

Counting the Cost of Privatised Provision: Women, Rights and Neoliberal Health Reforms in Chile

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1 Introduction

Under neoliberalism citizens in Chile and beyond have seen a reshaping of social service delivery, particularly in the health sector. The privatisation of many services undertaken as part of neoliberal reform programmes implemented in the 1980s and 1990s meant that health was no longer a right to which all citizens were entitled but instead a service to which access is determined according to ability to pay. At the same time citizens were encouraged to take responsibility for their own health and welfare – and that of their families. The gender dimensions of this have been the subject of much debate (Schild 2000 and 2007). The privatisation of healthcare services has resulted in many activities being transferred back into the household where the gender division of labour generally means that women have had to take responsibility for them. At the same time changes in production processes that have also been part of neoliberal reform programmes have led to a growing number of women moving into the paid workforce (Standing 1999). Many women are therefore subject to competing demands on their time.

Reconfiguring state–society relations has also been an integral part of neoliberal reform processes. In Chile the transition from authoritarian rule in 1990 facilitated this process. As Schild argues:

New ways of governing welfare were installed as a part of a necessary dismantling of pre-existing, and presumed undemocratic, structures. The reorganisation of power relations within state bureaucracy and between the state and society at large, along the lines of a new, market rationality, was thus accomplished ... (Schild 2007: 185)

The key feature of this change has been the co-optation of civil society organisations to participate in the delivery of services and again this process has been the subject of much criticism by feminists (Schild 2000). One of the central concerns in Chile has been the way in which this co-optation of civil society has led to the 'NGO-isation' and subsequent depoliticisation of the women's movement as a growing number of women's organisations have reformed into non-governmental organisations (NGOs) in order to meet funding criteria and be able to develop projects (Alvarez 1999; Bradshaw 2006). While spaces have been created for women's participation in the design of service delivery they have been limited and have little or no impact on key decision-making processes (Gideon 2005).

Another important feature of the modern state has been the emergence of rhetoric that attempts to address the question of gender inequality (Schild 2007). As other papers in this *IDS Bulletin* have illustrated (see, for example, Pereira) governments are particularly willing to address gender issues if they can do so instrumentally and be seen to be addressing other goals such as poverty reduction at the same time. By explicitly addressing gender inequities in the health sector the Chilean government is able to position itself as a forward-thinking 'modern' state. However, as feminist critics have pointed out, the government has not been so willing to address many of the essential concerns of the women's movement such as domestic violence and the right to abortion which remains illegal in Chile (Blofield and Haas 2005).

This article will examine these issues in relation to changes in the health sector in Chile and will

predominantly focus on the access to health services as defined by the right to health. The article will start with a brief discussion of how the right to health has historically been reshaped by successive regimes before focusing on the current situation and the design and implementation of the new Plan AUGE (el Acceso Universal con Garantías Explícitas en Salud) in the health sector that seeks to guarantee access to health for all citizens, regardless of their gender or income level. On the one hand, it is an important development in terms of addressing gender inequalities in access to health services which will play a central role in securing women's equal right to health. Women's groups were involved in the consultation process around the design of the reform package and over time some of their demands have been integrated into the Plan AUGE (OEGS 2006). On the other hand however, the Plan promotes a somewhat limited notion of women's right to health and the whole issue of reproductive rights is not addressed by the Plan. Similarly while the Plan makes no claim to address broader gender inequalities in the health sector, critics have argued that it does serve to reinforce the gender division of labour in unpaid care by transferring more health-related caring activities onto the household.

2 Accessing healthcare services: 1930s–70s

Between the 1930s and 1970s countries across Latin America were characterised by a model of state-led development. A small number of countries were able to develop rudimentary welfare states although none achieved universality of entitlement or coverage (Molyneux 2007).¹ In most countries, including Chile, workers in the formal economy were able to secure minimal levels of protection and entitlements. This was made possible through a process of national compromise – urban elites feared the spread of communism and class conflict so for the sake of the national interest were willing to concede some of the demands of organised labour and their supporters. By promoting the collective ideal, that which separated the groups (class, wealth and status) was lessened and what connected them (national prosperity, political engagement and bargains) was highlighted (Silva 1994). Through this, social and economic rights based upon redistribution could be sustained across various areas of social policy. However, the level of benefits and protection was highly stratified and mainly extended to urban workers – blue-collar workers received benefits later than white-collar workers and also had lower levels

of protection. Rural workers and those employed in the informal economy were excluded from benefits. In some countries including Chile, state agencies did in some instances dispense basic healthcare to these excluded groups but they had no legal rights or entitlements from which to make their claims. Charity organisations and philanthropic groups also provided limited support to those not incorporated in the formal structures.

