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Child-centered social policies in Argentina: Expansion, segmentation, and social stratification

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Abstract

Over the last two decades or so, social policy has expanded in many Latin American countries. In Argentina, public social expenditures increased, and new social programs were implemented to extend access to previously excluded populations. These developments also involved three child-centered social policies: child benefits in cash, maternal and infant health care, and early child education and care. Looking at key institutional features of new programs and policies, and using data on the distribution of children's access to benefits across socio-economic strata, this article evaluates the progress and limits of recent social policy developments to reduce segmentation and social stratification in child-centered social policies and promote egalitarian social investment for all children.

KEYWORDS

childhood, coverage, inequality, social policy

1 | INTRODUCTION

Over the last two decades or so, in the context of economic growth and more progressive governments, social policy expanded in Latin America (Cecchini, Filgueira, & Robles Farías, 2014; Huber & Stephens, 2012; Pribble, 2013). Many countries increased public social expenditures and implemented new social assistance programs, including conditional cash transfer (CCT) programs that provide small amounts of cash to poor or extremely poor families, and have a focus on children and on the intergenerational dynamics of poverty and inequality. Other child-centered social policies, including maternal and infant health care for the population with no health insurance, and early child education and care (ECEC) programs, also developed in some countries.

Argentina is among the Latin American countries with the broadest social protection systems. But despite the early origins and universalistic scope of key social policies such as education and health care, Argentine social policies have evolved into segmented structures, crossed by the division between formal and informal employment, public and private provision, and territorial inequalities. In the aftermath of the economic crisis that hit Argentina in

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2001, social policies acquired greater dynamism, public social expenditures grew, and new social programs developed for lower-income families. This article focuses on three child-centered social policies: (1) child benefits in cash; (2) maternal and infant health care; and (3) ECEC. While child benefits in cash (family allowances and, especially, CCTs) have received a great deal of attention in the academic and policy-oriented literature, there are fewer studies that jointly evaluate two or more child-centered social policies. There is, however, growing agreement on the multidimensional aspects of poverty, as well as on the need for an integrated inter-sectoral approach to child development (Araujo, López-Boo, & Puyana, 2013; Berlinski & Schady, 2015; De Achaval & Aulicino, 2015; Vegas & Santibáñez, 2010).

2 | CHILD-CENTERED SOCIAL POLICIES AND SOCIAL STRATIFICATION

Child-centered social policies received much attention in the debates surrounding the reform of advanced welfare states in the context of low growth and new social risks of post-industrial societies (e.g., Esping-Andersen, 2002; Esping-Andersen & Palier, 2011; Morel, Palier, & Palme, 2012). The emphasis on child-centered social policies is also supported by a body of interdisciplinary scholarly work that shows that inequalities in child development begin during the prenatal period and consolidate over the first years of life, producing disparities that can reinforce inequalities over the life course (Engle et al., 2011; Grantham-McGregor et al., 2007; Walker et al., 2011, p. 1325, among others). Thus, child-centered social policies can contribute to reduce inequalities at early ages, and before they have become more firmly established.

Social policies oriented to improve the living conditions and opportunities of lower income children have also recently received growing attention in Latin American countries (see e.g., Araujo et al., 2013; Berlinski & Schady, 2015; Vegas & Santibáñez, 2010). Enhancing universal access to essential benefits and social services is particularly relevant in Latin America for at least two reasons. First, in the context of segmented labor markets with widespread informality, traditional labor market regulations and social insurance do not reach most of the poor, who are largely outside the formal labor market, may have no regular incomes, and are not entitled to contributory benefits. Therefore, policies that extend access to essential goods and services to everyone (and beyond the formal labor market) can help to reduce the impacts that parents' employment status and social origins have on children's well-being and opportunities. Second, Latin American welfare regimes still largely rely on families and on women's unpaid work to provide care for young children (Cecchini, Filgueira, Martínez, & Rossel, 2015, pp. 111–112). This risks reproducing and consolidating both inherited socio-economic disadvantages, and gender inequality (Esping-Andersen & Palier, 2011; Filgueira & Aulicino, 2015).

A long-standing feature of Latin American welfare regimes is segmentation and stratification in social security coverage and in the quality of social services that families have access to (Filgueira, 2013; Mesa-Lago, 1978). This issue has been discussed in the social policy literature for some time. Recent studies have also focused on segmentation as a key dimension to evaluate the outcomes of social policy developments of the past two decades. For instance, Barrientos (2009) discusses the impacts of labor market liberalization and the expansion of social assistance on the types of segmentation characteristic of the conservative-informal welfare regime, and Pribble (2013) considers the “non-segmentation of benefits” as an indicator of progress towards universal social policy. Similarly, Martínez Franzoni and Sánchez-Ancochea (2016a, 2016b) focus extensively on social policy segmentation as the opposite of universalism, which they define as a combination of massive coverage, generous benefits, and equity.

