaking the rules to maintain the spirit of the law." Therefore, while the welfare literature would predict spending and coverage results expansion, results can at best point to continuity and top-level efforts at covert retrenchment were resisted by everyday actions.

## Everyday Strategies to Secure and Make Use of State Milk

Each regime combo in 1954–2010 Chile created the conditions for specific strategies to be enacted in neighborhood clinics. In the first regime combination

71. Examples came up in interviews and personal conversations. Macul clinic worker #1 (2011), author interview, Santiago, November 15. Personal conversations (2012–13), Santiago.

72. (2013), author interview, Santiago, July 26. Breastfeeding rates effectively fell after 2008 and hit the decade's record low of 41 percent. ("Por primera vez en diez años más de la mitad de los niños de seis meses solo toman leche materna," El Mercurio, June 21, 2016). A 2013 survey of mothers who attended clinics found that those who claim to consume *Purita Mamá* milk have slightly higher rates of breastfeeding (58.9 percent) than those who do not (53.6 percent) (Subsecretaria de Salud Publica 2013), a finding consistent with the hypothesis that women claim to not breastfeed to receive alternate milks.

73. For Dra Cecilia Castillo, the most serious problem with this practice is that mothers lie to service providers and potentially might make Chile's national primary health network vulnerable to losing its national coverage and universal status, therefore possibly debilitating the relationship between service providers and citizens (2012), author interview, Santiago, January 6.

**TABLE 2.** *Everyday strategies: Securing state milk*

| *Strategies* | *Informal Institutions* | *Regime Combo* |
|---|---|---|
| Exit | Citizens turn to alternate service providers | Authoritarian, retrenching |
| Silent voice | Uncoordinated individual citizen strategies to protest cutbacks | Authoritarian, retrenching |
| Plugging through | Persistence in demands despite worsening conditions | Authoritarian, retrenching |
| Funneling resources | Into clinics to provide services and out of clinics to resistance organizations | Authoritarian, neoliberal democratic, expanding |
| Resisting targeting | Scripting encounters to meet eligibility criteria | Democratic, expanding |
| Intrafamily dilution | Families share resource among members supplementing with market-purchased products | All regime types |
| Alternate preparations with state milk | Providers teach citizens to make alternate use of low-quality state milk | All regime types |
| Intracommunity solidarity | Citizens go to clinics for milk pickups and take to alternate service providers or churches, drop off for within clinic redistribution, or gift to neighbors | Authoritarian, retrenching democratic, expanding |
| Trafficking in state milk | Selling clinic milk | All regime types |

analyzed in this article: democratic, inward-focused state-led development with an expanding social state in which the implementation of a top-down project ended up effectively extending rights for citizens, we could say that expectations guided by formal theories are concordant with policy outcomes. In the authoritarian, neoliberal, and retrenching social policy combination (1973–89), received theories would predict retrenchment. Not only did this not occur but also the quality of services provided in this area improved during this period. In addition, while the regional literature mostly suggests that citizens *exit* from public services, an analysis of this program finds that citizens continued to *plug through*, and while eligibility rules for this program remained constant, coverage increased. In the third combination analyzed, with the return to democracy, the elections of increasingly leftist leaders, the relative prosperity of the country, and increased social spending, one would expect services and social rights to expand. What we find instead is that they improved in only a piecemeal way during the 1990s, modernizing and introducing some new services with on-the-ground provisions that failed to live up to citizens' expectations. In the 2000s, rather than the expansion the election of leftist presidencies might lead one to expect, a series of "technical" adjustments effectively lowered the quality of services provided and, for the first time, coverage rates began to decline, producing a de facto targeting. Therefore, as in the previous period, received theories do not predict the outcomes for this particular policy sector.

