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Critical realism and social inequalities: considerations from an evaluative research

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Abstract *Based on different theoretical references (public health, program evaluation, and critical realism), the paper analyzes whether conditional cash transfers contribute to the reduction of monetary poverty and improved health care. It employs evaluative research material, consisting of a case study on the health conditionalities of the "Bolsa Família" Program (PBF) and its implementation by the Family Health Strategy in a primary care service (PHC service) located in a slum area in Rio de Janeiro. Experiences and perceptions of managers, health professionals, and beneficiary families were prioritized to understand the dynamics of the program. A predominant perception is that the PBF "benefits those who need it, but also those who do not need it". On the one hand, health care is recognized as limited, since households are vulnerable and with health problems resulting from this condition. On the other hand, having access to the Clinic is a crucial resource since the benefit is seen as of little value, which reinforces the idea of "aid". It concludes that the three domains of stratified reality contribute to understanding the scope of programs that address the imbrication of biological and social aspects in contexts marked by inequality and poverty.*

Key words *Social inequalities, Poverty, Evaluation, Critical realism, Public health*

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Introduction

The paper presents a partial analysis of the results of evaluative research and aims to identify possible effects and limits of the conditional cash transfer for the reduction of monetary poverty and improved health care. It used critical realism[1] as its primary theoretical reference and the case study in a Basic Health Unit (UBS), located in a slum in Rio de Janeiro. The research adopted as reference two federal public policies, namely, the National Primary Care Policy (Ordinance nº 2.488, of October 21, 2011) and the *Bolsa Família* (Family Grant) Program (Provisional Measure nº 132, of October 20, 2003, transformed into Law nº 10.836, of January 9, 2004).

The Health Reform project and the development of a public health system (SUS) went hand in hand with the construction of democratic ideals based on the principle of social inclusion and equity. After three decades, the sustainability and institutional challenges of the SUS still gather many "critical nodes"[2], and, in this context, the Family Health Strategy (ESF) stands out as a preponderant element for the expansion and development of primary care. Changes occurred within the institutionalization of the socio-assistance model in the democratic context as well, giving rise to a set of regulations and policy structuring.

The National Social Assistance Policy (PNAS/2004) introduced conceptual changes that implied new logics of management, administrative structure, and action control. The essential elements of the policy were regulated and organized with the approval of the Basic Operating Standard of the Single Social Assistance System (NOB/SUAS, 2005). The *Bolsa Família* Program (PBF) was created within the then Ministry of Social Development and Fight against Hunger, which constituted the direct transfer of income, with conditionalities, to poor and impoverished households.

The establishment of both Systems (SUS and SUAS) imposed a series of challenges for the consolidation of social protection and the achievement of rights. This research is part of the debate that permeates income transfer policies in their interface with health, intersectorality, and social inequalities, given the importance of expanding investigations that address the relationship and interaction between the PBF and the ESF.

It is understood that critical realism (understood as a philosophical approach) is intertwined with studies on evaluation and constitutes one of the pillars of evaluation based on the theory of the program. Considering that the authors make different uses of critical realism, it merges with the approaches of theory- driven evaluation whose epistemological questions (which concern knowledge) overlap with those of ontological nature (which concern being) and put in check the outreach of scientific knowledge, including evaluative practice, theories produced about reality and health programs.

Using the model of Bhaskar[1] about the transitive (any knowledge) and intransitive (independent of the subject) dimensions of knowledge, it follows the concept of stratified reality consisting of the real, actual, and empirical domains. In this paper, this approach was operationalized given the specific context of the research: social inequalities, health care, conditional cash transfer, and family health programs in a territory marked by intricate experiences. It is worth emphasizing that the critical realism *tout court* was used in an unorthodox way since the work of Bhaskar appears in "different waves"[3] and has been adopted in evaluative studies in multiple approaches.