In this article, I build on that literature and focus on three child-centered social policies in one particular country. The focus on a single country allows me to consider the key features of social policy institutional structures in greater detail and identify which are the specific policy measures that matter to reduce segmentation, and how they do so. I refer to segmented social policies when separate systems or programs exist to offer benefits to different groups of the population—a measure mainly concerned with equity in access and in the quality of benefits and services received.[1] This means the focus is not only on the insider/outsider cleavage (i.e., coverage), but also on the

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differences in the benefits each one has access to. Thus, segmentation can co-exist with exclusion when some social groups are not covered by any of the existing programs, and it can produce stratified outcomes when access to one or another benefit is associated with socio-economic status. When the benefits obtained by higher income groups are better (in amounts, quality, conditions, and so on) than for the rest, social policy segmentation can end up reproducing socio-economic inequalities.[2] After the expansion of coverage, and the reduction of the insider/outsider gap, this study evaluates how the old and new types of segmentation evolved.

In section 3, I discuss recent developments in three child-centered social policies, and use several indicators to evaluate institutional structures and outcomes. On the one hand, I use indicators of segmentation in social policy institutional structures, which aim to capture how existing programs vary in terms of key variables of interest (i.e., eligibility conditions, sources of financing, benefits, and provider).[3] On the other hand, I use indicators of segmentation in policy outcomes, which refer to the delivery of benefits across social groups, in other words, what the population effectively receive. For this, I rely on data of the distribution of coverage by different programs across social strata. Other relevant aspects I consider as far as possible are variations in benefit amounts and quality across systems that are oriented to different social groups, as well as in the ways in which benefits are delivered (e.g., either as a matter of right or through discretional mechanisms).[4]

3 | RECENT EXPANSION OF THREE CHILD-CENTERED SOCIAL POLICIES IN ARGENTINA

In the aftermath of the economic crisis that hit Argentina in 2001, the government moved away from the policies of structural adjustment and privatization that had characterized the previous decade, to give a broader and more active role to the state. Pubic social expenditures increased, both in aggregate and in each of the main policy sectors included in this article (Figure 1). Both contributory and non-contributory benefits expanded following the rise of formal employment, and the development of targeted cash transfers and basic pensions.

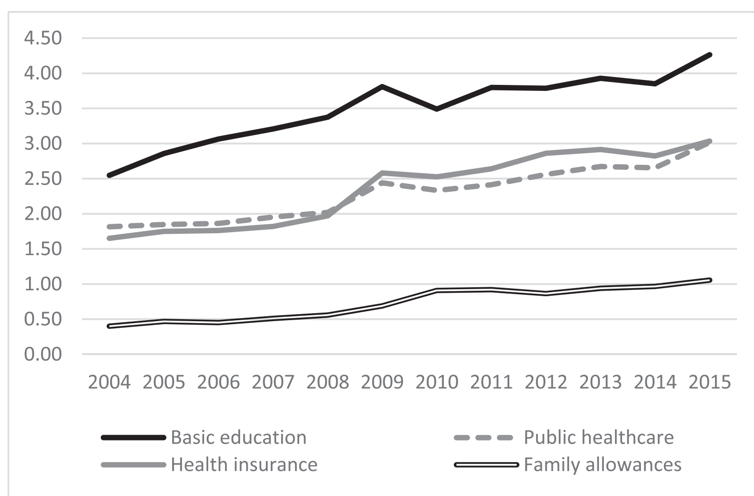

FIGURE 1 Public social spending as a percentage of GDP (2004–15): Basic education, health insurance, public health, and family allowances
Source. Own elaboration, based on National Ministry of Economy (Argentina), Sub-Secretariat of Macroeconomic Programming, Secretary of Economic Policy and Development Planning (Ministerio de Hacienda, 2017)
Note. Consolidated public spending (national, provincial, and municipal). "Health insurance" refers to *obras sociales*. "Basic education" includes primary and secondary education. "Family allowances" includes family allowances and universal child allowance (AUH)

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TABLE 1 Key features and reforms in three child-centered social policies in Argentina

	Child benefits in cash	Maternal and infant health care	Early child education and care
Current programs and providers	– Family allowance per child and pregnant women, for formal workers and pensioners (with incomes up to a ceiling) – Universal child allowance (AUH) and universal pregnancy allowance (AUE) for informal workers and other vulnerable groups – Social assistance pensions for mothers of seven or more children	– Universal public health care system – Employment-based health insurance ("*obras sociales*") – Private health care insurance and providers	–Universal public formal early education – Child development centers (governmental or non-governmental) – Private ECEC
Key reforms to expand/ improve access after the year 2000	2009 – Universal child allowance for informal workers and other vulnerable groups (AUH) 2011 – Universal pregnancy allowance for informally working and other vulnerable women (AUE) 2016 – Family allowances per child for lower income self-employed	2004–5 – *Plan Nacer*; preceded by Maternal–infant health insurance program (2002–03); continued by *Programa Sumar* (2012) 2002 – *Programa Remediar*	2006 – National Education Law: early education as pedagogical unit (45d to 5y), ratifies compulsory education from age 5 and universalization from age 4 2007 – Law of Promotion and Regulation of Communitarian Centres for Child Development 2015 – Compulsory education from age 4, universalization from age 3 2016 – National Early Childhood Plan

Source. Own elaboration.