Table 2 presents the everyday strategies observed in all three periods. Examining these microinteractions and their macroeffects on policy outcomes where change was resisted by the same forces under both right-wing dictatorship and left-wing democracy leads us to rethink standard views on the importance of political regime

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type for policy results. It pushes us to examine our conceptual tools for thinking about continuity, which in this case is an outcome of a series of agentic actions enacted in everyday encounters between families and local service providers.

## Conclusion

Between 1954 and 2010 Chile changed dramatically. PNAC, however, did not and outlived government turnover and privatizations, constituting an extensive infant-maternal primary health care network[74] that has been underexamined by scholars who focus exclusively on formal institutions. This article uses the PNAC as a lens to observe how macroeconomic changes affect everyday interactions between citizens and local service providers. It finds that changes in regime type and program rules are filtered through and resisted using practices and strategies deployed in face-to-face encounters between local state representatives and citizens. As the political, economic, and provision landscape changes, bottom-up practices are constantly adjusted, mobilizing empathetic local providers to move beyond formal rules, drawing on paralegal routes to services, or activating resistance networks to locate service providers who draw from and distribute state services.

Beyond the Chilean case, the article's most important finding is that political, economic, and social policy regime types shape but do not determine levels of provision. Welfare provision does not only occur as and when mandated by politicians, but also in everyday interactions between state workers and citizens. There is often a large gap between central policy and these informal institutions that coexist, compete, and clash with formal rules. The informal institutions created in on-the-ground encounters between state workers and citizens are the sites of welfare provision. Finally, people who are regulated by the state and have some capacity to control the state and state workers who organize and are organized by the state to distribute resources have some discretionary power, often breaking rules to follow their vision of the correct state or what they interpret as the spirit of the law. The contents of the interactions between service providers and recipients have substantive ramifications on the level of services received, quality of life for individuals and families, and state strength, efficacy, and stability. Therefore, everyday citizens and public servants—regulated and regulators of formal rules—also find ways to exert agency through informal institutions.

Taken together, the observed everyday strategies constitute informal institutions and present an innovation to the institutionalist literature. This article concludes by suggesting avenues for research that, while referring to macroprocesses of substantive importance, are attentive to the everyday people who experience these in their lives.

74. This continuity extends beyond the infant-maternal services examined in this article. In fact, despite the changes in regime type, the relative proportion of citizens that rely on private services has remained constant and, after a brief hike in ISAPRE users in the 1990s, numbers have dropped to similar rates (13 percent) as the 10 percent of private health users in prehealth reform 1979 Chile (Castañeda 1990 106–7; Ewig and Kay 2011: 75; Gideon 2015: 76).

In this vein, it proposes two lines of inquiry to the welfare literature. The first implies dehomologating formal program guidelines and implementation and proposes the necessity to empirically examine implementation. The second is related to reconceptualizing service beneficiaries and local bureaucrats as agents who influence policy outcomes. Therefore, informal institutions, norms, and networks observed at the implementation level are essential for understanding how people experience welfare "on the ground," and formal institutions are best understood as shaping but not determining the possibilities for citizens to extract resources and services from the state.

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## References

Amenta, Edwin (1993) "The state of the art in welfare state research on social spending efforts in capitalist democracies since 1960." American Journal of Sociology 99 (3): 750–63.

——— (2003) "What we know about the development of social policy: Comparative and historical research in comparative and historical perspective." in Dietrich Rueschemeyer and James Mahoney eds. Comparative Historical Analysis in the Social Sciences. Cambridge and New York: Cambridge University Press: 91–130.

Arellano, José Pablo (1985) Políticas Sociales y Desarrollo: Chile 1924–1984. Santiago, Chile: CIEPLAN.

Atalah S., Eduardo, Glora Vera, Gastón Rosselot P., Héctor Araya L., Ramón Andreu R., Marcela Alviña W., Marcela Araya B., Vianny Vargas P., Karina Peñafiel W., Catalina Barba G., and Tito Pizarro Q. (2008) "Desarrollo, Consumo y Aceptabilidad de una Bebida Láctea con DHA para Embarazadas y Nodrizas." Revista Chilena de Nutrición 35 (4): 433–442.