The establishment of welfare provision was intrinsically gendered and reinforced gendered contracts around the male breadwinner model, many of which have persisted (Gottfried 2000). At the same time the model promoted a moral discourse that differentiated between reputable, productive (male) workers with rights and entitlements and those who were not, and therefore had little access to rights and few entitlements. As Roseblatt has argued with reference to Chile:

Political elites justified political and economic entitlements by acknowledging (male) workers' productive contributions to the nation and by linking the rights and responsibilities of workers to their role as family heads. They also advanced workers rights by contrasting productive, reputable, mainly men with both dependent family members and disreputable men. In doing so [governments] not only failed to recognize the importance of the labour performed outside the formal sector. They also advanced the rights of presumably productive workers by asserting their masculine privilege and power *vis-à-vis* nonworkers and dependents. (Roseblatt 2001: 557)

Women were generally inserted into the system as female dependants and had little say in how entitlements were administered from the state. Benefits such as family allowance and maternal healthcare payments would be paid to the male worker, reinforcing the notion of female dependence. Women's welfare provision was essentially based on maternalist assumptions – that is, entitlements were accessed by virtue of being a mother, assumed as the present or future destiny of all women (Molyneux 2007: 5). Where women did gain rights as workers, again these were also usually premised on maternalist assumptions. In reality, women's entitlements were restricted to a very small sector of the population and were often merely formal since they were unclaimable

in practice, for example, because women were unaware of their rights or in the case of indigenous women they lacked the required identity cards to claim their rights (Molyneux 2007: 7).

3 The privatisation of social rights: 1970s–90s

By the mid 1970s it was becoming apparent that the hegemonic development model was no longer viable. The following decade saw a range of neoliberal reform programmes being implemented across Latin America. In the health sector these included programmes of privatisation and the introduction of private health insurance companies to compete alongside public sector provision, as well as reductions in state spending on health and welfare. These reforms resulted in the progressive removal of the state as a guarantor of rights. Economic and social rights were no longer acknowledged as rights that were the responsibility of the state, instead they became benefits and services that could be paid for in the market. This was clearly evident in Chile with the privatisation of the healthcare sector and an increased shift towards a marketised system of provision in the public sector. In 1981 private insurance companies, the ISAPRES (Instituciones de Salud Previsional) were introduced alongside the public system of FONASA (Fondo Nacional de Salud) and users were encouraged to choose between the two systems. This was all part of a broader process of social sector reform oriented towards replacing the Welfare State (Estado de Beneficiencia) with a Subsidiary State (Estado Subsidiario) governed by the dictates of the market. In other words, the state shifted its focus away from mediating class conflict through its 'protection' of labour to explicitly protecting employers (Schild 2000).

The creation of the dual health system led to marked inequalities and the problem of 'cream skimming' where younger and wealthier sectors of the population and those representing a low medical risk joined the ISAPRES while those representing a higher risk, low-income groups and older people all remained in FONASA, making it the provider of 'last resort' (Sapelli 2004). The shift towards a marketised system also raises concerns regarding notions of citizenship and entitlements to healthcare, signifying a shift from citizens as bearers of social rights to becoming primarily consumers of healthcare services (Gideon 2006b). At the same time entitlements were dependent on individual earnings rather than on redistributive mechanisms based on collective earnings (Giménez 2005). Access to rights therefore

became conditional on the ability to pay and this had important gender implications.

Most significantly women's lower wages have been identified as a key constraint in limiting women's access to the private health insurance companies, the ISAPRES (Ramírez 1997; OPS/OMS 2002). Chilean women in all socioeconomic groups earn up to 30 per cent less than men (Vega *et al.* 2003). In addition, the cost of health plans is generally higher for women of all age groups than for men of the same age but for women of reproductive age the cost of a health plan, prior to the introduction of the Plan AUGE, was around three times that of a man's health plan (Pollack 2002) unless they signed up for a 'plan without uterus' which excluded services relating to pregnancy and birth. Not surprisingly ISAPRES members were predominantly men aged 25–49 and in 2001 only 32 per cent of ISAPRES members were female (OPS/OMS 2002: 13). As out-of-pocket expenditure and other health-related expenditure rise, the implications of this wage gap go beyond limiting women's access to the private sector. Studies have shown that in reality such households manage the cost of sickness by extending the threshold of seriousness at which they seek treatment (Bloom and Standing 2001), implying an absorption into the household of the care and management of such individuals. The prevailing gender division of labour means that it is generally women who absorb this cost (Pearson 2000) and studies from Chile have confirmed this (Provoste and Berlagosky 2002).