The three child-centered social policies analyzed in this article have been reformed in one way or another with the aim of expanding coverage of the population and of lower income households in particular. Table 1 presents an overview of the structure and main features of these three policies and the most important reforms implemented in recent years. In Argentina, child benefits in cash are part of the social security system. Originally based on a contributory system, family allowances excluded families outside the formal labor market, but recent reforms have included them as well (section 3.1). In contrast, both health care and early education are based on a public, free, and universal system with decentralized administration (sections 3.2 and 3.3). In the case of health care, an employment-based health insurance system ("*obras sociales*") exists alongside the public universal system and private providers. In the case of ECEC, a policy with a still more limited development, public services coexist with services provided by the private sector, and institutions that are part of formal education with those that are not. In most cases, and especially in lower income households, the family (and most of the time, the women of the family) continues to be the main provider of care for small children.[5]

3.1 | Child benefits in cash

Family allowances have long existed in Argentina as part of the contributory social security system for formal sector workers and pensioners. This system provides regular monthly cash benefits to eligible parents for each child aged zero to 17. Up until 2009, informal workers had no access to these types of benefits. In 2002, in response to the deep socio-economic crisis, the government created a wide-ranging program providing cash benefits to unemployed workers "heads of households", benefiting over two million people (CELS, 2003; Golbert, 2004). Shortly after, the coverage of a social assistance pension (which began in 1989) for mothers of seven or more children in socio-economically vulnerable families widely expanded, rising from 56,482 to 313,923 benefits between 2002 and 2016 (MTESS, 2017, p. 47).

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Those two policies preceded a more structural policy shift, taking place in 2009, when the government created a new non-contributory benefit, the "Universal Child Allowance for Social Protection" (AUH, the acronym in Spanish), and in 2011, the prenatal benefit "Universal Pregnancy Allowance" (AUE, the acronym in Spanish). Both are regular monthly cash transfers of about U$S73[6] for each child or pregnant woman. In order to qualify, workers must have earnings below the minimum legal wage (or no earnings at all) and provide certification that children are enrolled into the health care program *Plan Nacer/Sumar* (see below), make required health visits, comply with mandatory vaccination, and attend public school (if of compulsory education age)[7] (Arza & Chahbenderian, 2014; Bertranou & Maurizio, 2012; Díaz Langou & Acuña, 2016; Lo Vuolo, 2013). This program currently covers 3.7 million children (MTESS, 2017, p. 34). Lastly, in 2016, family allowances were extended to the self-employed in lower income brackets (*monotributistas*), who were previously not entitled to either of the existing child benefits. As a result of all these policy measures, informal and unemployed workers, as well as the lower income self-employed, became eligible to receive a regular child benefit in cash, in a multi-layered system (Arza, 2018).

Across Latin America, CCT programs have been promoted on the expectation that these benefits will contribute to enhance human capital accumulation encouraging lower income families to send their children to school and take them for regular health visits. Many studies have been directed to evaluate the impacts of CCTs on these aspects (for a review, see Cecchini et al., 2015, pp. 103–104; Rossel, 2013).[8] While the role and impacts of welfare conditionality remain controversial, the cash received increases the income of households where children live. Recent studies find that AUH has had a positive impact on poverty reduction (Bracco, Falcone, Galeano, & Gasparini, 2017; Salvia, Tuñón, & Poy, 2015). However, studies also show that these benefits tend to reduce the poverty gap, but are not sufficient to take most children out of poverty (ANSES-UNICEF, 2017, p. 16). Benefit generosity is crucial for this matter, and the facilities to obtain and continue receiving benefits are also important. In this aspect, a positive feature of AUH is that the application procedure is quite simple, there are no waiting lists, and the allocation of benefits is largely isolated from clientelistic networks (Zarazaga, 2014). However, the failure to certify the conditionalities can trigger the cancelation of benefits, leaving the poor with less income and administrative hassles to get benefits back.[9]

With AUH, coverage increased, and currently the majority of children in Argentina receive a cash benefit (about 71–79%, depending on the estimation).[10] Furthermore, AUH benefits are concentrated in lower income groups, targeting expansion at the most vulnerable families. Children from lower income households are more likely to receive AUH, while children from middle and higher income households either receive contributory family allowances, or receive no benefit. However, and despite the fact that coverage is higher for children from lower income households (quintiles 1 and 2) than for the rest, many of them are still not covered (about 23.6% in 2015, see Figure 2).

The way in which the expansion of benefits was designed and implemented (i.e., supplementing existing family allowances with targeted and conditioned benefits, rather than integrating everyone into a single system) generated a multi-layered system that divides children based on socio-economic position and employment status of their parents. Three national programs currently provide similar benefits to different socio-economic groups: AUH for informal and unemployed workers, family allowances for formal workers, and social assistance pensions for vulnerable mothers of seven or more children. As a result, children from different socio-economic origins have access to different programs, under different conditions, a feature that is observed in other Latin American countries as well (Arza, 2018).