Borzutzky, Silvia (2002) Vital Connections: Politics, Social Security, and Inequality in Chile. Notre Dame, IN: University of Notre Dame Press.

Borzutzky, Silvia, and Gregory Weeks, eds. (2010) The Bachelet Government: Conflict and Consensus in Post-Pinochet Chile. Gainsville: University of Florida Press.

Brooks, Sarah M. (2004) "International financial institutions and the diffusion of foreign models for social security reform in Latin America." in Kurt Weyland (ed.) Learning from Foreign Models in Latin American Policy Reform. Washington, DC: John Hopkins University Press: 53–81.

——— (2007) "Globalization and pension reform in Latin America." Latin American Politics and Society 49 (4): 31–62.

Castañeda, Tarsicio (1990) Para Combatir la Pobreza: Política Social y Decentralización en Chile durante los 80./Combattng Poverty: Innovative Social Reforms in Chile During the 1980s. Santiago, Chile: Centro de Estudios Públicos.

Castiglioni, Rossana (2005a) The Politics of Social Policy Change in Chile and Uruguay: Retrenchment versus Maintenance, 1973–1998. Latin American Studies. New York: Routledge.

——— (2005b) "Reforma de pensiones en América Latina: Orígenes y estrategias, 1980–2002." Revista de Ciencia Política 25 (2): 173–89.

Collier, Ruth Berins, and David Collier (1991) Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America. Princeton, NJ: Princeton University Press.

https://doi.org/10.1017/ssh.2018.20 Published online by Cambridge University Press

Collins, Joseph, and John Lear (1995) Chile's Free-Market Miracle: A Second Look. Oakland, CA: A Food First Book.
Contreras M., Angela, Yilda Herrera, Lorena Rodríguez O., Tito Pizarro Q., and Eduardo Atalah S. (2011) "Aceptabilidad y consumo de una bebida láctea con Omega-3 en embarazadas y nodrizas del Programa Nacional de Alimentación Complementaria." Revista Chilena de Nutrición 38 (3): 313–320.
Davila, Mireya (2005) "Health reform in contemporary Chile: Does politics matter?" Master's thesis, University of North Carolina.
Dreze, Jen, and Amartya Sen (1989) Hunger and Public Action. New York: Oxford University Press.
Esping-Andersen, Gøsta (1990) The Three Worlds of Welfare Capitalism. Princeton, NJ: Princeton University Press.
Estevez-Abe, Margarita, Torben Iverson, and David Soskice, (2001) "Social protection and the formation of skills: A reinterpretation of the welfare state." in Peter A. and David Soskice Hall eds. Varieties of Capitalism: The Institutional Foundations of Comparative Advantage. New York: Oxford University Press.
Ewig, Christina, and Stephen J. Kay (2011) "Postretrenchment politics: Policy feedback in Chile's health and pension reforms." Latin American Politics and Society 53 (4): 67–99.