Theoretical approach

The real, the actual and the empirical: the ontology of inequalities and social programs

Critical realism allows questions to arise, refinements of approaches and new strategies for evaluative research in health field. In the case of evaluative research, one of the main contributions refers to the understanding of public programs and initiatives based on ontology about what is real. The ontological question "what are social programs?" allows different possibilities of response in the literature, from a more normative and empiricist stance to those anchored in critical realism. These possible responses are of interest to ponder on the intersections between the PBF and the ESF and their implications on social inequalities in health.

Potvin et al[4] provide their interpretation of Bhaskar, and this will be followed here and complemented with other authors who have dedicated themselves to critical realism concerning the field of evaluation – such as Pawson & Tilley[5], who systematized the perspective of "realistic evaluation" – or who brought reflections articulated to social theory or social and human sciences[3] for this debate. This paper connects these authors in order to start from the (abstract) model

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and articulate it with the empirical material of the case study.

We start from the operationalization of the domain of the actual (understood here as that of action), which includes the social programs and their emerging powers that trigger the changes, and we intend to illustrate them from the implementation of the PBF and the ESF, within the scope of health conditionalities. After showing how programs are designed (based on program theory and implementation theory[6]) and mechanisms are put in place, intricate context in which programs and initiatives operate and the multiple experiences at stake are described. Finally, the leading social mechanisms and aspects that affect social inequalities are selected in the domain of the real from the principle of their intransitivity.

Treating each domain separately does not mean that they are isolated and do not interrelate. We understand that the three domains operate simultaneously, although it is not possible to distinguish or perceive them. Although different authors have used critical realism in evaluative research, it is essential to note that the concepts adopted also differ among them, such as that of "mechanism". Bhaskar uses it to distinguish between "real structures" and "generative mechanisms", which constitute the intransitive objects of scientific theory[1]. In dialogue with the natural sciences, his theory about stratified reality makes use of both the concept of mechanisms and experience or experiments.

The idea of "mechanism" is not new and is part of the vocabulary of the sciences as a whole. Gorski[7] dedicated himself to the study of the concept of social mechanisms, from a historical-comparative perspective in sociology, and even proposes a theory of causal mechanisms from a critical realism approach. Several meanings of the term relate to critical realism in varying degrees. Concerning the analysis, social mechanisms are understood to be distinct from natural mechanisms[7], as attached to the domain of the real[8], and which have emerging causal powers. Furthermore, as emphasized in critical realism, the reality is not only captured by concepts: it is established by concepts. The concept-dependency principle implies, in this sense, an ontology of the social world that varies over time and space[7].

Concerning overlapping domains of reality, the empirical can be understood as of experience. From Raymond Williams' entry (Keywords, 1976), Scott reminds us that experience and experiment were closely related terms until the mid-early 18th century, and that it designated how knowledge was achieved through tests and observations[9]. Besides the socio-historical changes regarding the concept of experience, it is essential to note that, in Bhaskar, we can understand it as experiments and also experience. In agreement with Vandenberghe's analysis[10], in his second book, Bhaskar adopts a posture of "critical hermeneutics", which brought to the fore the idea of concept-dependency of agency-structure. The author argues[10] that there is, thus, a change in perspective that makes hermeneutics compatible with critical realism. This work adopts these conceptions, as well as the one formulated by Scott, which rejects the separation between experience and language: the subjects are established discursively, where experience is a linguistic event, but never confined to a fixed order of meanings. Thus, instead of naturalizing the experience, the categories of analysis are taken as contextual, contestable and contingent[9].

Concerning social inequalities and health care

According to Potvin et al.[4], based on the perspective of Bhaskar's critical realism, the programs are located in the domain of events, occurrences, and, consequently, of action (the domain of the actual), and express problematic situations. When locating programs in this domain, the authors highlight three implications concerning evaluation: *i)* the definition of what is a program, *ii)* the importance of exploring the mechanisms activated in solving a problem, and *iii)* the relevance of mechanisms identification. It is essential to understand the programs beyond their prescriptive and normative character. A program is an "object in transformation"[4] constituted by a "matrix of interrelations": all the subjects involved can exercise causal powers that can trigger mechanisms that (re)structure relationships between the programs' components.