Although in Argentina there are some program features that help narrow segmentation (equal basic benefit, indexation rule, and source of financing for AUH and family allowances), the types of benefits and the conditions to get them are not the same. Formal workers have access to other family benefits that informal workers do not get (e.g., for marriage, childbirth, and adoption), and their benefits are unconditional. Furthermore, families receiving AUH receive only 80% of the total benefit each month and the remaining 20% at the end of year when they provide the required certificates. If conditionalities are not certified for two years the benefit is discontinued (ANSES-UNICEF, 2017, p. 46). This produces unequal treatment, as lower income families are the subject of greater social control, treated in a more paternalistic way, and punished if they do not comply (Lo Vuolo, 2013; Straschnoy, 2016). The fact

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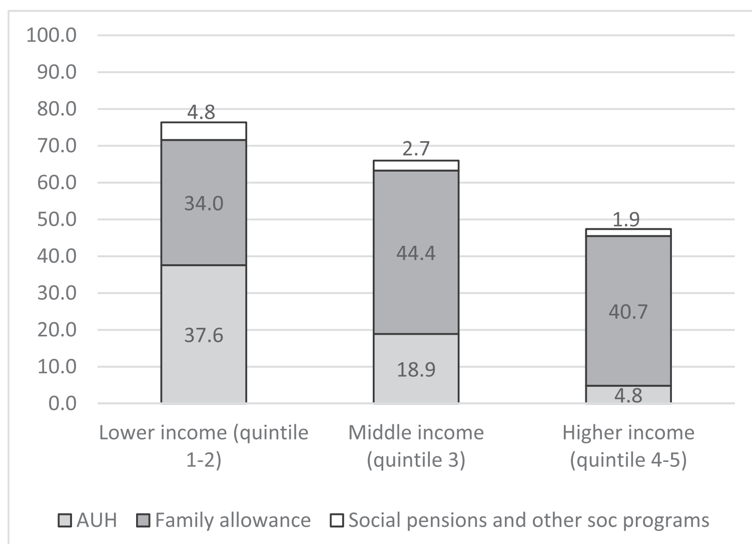

FIGURE 2 Family allowances and other child-related benefits in cash: Coverage of children by income group, 2015 (% of children aged 0–17)
Source. Own elaboration based on the Survey of Social Protection and Social Security (ENAPROSS II, 2015), Ministry of Work, Employment and Social Security, http://www.trabajo.gov.ar/estadisticas/enapross/2015.asp
Note. ENAPROSS II is a survey that includes the following geographical areas: City of Buenos Aires, 24 districts of Greater Buenos Aires, and districts with 5,000 or more inhabitants in provinces of Catamarca, Corrientes, Chaco, Jujuy, and Río Negro

that AUH and family allowances are separate programs, with different names, selection mechanisms, requirements, and administrative procedures, can also generate transaction costs of shifting from one program to the other, and difficulties in understanding and comparing rights and conditions across systems (ANSES-UNICEF, 2017, p. 50).

Thus, overall, the expansionary process involved a double movement: to child-centered benefits that more and better cover children from lower income households, and to a segmented benefit structure that separates families from different socio-economic groups in different systems.

3.2 | Maternal and infant health care

Segmentation is a longstanding feature of the Argentine health care system, and a characteristic of most Latin American systems as well (Cetrángolo, 2014; Cotlear et al., 2015). In Argentina, three main sub-systems provide health care to different groups of the population, depending on employment status and ability to pay. The first one is the public health care system, a free universal system with decentralized administration and financing. The second is the contributory employment-based health insurance system (with about 314 national and provincial "*obras sociales*"), organized by occupation and managed by trade unions, providing coverage to formal workers and their families. The third sub-system is a heterogeneous group of private health care providers, including private health insurance companies, private clinics and practitioners, which also interact with, and provide services to, *obras sociales* as well as to individuals purchasing these services directly. To these three sub-systems a fourth provider should be added: the publicly administered health insurance for pensioners (INSSJP, known as PAMI). In the 1990s, the deregulation of the employment-based health insurance system contributed to expand the reach of the private health care sector, making it possible for workers to shift from one to another *obra social*, and in practice also to redirect their wage-related mandatory health insurance contributions to purchase a private health insurance plan.[11]

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This segmented structure generates differences in coverage depending on the system and specific provider (*obra social*, private clinic, public hospital), which in turn depends on occupation, place of residence, income level, and ability to pay. Lower income families are less likely to have health insurance and mostly rely on the public system of hospitals and primary health care centers. Despite the universal design, the public system in practice assists mostly the population lacking health insurance, who are mainly families in low and middle-low income groups. In 2015, only 36% of young children (aged zero to five) in the lowest income households (quintiles 1 and 2) had access to health insurance of some kind (employment-based or private), compared to about 91% of children in the highest income groups (quintiles 4 and 5) (Figure 3). In addition, younger children are more likely to lack health insurance than the rest of the population: the National Census of 2010, reports that about 45% of children aged zero to four have no health insurance compared to 36% of the total population (INDEC, 2010).