Farías Antognini, Ana (2014) "Segmentación en la distribución del bienestar. Chile, reformas sociales 2000–2010." Paper presented at the XI Congreso Chileno de Ciencia Política, Santiago, Chile.
Filgueira, Fernando (2005) "Past, present and future of the Latin American social state: Critical junctures and critical choices." Working Paper UNRISD.
——— (2013) "Basic universalism—The way forward or a dead end? Or: The What kind of social policy in the new social contract?" Paper presented at Latin American Studies Association, Washington, DC.
Foxley, Alejandro, and Dagmar Racynski (1984) "Grupos vulnerables en situaciones recesivas: El caso de los niños y jóvenes en Chile." Colección Estudios Cieplan 13 (89): 107–39.
Fraser, Nancy (1996) "Gender equity and the welfare state: A postindustrial thought experiment." in Seyla Benhabib (ed.) Democracy and Difference: Contesting the Boundaries of the Political. Princeton, NJ: Princeton University Press.
George, Alexander L., and Andrew Bennett (2005) Case Studies and Theory Development in the Social Sciences. Cambridge, MA: MIT Press.
Gideon, Jasmine (2012) "Accessing economic and social rights under neoliberalism: Gender and rights in Chile." Third World Quarterly 27 (7): 1269–83.
——— (2012) "Engendering the health agenda? Reflections on the Chilean case, 2000–2010." Social Politics 19 (3): 333–60.
——— (2015) Gender, Globalization, and Health in a Latin American Context. New York: Palgrave Macmillan.
Glatzer, Miguel, and Dietrich Rueschemeyer (2005) Globalization and the Future of the Welfare State. Pittsburgh, PA: University of Pittsburgh Press.
Gobierno de Chile, ed. (2005) Nutrición para el desarrollo: El Modelo Chileno. Ministerio de Salud. Santiago, Chile: Lom Ediciones.
Goldsmith Weil, Jael (2017a) "Milk makes state: The extension and implementation of Chile's state milk programs, 1917–1971." Historia 50 (I): 79–104.
——— (2017b) "Using critical junctures to explain continuity: The case of state milk in neoliberal Chile." Bulletin of Latin American Research 36 (1): 52–67.
Grzymala-Busse, Anna (2010) "The best laid plans: The impact of informal rules on formal institutions in transitional regimes." Studies in Comparative International Development 45 (3): 311–3.
Haggard, Stephan, and Robert R. Kaufman (2008) Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe. Princeton, NJ: Princeton University Press.
Hancock, Ange-Marie (2004) The Politics of Disgust: The Public Identity of the Welfare Queen. New York: New York University Press.
Haney, Lynne (2002) Inventing the Needy: Gender and the Politics of Welfare in Hungary. Berkeley and Los Angeles: University of California Press.