It is necessary to apprehend the "processes through which events are transformed" in the context of health programs. More than knowing the causes and determinants of a health problem, we should explore how a problem is produced, reproduced, and transformed, or "what mechanisms and actions are developed to arrive at a problematic event"[4]. The third implication, above mentioned, is of a methodological nature since the identification of the concrete mechanisms is not limited to the perceptions of the subjects involved. As they add: "theory becomes an interesting assessment tool"[4].

It is important to know social programs from multiple theories to answer the question about what they are. As formulated by Weiss[6], social programs are complex undertakings that involve a wide range of people, styles, and procedures, which makes them unspecific and difficult to describe. The author adds[6]: "How is the program expected to bring about changes?"

In the case of the PBF and the ESF, what changes are intended? Weiss[6] recommends that we should dedicate ourselves to the broad knowledge of the programs and their objectives – not in the sense of investigating whether or not they have been completed and in what way – and adds that many programs have multiple objectives. Amid its complexity and multiple scopes, managers and employees have the opportunity to select the part of the program they want to focus on, which makes it relevant to identify which of these goals are real to them.

In the case of the selected programs, ESF and PBF, are complex initiatives with objectives, historical contexts, and different systems (SUS and SUAS), which are articulated in specific aspects. A decade of remarkable events in the country separate the creation of the two programs and bring analytical challenges. The programs combine different narratives about health care and poverty reduction, and this heterogeneity influences the decision-making process.

Methods

The case study method was selected for the development of the research approved by the Ethics Committees of ENSP and the Secretariat of Health/PMRJ, in which we intended to reach a comprehensive understanding of the implementation of the PBF, from a Basic Health Unit Unit (UBS), which serves households benefiting from the Program. For reasons of confidentiality and privacy, the place of the case study, and the respondents will not be identified, as described in the Informed Consent Form. The semi-structured interviews were recorded and later transcribed using resources from the Stricto Sensu Postgraduate Program in Public Health, from the Sergio Arouca National School of Public Health (ENSP), Fiocruz. Thirty people were interviewed, including professionals from the ESF, Education sector, Social Assistance Reference Center (CRAS), and women from the PBF, totalling 32 hours of statements.

The work process was divided into three stages, as suggested by Minayo et al.[11]: 1) exploratory (in 2016 and 2017), 2) fieldwork (from August 2018 to March 2019), and 3) analysis and treatment of the empirical and documentary material underway. The choice of the case study is based on both the purpose and the research strategy. Becker points out that, in general, there is a dual purpose: a comprehensive understanding and the development of theoretical statements about regularities in the process and social structures[12]. The comprehensive understanding was required given the diverse social conditions of the PBF/ESF beneficiaries, which in turn circumscribes specificities.

The methodological design favored the analysis and interpretation of qualitative data. The two moments are conceptually distinct, but intertwined, as indicated by Patton[13]: the analysis refers to the process of gathering data, organizing them into patterns, categories, and descriptive units. The interpretation concerns assigning meanings and significance to the analysis, explaining the descriptive patterns, and systematizing the pattern of relationships and connections between the descriptive dimensions. It employed content analysis[13] as a resource, that is, the setting up of a classification system based on themes and categories. It adopted inductive analysis (themes and categories of analysis that emerge from the collected data), native categories (as used by the participants), and typologies built in the research process (created by the researcher).

Bearing in mind that the framework uses the categories proposed by Bhaskar, the stratified ontology typology was used when analyzing the interviews. Sayer[14] shares this conception and defines it as follows: the real is whatever exists (natural or social), including objects, their structures, and powers. The actual (or factual) refers to what happens (if and when these powers are activated), and the empirical concerns the domain of experience and can be accessed by direct observation. Regarding the domain of the factual, Hamlin adds: "what happens, in reality, is not necessarily perceived the way it occurs and, contrary to what empiricists believe, 'being' is not 'being perceived': something can exist without being directly perceived, only inferred from the effects it generates"[8].