After the Argentine economic crisis of 2001, rising unemployment and informality brought a reduction in health insurance coverage and increased the demands on an underfunded public system. Social conditions dramatically deteriorated and infant mortality rose, especially in some provinces (Ministerio de Salud, 2016, Table 33, p. 118). In this context and with the specific purpose to reduce maternal and infant mortality, in 2004–05 the government launched *Plan Nacer*, a health program oriented to guarantee access to essential health monitoring and treatment in the public health care system for pregnant women and children with no health insurance. The program was first implemented in some of the poorest provinces and those presenting the worst indicators of infant and maternal mortality, and later expanded to the rest of the country (Ministerio de Salud, 2013; Potenza Dal Masetto, 2012; Sabignoso, Silva, & Curcio, 2014).

Plan Nacer worked within the existing public health care system, providing funding and introducing incentives for public hospitals and primary health care centres in the sub-national districts to improve the supply of specific health care services for the target population. Based on a model of result-based financing, provinces receive funds from the National Ministry of Health based on the number of people enrolled onto the program and the number of services provided; and hospitals can use these funds for health care equipment, infrastructure, human resources, and/or

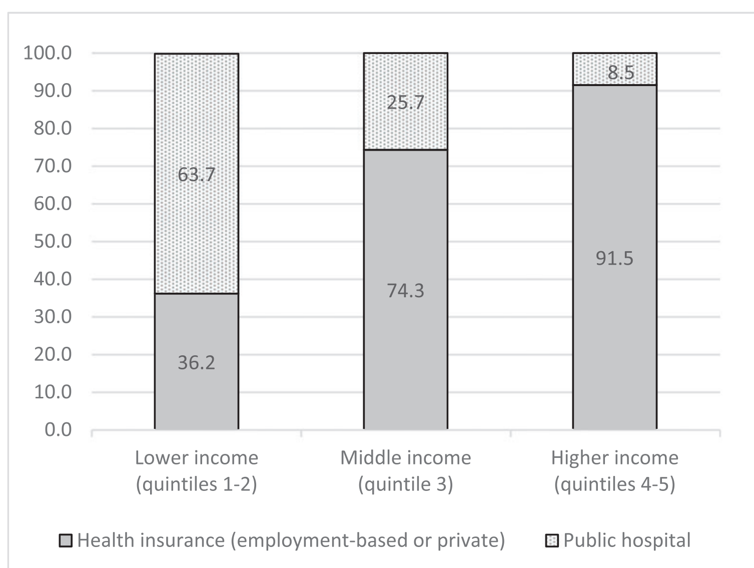

FIGURE 3 Child health care: Coverage of young children (aged 0–5) by income group, 2015 (% of children aged 0–5)
Source. Own elaboration based on the Survey of Social Protection and Social Security (ENAPROSS II, 2015), Ministry of Work, Employment and Social Security, http://www.trabajo.gov.ar/estadisticas/enapross/2015.asp
Note. On ENAPROSS II geographical coverage, see note to Figure 2

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supplies (Cortez & Romero, 2013; Repetto & Tedeschi, 2013). In 2012, Program *Sumar* followed from *Plan Nacer*, targeting a wider population (currently all men and women up to the age of 64 lacking health insurance). Another important policy in the post-crisis period was *Remediar* program, established in 2002, to guarantee access to essential medicines to the population with no health insurance.

Plan Nacer and *Sumar* contributed to improving access to health monitoring and treatment by pregnant women and children lacking health insurance.[12] The programs also interact with CCT programs (AUH and AUE), because children and pregnant women who receive cash transfers must enroll as a condition of receiving the cash. Existing impact evaluations of *Plan Nacer* point at positive results, such as a lower incidence of low birth weight, lower probability of in-hospital neonatal death, higher use of prenatal care services (World Bank, 2013), and a reduction of stunting and underweight (Nuñez et al., 2016; see also Ministerio de Salud, n.d.). In the context of improvement in the socio-economic conditions in the post-crisis period, rising public health care expenditures (see Figure 1), and the implementation of *Plan Nacer*, infant mortality rates dropped and the gap narrowed between infant mortality rates in some of the poorest provinces and the national average (Repetto & Tedeschi, 2013).

Besides these achievements, the health care system maintained its multi-layered structure, which produces segmented coverage and in practice also constrains further developments towards an integrated public universal health care system. The role of the private sector remains significant. According to a survey by the National Ministry of Health in 2010, about 45% of all medical consultations were made in a private clinic or doctor's consulting room (Ministerio de Salud, 2012, p. 14). We need more data on the differences in service quality and use across the population and across providers. However, existing data indicate that significant socio-economic and territorial inequalities prevail in coverage and outcomes. For instance, people without health insurance are less likely to make regular health visits (Ministerio de Salud, 2012, p. 3), and undertake preventive check-ups (such as checking their blood pressure, cholesterol, and blood glucose, and in the case of women, having regular smear tests and mammograms) (Ministerio de Salud, 2015). In addition, regional inequalities in supply and outcomes are also large, reflecting multi-dimensional territorial inequalities (Niembro, 2015). Just as an example, maternal mortality is almost three times as high in the North East region than in the city of Buenos Aires, and infant mortality almost twice as high. Indicators of the supply of health care services, such as the number of hospital beds or doctors per inhabitant, also remain strikingly different across provinces (see Ministerio de Salud, 2017a).