https://doi.org/10.1017/ssh.2018.20 Published online by Cambridge University Press

Helmke, Gretchen, and Steven Levitsky (2004) "Informal institutions and comparative politics: A research agenda." Perspectives on Politics 2 (3): 725–40.
Hicks, Alexander (1999) Social Democracy and Welfare Capitalism: A Century of Income Security Politics. Ithaca, NY: Cornell University Press.
Hicks, Alexander, and Lane Kenworthy (2003) "Varieties of welfare capitalism." Socio-Economic Review 1: 27–61.
Hicks, Alexander, Joya Misra, and Tang Nah Ng (1995) "The programmatic emergence of the social security state." American Sociological Review 60 (3): 329–49.
Hirschman, Albert O. (1970) Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States. Cambridge, MA: Harvard University Press.
Huber, Evelyne (2013) "Basic universalism—The way forward or a dead end? Or: The what kind of social policy in the new social contract?" Paper presented at the Latin American Studies Association, Washington, DC, May 30.
Huber, Evelyne, and John D. Stephens (2001) "Welfare state and production regimes in the era of retrenchment." in Paul Pierson (ed.) The New Politics of the Welfare State. New York: Oxford University Press: 107–45.
——— (2012) Democracy and the Left: Social Policy and Inequality in Latin America. Chicago and London: University of Chicago Press.
Illanes, Maria Angelica (2007) Cuerpo y sangre de la politica: La construccion historica de las Visitadoras Sociales (1887–1940). Santiago, Chile: LOM ediciones.
Inhorn, M. C. (2006) "Defining women's health: A dozen measures from more than 150 ethnographies." Medical Anthropology Quarterly 20 (3): 345–78.
Iversen, Torben (2001) "The dynamics of welfare state expansion: Trade openness, de-industrialization, and partisan politics." in Paul Pierson (ed.) The New Politics of the Welfare State. New York: Oxford University Press: 45–79.
Jímenez de la Jara, Jorge (2009) Angelitos Salvados: Un recuento de las políticas de salud infantil en Chile en el siglo XX. Santiago, Chile: Uqbar Editores.
Kaufman, Robert (2013) "Basic universalism—The way forward or a dead end? Or: The what kind of social policy in the new social contract?" Paper presented at Latin American Studies Association, Washington, DC, May 30.
Kubal, Mary Rose (2006) "Contradictions and constraints in Chile's health care and education decentralization." Latin American Politics and Society 48 (4): 105–35.
Lister, Ruth (2002) "The responsible citizen: Creating a new British welfare contract." in Catherine Kingfisher (ed.) Western Welfare Decline. Philadelphia: University of Pennsylvania Press.
Lynch, Julia (2006) Age in the Welfare State: The Origins of Social Spending on Pensioners, Workers, and Children. New York: Cambridge University Press.
Madrid, Raúl L. (2003) Retiring the State: The Politics of Pension Privatization in Latin America and Beyond. Stanford, CA: Stanford University Press.
Mahoney, James, and Kathleen Thelen, eds. (2010) Explaining Institutional Change: Ambiguity, Agency, and Power. New York: Cambridge University Press.
Mardones, F., and R. Zamora (1990) "Evaluación socio-económica de la entrega de leche 'Purita' a la embarazada en Chile." Revista Médica de Chile 118: 1043–51.
Mardones, F., M. T. Urrutia, L. Villarroel, A. Rioseco, O. Castillo, J. Rozowski, J. L. Tapia, G. Bastias, J. Bacallao, and I. Rojas (2008) "Effects of a dairy product fortifies wth multiple micronutrients and omega-3 fatty acids on birth weight and gestation duration in pregnant Chilean women." Public Health Nutrition 11 (1): 30–40.
Martínez Franzoni, Juliana (2008) Domesticar la Incertidumbre en America Latina: Mercado laboral, politica social y familias. San Jose, Costa Rica: Editorial Universidad de Costa Rica.
Martínez Franzoni, Juliana, and Diego Sánchez-Ancochea (2016) The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures. New York: Cambridge University Press.
Martínez Franzoni, Juliana, and Koen Voorend (2012) "Blacks, whites, or grays? Conditional transfers and gender equality in Latin America." Social Politics 19 (3): 383–407.

https://doi.org/10.1017/ssh.2018.20 Published online by Cambridge University Press