Results

Despite changes that have been implemented over time, both concerning management and the dynamics of the work teams' activities, per-

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ceptions about the ESF are similar among health professionals, especially concerning the importance of service in a territory with a recurrent scarcity and where the Clinic and its professionals represent the access to care that, as a rule, transcends health. The ESF encourages different generative mechanisms for the production of care within the scope of Primary Health Care (control of diabetes, hypertension, tuberculosis, sexually transmitted diseases, and prenatal care and postpartum follow-up). At the same time, an insufficient number of professionals by the Family Health Team (EqSF) has been assessed, and violence in the territory is seen as a factor that hinders access to the Clinic and the implementation of the ESF. The lack of professionals in the teams, especially doctors – not provided for in the program's theory – is recurrent and affects the work routine. One of the Clinic's professionals reports his experience, and another speaks of the impact of this absence:

In March 2016, I was alone. In January 2017, I worked with a female doctor [...] *she left a month and a half later. And then I spent another six months alone again. And then another female doctor came in and stayed three months. Then I spent three more months alone. Another doctor came in for another three months, and then I was alone again. Until I got to this point. I've been working since May, but to be more precise, since the beginning of June with the current team female doctor, who is the family doctor* [...] *(E05).*

- [It's] *horrible.* [being without a doctor.] *Because first, as much as I try to reiterate with the* [Community Health Workers] *ACS, with the community workers who are at the reception, that there are things that I cannot attend to. I cannot make referrals, and I cannot prescribe antibiotics. There are some things that they will put up a barrier because they do not feel; it is not their responsibility to send patients away. However, from the moment people enter your office, they expect you to meet their demands.* [...] *What I have to do, generally, is to get up, go to someone's office, wait for him to finish his visit, talk to him about the case, convince him that the person has some medical demand to be met, wait for him to either get up or tell me what to do. Then I come back, do what I have to do, take it to the person to stamp and deliver it* [...]. *(E09)*

Although the ESF operates with a broad and multidisciplinary concept of care, medicine is central to the implementation of the policy. However, medical practice gains well-defined contours given the training in family medicine, although different groups coexist within this specialty and around their epistemology, as analyzed by Bonet[15]. We can state that "the ability to feel the life of a community"[15], which would distinguish the experience of family doctors, is distributed differently among ESF professionals and returns to clinical practice intertwined with the values of each member of the teams, and is most striking in the case of Community Health Workers (ACS).

A certain regularity is recognized in the statements about what the ESF is and how it has been changing: the intricate intervention; the causal powers of EqSF; the multiple objectives to be achieved and the "selection" of what is feasible; contingent elements not provided for in theory; the limits of care for "complicated cases"; the difficulty of intersectoral actions; the need to comply with indicators and the instability of labor relationships. On the other hand, the PBF has a greater multiplicity of perceptions and experiences, both on the meaning of the Program and its implementation, especially concerning health conditions, and it can even be said that it is a controversial topic.

In the context studied, the low volume of services provided by the public authorities and the condition of the vulnerability of most of the population allows us to affirm that EqSF gradually disseminated health care: through the access of residents to the offices in the Clinic, through home visits (HV) or by the improved epidemiological indicators.

The routine of monitoring the conditionalities of the PBF was incorporated into the Clinic in 2012 because there was no precise identification of the PBF beneficiary users when it was launched. Given that most of the population has poor housing and income conditions, PBF beneficiaries do not stand out significantly among users of the Clinic in order to encourage specific actions beyond conditionalities. As health care is seen by professionals who participated in the research, besides biomedical care, the ESF covers directly or indirectly the PBF beneficiaries, although specific actions to record compliance with conditionalities are implemented. The biomedical model coexists with other care practices, despite users' prevailing idea of care often dissociated from prevention, which requires investment in changing perspectives on this care. Given the normative and prescriptive field of health actions, the social conditions of users (beneficiaries or not) impose other practices, in order to guarantee access to social rights. The limits of health care are

given not only by primary care per se but also by the recognition that this care is not limited to access to health services.