3.3 | Early child education and care

ECEC has recently received increasing attention in policy debates and practice in Latin America. Some countries have started to implement new programs and expand access (e.g., Uruguay and Chile; see Blofield & Martínez Franzoni, 2015; Staab, 2013). Considered a key social investment policy, ECEC can have multiple positive impacts. On the one hand, early education contributes to the development of cognitive abilities and future educational outcomes of children. Indeed, the PISA results show that 15-year-old students in virtually every OECD country who attended early education perform better than those who did not attend (OECD, 2011). On the other hand, full-time ECEC can also help parents better reconcile work and family life, facilitate the employment of both parents, contribute to increasing households' income, and reduce child poverty.

In Argentina, however, limited supply and stratified access to these services constrains their potential for enhancing both children's equal opportunities and gender equality across social strata. The provision of ECEC is segmented across three main levels. First, different types of institutions coexist. On the one hand, public schools are part of the formal educational system, offer universal and free early education, and are managed by sub-national governments. On the other hand, a heterogeneous set of non-formal public and non-governmental institutions offer childcare, protection, and early stimulation for young children in vulnerable families, and allocate places based on a socio-economic criteria of eligibility (Marzonetto, 2016; Ministerio de Desarrollo Social, 2013; Repetto, Díaz Langou, & Aulicino, 2012; UNICEF-FLACSO-CIPPEC, 2016).[13] Similar types of institutional segmentation exist in other Latin American countries as well (see Staab, 2010; Staab & Gerhard, 2010). A second level of segmentation in ECEC relates

to territorial heterogeneity in supply and quality in a public system with decentralized administration and funding. Across provinces, differences in public spending per student are wide (for instance, Santiago del Estero spends per student in early and primary education about 22% of the amount spent by Santa Cruz, and 53% of the country average: Ministerio de Educación, 2017, p. 75). Lastly, a third source of segmentation relates to the important role of private providers of ECEC (also a highly heterogeneous group) especially for the youngest children, for whom public supply is very limited.

Over the past decade or so, ECEC policies have received greater attention in government agendas as well as in academic and policy-oriented research (Esquivel, Faur, & Jelin, 2012; Faur, 2011; Lupica, 2014; Repetto et al., 2012; Rodríguez Enríquez & Pautassi, 2014, among others). In 2014/15, national legislation made early education mandatory as of four years of age (it was previously five), something which some provinces had already established in their jurisdictions (Batiuk & Coria, 2015, p. 25). In the formal educational system, it was indeed in the class of four years old that enrolment increased the most (by 63% between 2004 and 2015). The same piece of legislation established the commitment of national and sub-national governments to universalize access for the class of three years old. In 2016, a reform bill to make early education compulsory as of the age of three received a positive vote in the Chamber of deputies (but at the time of writing, the bill had not yet been passed by the Senate) (La Nación, 2016). That same year, the new government announced a National Program of Early Childhood, aimed at integrating and expanding the heterogeneous network of non-formal childcare and child development services throughout the country under the coordination of the national Ministry of Social Development, and maintaining the social assistance focus.

Up-to-date data on enrolment comprising all types of institutions providing ECEC for all age-groups are scarce, and it is even harder to obtain indicators of service quality (trained personnel, opening hours, infrastructure, etc.). There is, however, consistent evidence that currently almost all children attend pre-school at the age of five, that enrolment rates fall substantially at earlier ages, and that most children aged zero to two do not attend. A survey carried out by the National Ministry of Social Development in 2011–12 (ECOVNA) estimates that only 8.4% of one-year-old children, and 20% of two-year-old children attend ECEC institutions.[14] Another more recent survey (ENAPROSS II, carried out in 2015) confirms that enrolment is overall very low for the earlier ages (zero to three years old), and is stratified by socio-economic status. According to these data, 35% of children aged from zero to three in the highest household income groups (top two income quintiles) attend ECEC, compared to only 17% of children in the bottom two income quintiles (Figure 4). The stratification of enrolment is problematic for a strategy of equality: it means that children from higher income households join ECEC institutions earlier, which may provide them with more tools to succeed in the educational system later on, thus consolidating inequalities.

Across income groups, children differ not only in terms of enrolment, but also in the type of institution to which they are enrolled. Most non-formal institutions run by sub-national governments or community organizations target lower income children. Unfortunately, there are limited data on the quality of services provided, but existing studies point to high levels of heterogeneity in all relevant dimensions, including amount of trained personnel, infrastructure, and per capita spending (Araujo et al., 2013, Table 30; Cardini, Díaz, Guevara, & Achával, 2017, p. 4; Marzonetto, 2016; Rodríguez Enríquez & Pautassi, 2014, p. 41; UNICEF-FLACSO-CIPPEC, 2016, p. 31). An additional source of segmentation is between public and private providers. Many families that can afford it take their children to private ECEC institutions. According to data from ENAPROSS II, 36% of children aged zero to five who attend are enrolled at a private institution. The private-public choice is also, as expected, highly stratified: children from higher income households are much more likely to attend a private institution (73% of children enrolled [aged zero to five], compared to 23% of children enrolled coming from lower income households) (Figure 5). Administrative data of the formal educational system also show that the private sector's share of enrolment in early education is the highest of all educational levels, which may be reflecting a shortage of public provision. The private share is also growing for some age groups: between 2004 and 2015, the number of five-year-old children attending public schools dropped, while the number of those in private schools rose by 25% (based on DINIECE, 2004, 2015).