McGuire, James (2010) Wealth, Health, and Democracy in East Asia and Latin America. New York: Cambridge University Press.
Ministerio de Desarrollo Social (1990–2011) La Encuesta de Caracterización Socioeconómica Nacional, Chile.
Mönckeberg Barros, Fernando (2003) "Prevención de la desnutrición en Chile. Experiencia vivida por un actor y espectador." Revista Chilena de Nutrición 30 (1): 160–76.
Mooney, Jadwiega E. Pieper (2009) The Politics of Motherhood: Maternity and Women's Rights in 20th Century Chile. Pittsburh, PA: University of Pittsburgh Press.
Nelson, J. M. (2007) "Elections, democracy, and social services." Studies in Comparative International Development 41 (4): 79–97.
O'Donnell, Guillermo A. (1993) "On the state, democratization and some conceptual problems: A Latin American view with glances at some postcommunist countries." World Development 21 (8): 1355–69.
Orloff, Ann Shola (1993) "Gender and the social rights of citizenship: The comparative analysis of gender relations and the welfare states." American Sociological Review 58 (3): 303–28.
——— (1996) "Gender in the welfare state." Annual Review of Sociology 22: 51–78.
Pierson, Paul (1994) Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment. Cambridge and New York: Cambridge University Press.
——— (2000) "The three worlds of welfare state research." Comparative Political Studies 33 (7): 791–821.
——— (2001) The New Politics of the Welfare State. Oxford and New York: Oxford University Press.
Pribble, Jennifer (2006) "Women and welfare: The politics of coping with new social risks in Chile and Uruguay." Latin American Research Review 41 (2): 84–111.
——— (2013a) "Basic universalism—The way forward or a dead end? Or: The what kind of social policy in the new social contract?" Paper presented at Latin American Studies Association, Washington, DC, May 30.
——— (2013b) Welfare and Party Politics in Latin America. New York: Cambridge University Press.
Racynski, Dagmar (1991) "Social policy and economic change in Chile 1975–1985: The case of children." International Journal of Health Services 21 (1): 17–47.
Racynski, Dagmar, and Cesar Oyarzo (1981) "¿Por Qué Cae la Tasa de Mortalidad Infantil en Chile?" Colección Estudios Cieplan 6 (55): 45–84.
Richards, Patricia (2004) Pobladoras, Indígenas, and the State: Conflicts over Women's Rights in Chile. New Brunswick, NJ: Rutgers University Press.
——— (2013) Race and the Chilean Miracle: Neoliberalism, Democracy, and Indigenous Rights. Pittsburgh, PA: University of Pittsburgh Press.
Rojas Flores, Jorge (2010) Historia de la Infancia en el Chile Republicano: 1810–2010. Santiago, Chile: Junta Nacional de Jardines Infantiles.
Ruiz Tagle, J. U., and R. Urmeneta (1984) Los Trabajadores del Programa de Empleo Mínimo en el Capitalismo Autoritario: Condiciones del Trabajo, Comportamiento, Rol Sociopolítico. Santiago, Chile: Programa de Investigaciones Sociales sobre Población en América Latina.
Sandbrook, Richard, Marc Edelman, Patrick Heller, and Judith Teichman (2006) Social Democracy in the Global Periphery: Origins, Challenges, Prospects. Cambridge: Cambridge University Press.
Sarigil, Zeki (2015) "Showing the path to path dependence: The habitual path." European Political Science Review 7 (2): 221–42.
Scott, James C. (1985) Weapons of the Weak: Everyday Forms of Peasant Resistance. New Haven, CT, and London: Yale University Press.
Scully, Timothy (1992) Rethinking the Center: Party Politics in Nineteenth- and Twentieth-Century Chile. Stanford, CA: Stanford University Press.
Siavelis, Peter M. (2006) "Accomodating informal institutions and Chilean democracy." in Gretchen Helmke and Steven Levistsky (eds). Informal Institutions and Democracy: Lessons from Latin America. Baltimore, MD: John Hopkins University Press: 33–55.
——— (2009) "Enclaves de la transición y democracia Chilena." Revista de Ciencia Política 29 (1): 3–21.
Staab, Silke (2012) "Maternalism, male-breadwinner bias, and market reform: Historical legacies and current reforms in Chilean social policy." Social Politics 19 (3): 299–332.

https://doi.org/10.1017/ssh.2018.20 Published online by Cambridge University Press

——— (2016) "Opportunities and constraints on gender-egalitarian policy change: Michelle Bachelet's social protection agenda (2006–2010)." in Georgina Waylen (ed.) Gender, Institutions, and Change in Bachelet's Chile. New York City: Palgrave Macmillan: 121–47.

Subsecretaria de Salud Pública (2013) Informe técnico encuesta nacional de lactancia materna en la atención primaria (ENALMA). CHILE 2013. Edited by Ministerio de Salud: Gobierno de Chile.

Taylor, Marcus (2004) "Labor reform and the contradictions of 'Growth with Equity' in postdictatorship Chile." Latin American Perspectives 31 (4): 76–93.

Tsai, K. (2006) "Adaptive informal institutions and endogenous institutional change in China." World Politics 59 (1): 116–41.

Waylen, Georgina, ed. (2016) Gender, Institutions, and Change in Bachelet's Chile, Studies of the Americas. New York: Palgrave Macmillan.

Weyland, Kurt Gerhard, ed. (2004) Learning from Foreign Models in Latin American Policy Reform. Baltimore, MD: Johns Hopkins University Press.

https://doi.org/10.1017/ssh.2018.20 Published online by Cambridge University Press