Attention to "poor and impoverished households" in their diverse configurations is a common aspect between the two Programs. The concern to ensure that the poorest have a minimum income regardless of their earnings is not new to some European countries. Among others, Polanyi[16] analyzed, in England, the "Speenhamland Law" (1795), which, through an allowance system subsidized through public funds, guaranteed the poor a minimum income regardless of their earnings. Foucault[17] argues that the Law of the Poor introduced a critical factor in the history of social medicine, which is the idea of supervised care.

The ACS are called in and trigger the PBF's health conditionalities. One must reside in the territory to be an ACS, which, in principle, means having a good knowledge of its geography and population. In cases such as Rio de Janeiro, moving across the territory is only possible if accompanied by an ACS. The ACS (if desired) should be responsible for the HVs to the households in the area in which they live, which allows them greater circulation. Visits are central to ESF because they allow the provision of health care "outside the walls". This is a social mechanism that allows reaching those who do not go to the Clinic for different reasons, as well as those who intentionally do not wish to receive the visit. On the other hand, HVs also allow "mapping" the territory once the spaces where the most vulnerable families live are identified and, thus, provide elements to plan and monitor actions. The HV is also perceived as a time to understand the households' living conditions better, which is often not shown in a visit. Households' dynamics and housing conditions are thus discussed, and, with each visit, it allows creating and consolidating links between service users and professionals.

Neighborhood relationships can take on other meanings if ACS know and visit the households with which they coexist, and health care can be interpreted as control and even lack of privacy. Some ACS recognize that this intimacy does not please them or that they end up being available 24 hours a day. In summary, the HV in the studied territory is a mechanism that accesses both "care" and "control" over households. In the case of beneficiary households, the binomial care-control or "control over care" brings this dual characteristic, which reinforces some refusals.

The term "home visit" is revealing because a visit implies an invitation, and, in this case, there is a tacit agreement that an "invitation" can be triggered at any time by the EqSF. The invitation is implicit in the ESF, especially in a territory that is not "accessed" by the State. In this respect, the HV guides the dual meaning: both consent (to the invitation implied in the relationship) and refusal (since there was no invitation). The HV allows the meaning of care to be carried out daily: it is the home of the bedridden older adult living alone; it is the house that was built on the "extension of the extended home", and whose only access is a parapet from which the ACS has already fallen; it is the room of the schizophrenic living on the floor below the family's residence and, establishing some external contact and receiving food and water through the barred window. Other situations reveal the drama of someone with diabetes in wheelchairs quarreling with his brother, living alone in a room and bedridden, without bathing and surrounded by garbage, which leads neighbors to ask the health team for help. The ESF is also present in the case of the patient sleeping on a mattress in the "living room" because she had syphilis and is HIV-positive, is restrained by a "stroke", living with her young daughter and some relatives.

The ACS also started to have control over safety on the way from the houses to the Clinic. Due to insecurity in the territory, EqSF started to adopt "Safe Access" (an official communication network between the ACS and incorporated into the work routine that guides the opening or not of the Clinic, and the circulation through the micro areas of the territory depending on the armed clashes). In other words, it is not possible (since access is not always easy) and recommended (due to illicit trade activity) to move across the territory without ACS presence.

Controversies about the PBF can be better understood if we take into account that the ACS reside in a territory whose life paths are similar to those of the beneficiaries. They are part of families that settled decades ago or more recently from other neighborhoods, slums, or states. The children of these families, who were raised and established other families in the same place as their parents, studied and saw a job opportunity at the Clinic, even without knowing the type of work, what ESF or being an ACS was. Besides the experience in the territory is the monitoring of the ways of life of the beneficiaries, who do not necessarily use the resource exclusively for food. Not all beneficiaries are judged as those who need the resource: this happens so much because some people need and do not receive

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(and vice versa) benefits in the ACS' families, as well as families who in the HV or at the Clinic do not receive the benefits, but it is believed that they need them. While aware of the PBF's erratic outreach, a regular thought was the fact that the benefit "helps those in need", and even if it serves households that "don't need it", the benefit must remain because its value is shallow. The Program (especially Social Assistance) hardly "monitors" households to avoid the misuse of the benefit or its access for households not living in conditions of poverty and extreme poverty:

People are forced to come here. You should see this. It's because you're not here every day. You should see this. Some people come, weigh, and measure. However, this is not what we want. We want them to go to the clinic, enter the office, have a visit, and talk about their problems. If appropriate, we refer them to a psychologist to find out whether the child is being nourished or not, and what use they make of the monies. This is what we want to know. (E06)

[...] *However, it is not to say that I am against Bolsa Família, I am against the policy of what seems to be giving alms, but you do not provide the conditions to get out of it. You have to be able to get out of that* [...] *So it ended up being a very flawed exchange currency. (E08)*

I think the Bolsa Família program is the opposite of Family Health. The Bolsa Família program is for you to chip in a little money in the hands of people there, and there is no monitoring of what people are going to do with that money, which is also not money for nothing. [...] *This is my view. Politically speaking, I have a different idea because you see politicians also receiving various types of public money allowances, with various types of names, and people cannot earn a hundred reais or so? (E13)*

The other professionals interviewed reveal the development of a "sensitivity" for health work aimed at vulnerable populations. These professionals did not necessarily know the territory, and for some to go to work in a known dangerous region was a surprise, but also a learning experience that linked them to the Clinic. If the PBF can cause a terrible feeling and sensation of being "babysitters" of the beneficiaries among the ACS interviewed, for the others, the experience of serving the beneficiaries is evaluated positively, as follows:

I already had much prejudice against it; I already had many things about it, bothering me. It bothered me a lot… at first, then, I didn't understand so well… and now I try to improve my thoughts about it because I thought "guys, how can this be? People receive the Bolsa Família and do not come here. They don't work; they have to come here." Then I started to think differently: "no, people can work and receive the Bolsa Família, because depending on the income they share among many people, one can have both. [...] *(E04).*

If Clinic professionals disagree on the effects of the Program concerning the reduction of inequalities and the limits of follow-up actions for changes in health care standards, most beneficiaries interviewed recognize that the benefit "helps", although it is not enough. The generative mechanisms of reproduction of inequalities are the most felt and identifiable in the paths and life experiences of these beneficiaries.

These generative reproduction mechanisms operate from the dynamics of gender ("the beneficiaries" are an almost exclusively female population), ethnicity and class; colonialism (understood here from the decolonial theory[18]) and capitalism itself[19] if we can separate them at all. The benefit holders interviewed express the experience of living in a territory where violence contributes to isolation, and opportunities to enter the formal job market are rare, and where caring for the family is one of the leading life projects. Most recognize the importance of the benefit: because it complements the household's income or because it is the only source of regular income. Health care is materialized in the Clinic's daily routine, and not only in the compliance with conditionalities.

Final considerations

Adopting critical realism, we can conclude that health care provided in the context of conditionalities is limited since households – in their multiple configurations – are inserted in social contexts of vulnerable relationships. In this context, they carry health conditions resulting from this situation: poor housing and no sanitation; low schooling level; nonexistent or insufficient income; overburdened women, generally young and black; upholding intergenerational poverty cycles. Despite the disagreement over the scope of the benefit for the households, the need for income transfer is recognized as a necessary social mechanism for the improvement of living conditions, since it enables access to services (education, health, and assistance) and goods. The clinic and the ESF are perceived as a fundamental resource since the benefit is seen as of low val-

ue, even among the poorest, which reinforces the idea of "aid".

We can conclude that the three domains of stratified reality contribute to understanding the outreach of the programs: the experiences in conceiving what health is in a way that is not dissociated between the biological and the social; the programs that generate actions and changes, such as the PBF and the ESF, and the invisible and constantly moving structures that affect the permanence and the increase of inequalities, especially with specific social groups.

Collaborations

DM Costa and R Magalhães contributed substantially to the design and planning, the analysis and interpretation of the data, the drafting and critical review of the content. The authors also participated in the final approval of the manuscript.

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