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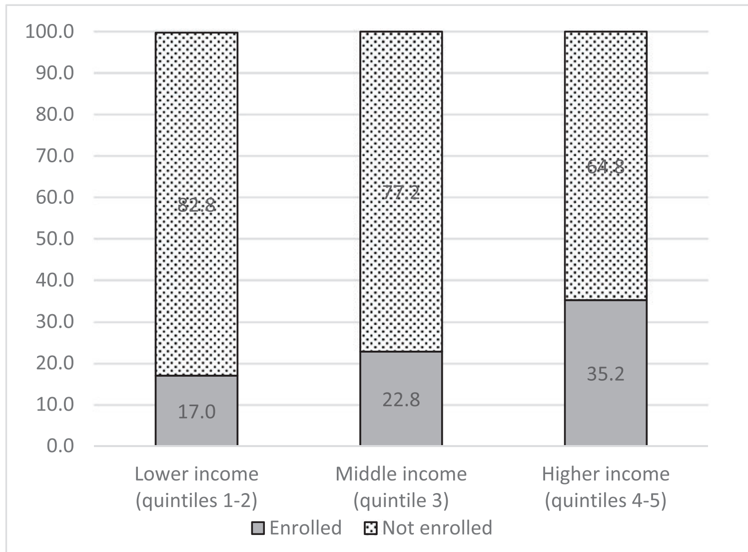

FIGURE 4 Early education and childcare: Young children's (aged 0–3) enrolment to ECEC institutions by income group, 2015 (% of children aged 0–3)
Source. Own elaboration based on the Survey of Social Protection and Social Security (ENAPROSS II, 2015), Ministry of Work, Employment and Social Security, http://www.trabajo.gov.ar/estadisticas/enapross/2015.asp
Note. On ENAPROSS II geographical coverage, see note to Figure 2

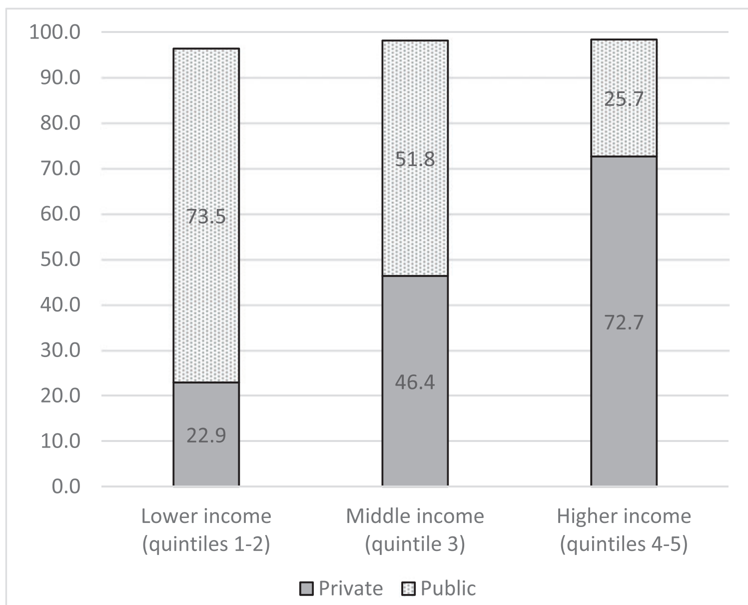

FIGURE 5 Early education and childcare: Young children's (aged 0–5) enrolment by type of institution and income group, 2015 (% of children aged 0–5)
Source. Own elaboration based on the Survey of Social Protection and Social Security (ENAPROSS II, 2015), Ministry of Work, Employment and Social Security, http://www.trabajo.gov.ar/estadisticas/enapross/2015.asp
Note. On ENAPROSS II geographical coverage, see note to Figure 2. The percentage that remains to reach 100 corresponds to children who report being enrolled to "communitarian" institutions and to non-response

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Thus, despite recent developments in terms of enrolment and supply, and more broadly in the placing of the issue in government agendas, access to ECEC remains highly segmented, with incomplete and stratified enrolment at early ages, and an important role for private provision, mainly among middle to high income groups.

4 | FINAL REMARKS

Over the past 15 years, in the context of economic growth and the recovery of a more active role for the state, Argentine social policies expanded to cover a wider population and incorporate many lower income families. Some of these policies had a prominently child-centered focus. AUH established a regular benefit for children of informal and unemployed workers, *Plan Nacer* and *Sumar* focused on essential health care services for the uninsured population, prioritizing pregnant women and children, and access to ECEC increased as a result of a range of measures including more places in the public educational system, the introduction of mandatory schooling from age four, and the development of child development centers for children of vulnerable families.

New policies made progress in basic access and coverage. However, either by design or in practice (or both) the type and quality of benefits received in these three fundamental social policy areas continues to be segmented, either by type of employment of parents, by socio-economic status and ability to pay, by place of residence, or by a combination of two or more of these factors. The degree of segmentation varies across policy sectors, but in the three policies analyzed in this article different programs are directed to (or used by) different socio-economic groups. Children from lower income households are still less likely to be enrolled into early education, less likely to have health care insurance (employment-based or private), and more likely to receive conditional (rather than unconditional) child benefits than children from higher income households. This type of segmentation is problematic for children's equal opportunities, and may also potentially hinder broad cross-class support for progressive social spending. For instance, as the middle class migrates to private education and health care, its support and willingness to finance high quality public services is likely to narrow.

These findings are also relevant for other Latin American countries, many of which have made substantial progress in expanding access to benefits of the social protection system over the past 15 years or so, but have tended to focus more on targeted programs for "the poor" than on universal programs. While the expansion of coverage to the poorest is undoubtedly positive and needed, it may be insufficient to overcome entrenched inequalities if the benefits and services the poor have access to remain too different from those of middle and higher income groups. This is an issue that policies aiming to have a transformative impact on structural inequalities will have to address.

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CONFLICT OF INTEREST

None declared.

ENDNOTES

[1] This is related to Martínez Franzoni and Sánchez-Ancochea's approach (2016a, 2018). However, while these authors also include generosity as a measure of segmentation, here I only refer to it in terms of the variation in benefits amounts or service quality across existing systems and population groups. Instead, I focus more specifically on program differentiation and on distribution of access across programs.

[2] I do not assess social policy impacts directly in this article (i.e., impacts on poverty and inequality, on infant mortality and morbidity, on educational attainment, employment and earnings, and so on), but later on I refer to a number of studies that have done so.

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[3] These variables are standard variables in the social policy literature and are also four of the main dimensions in Martínez Franzoni and Sánchez-Ancochea's (2016a) operationalization of “social policy architectures”. These authors also include a fifth dimension (regulation of the “outside option”), which is not considered separately here but as part of market provision (i.e., together with “provider”).

[4] This is a dimension that Pribble (2013) and Arza (2013) also consider.

[5] These are key child-centered policies, but not the only ones. Other policies that can be important for children's welfare are nutrition, access to water and sanitation, and maternity and paternity leaves. For a comprehensive survey of child-centered policies in Argentina, see Repetto and Tedeschi (2013); see also Aulicino, Gerenni, and Acuña (2015), and Filgueira and Aulicino (2015). On early child development policies in Latin America, see Vegas and Santibáñez (2010), and Araujo et al. (2013), among others.

[6] Benefit amount for March 2018, converted to US dollars (U$S) using the exchange rate for March 15, 2018.

[7] ANSES-UNICEF (2017, p. 46, footnote 10) explains that children in private schools with full state subsidy (and zero fee) are also eligible.

[8] In the case of Argentina, recent studies show mixed results (see, among others, Goldschmit, 2017; Marchionni & Edo, 2017; Salvia et al., 2015). Besides impacts on the use of social services (number of doctor visits and school enrolment rates), what matters most for a social investment strategy are outcomes (e.g., learning, health status, future work and earnings opportunities). While several studies for Latin America find positive impacts on the former, results on the latter are as yet inconclusive (Cecchini & Vargas, 2014, p. 124; Nelson, 2017, pp. 28–29).

[9] Over 404,000 benefits were suspended in 2014 for not certifying health and educational conditionalities (ANSES-UNICEF, 2017, p. 46, footnote 8).

[10] Based on data from ENAPROSS II, a household survey carried out by the National Ministry of Work in 2015, it is estimated that 70.6% of children received a cash benefit (including AUH, family allowances, social pensions or other social programs). However, this survey is not representative of the entire country (see details in the note to Figure 2). Also, after this survey was carried out, coverage increased (the total number of child benefits—family allowances plus AUH—rose by about 25% between December 2015 and September 2017: MTESS, 2015, pp. 31–32; MTESS, 2017, pp. 49–50). More recent estimations based on administrative data suggest that child benefits in cash cover about 79.4% of children (and for another 8% of children, parents are eligible to income tax deduction, see ANSES-UNICEF, 2017, p. 24).

[11] According to the 2010 National Census, 4.2 million out of the 6.2 million people who have private health insurance have joined the private system in this way (INDEC, 2010).

[12] According to the 2017 Annual Report, *Sumar* has 15.7 million beneficiaries and since 2005 *Nacer/Sumar* offered over 100 million benefits (Ministerio de Salud, 2017b).

[13] According to Rozengardt (2014), in 2013, the National Secretary of Childhood, Adolescence and Family of the National Ministry of Social Development registered 5,489 of these institutions in the country, 59% of which were non-governmental institutions and 41% were public institutions managed by provincial and local governments.

[14] The survey measures enrolment to both formal early education institutions and child development centers that are not part of the formal educational system (Ministerio de Desarrollo Social, 2013, pp. 63–64). The sample includes urban districts with 5,000 or more inhabitants.

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