This overall failure on the part of the private sector to effectively regulate itself has been the subject of much debate and some critics have argued that since the agenda for health reform continues to be set by the World Bank and other International Financial Institutions (IFIs), the main beneficiaries of the reforms have been the private health insurance companies (Homedes and Ugalde 2005), the majority of which are owned by transnational corporations (Iriart *et al.* 2001), rather than health service users. The long-standing role of US-based economic institutions in the Chilean economy has also sustained the technocratic nature of policymaking in Chile (Silva 1991). Given the strength of interests of the ISAPRES and other stakeholders in the private health sector, the privatisation of social rights also restricted the arena for agency around healthcare.

4 The Chilean health sector today

Chile currently has a mixed insurance system where workers can choose between the public (FONASA) and private (ISAPRES) sector to contract their mandatory 7 per cent health insurance contributions. Around 68 per cent of the population is in FONASA, while the majority of others are either in an ISAPRES or covered by special social insurance funds, such as those for the armed forces and police (Pollack 2002). A small percentage of the population is not covered by any health insurance plan.

Until the introduction of the AUGE, within FONASA entitlements depended upon earnings-related contributions and contributions financed the benefits provided. The lowest income groups are entitled to free care directly from FONASA, but prior to the AUGE were only eligible for certain services and a number of important exclusions existed (Bitrán *et al.* 2000). Within the ISAPRES users select a contract which defines the degree of coverage and types of benefits for individuals and their dependants. The benefits offered vary according to the premium paid and the medical risk of the insured person(s). Contracts last one year, after which time the ISAPRES are entitled to change their coverage and cost.

The aim of the Plan AUGE was to remove any inequalities in provision and ensure equity in access to healthcare services, regardless of the type of provider used by people or their income levels (Biblioteca del Congreso Nacional de Chile 2002). This would be an important step to bridging the gap faced by many users between health insurance coverage and healthcare. Law 19,966 came into force on 1 July 2005 and made apparent the 'explicit guarantees in health' (*Garantías explícitas en salud*, GES) relating to 25 health conditions that were to be made available to the population, regardless of their affiliation to FONASA, ISAPRES or other health system. Additional health conditions were added in 2006 and 2007 and by the end of 2007, 56 health conditions were included in the Plan AUGE.

Many of the services guaranteed under the Plan AUGE are expensive and highly complex, and would not previously have been available to all health sector users because of cost issues. There are however limits to the Plan AUGE – if, for example, a different course of treatment is required to that specified in the protocol the patient will not be covered by the

AUGE and will have to fund the care through alternative means. In this instance those in the ISAPRES benefit since they can often use their health insurance plans to pay for alternative treatment while those in FONASA may not be covered. In this respect, the AUGE does not resolve the issue of inequality between the public and private systems (Letelier and Bedregal 2006).

5 Gendered assumptions and unpaid work

From a gender perspective it is important to determine what implicit assumptions are made within the design of the reform package about household and family structures. It is also necessary to consider if unpaid household contributions to healthcare have been taken into account (Mackintosh and Tibandebago 2006). As Provoste (2002) has argued, the Chilean health system continues to be a 'maternalised' system, which is dependent on the assumed domestic, caring role of mothers, who are willing and able to exclusively take on a care-giving role. Feminist critics have argued that the current reforms and the Plan AUGE have done little to address the underlying gender bias in the health sector and gendered assumptions about women's capacity to undertake unpaid care work remain prevalent. For example, the emphasis in many of the protocols on reducing the time patients will spend in hospital, and increasing home care for those with chronic or terminal illnesses, contains an implicit assumption that once transferred back home patients will have someone available to look after them. Moreover the amount of time spent accompanying chronically and terminally ill patients to hospital appointments is also likely to increase under the AUGE (Provoste and Berlagosky 2002).

Two recent Chilean studies conducted in Greater Santiago have shown that both primary and secondary care-givers within the household for the chronically and terminally ill are predominantly female and in the majority of cases close family members of the patient – either mothers, partners or daughters (Reca *et al.* 2002; Medel *et al.* 2006). The studies also found that the women were typically aged 38–59 (Reca *et al.* 2002), but in many cases carers were as young as 15 and over 65 (Medel *et al.* 2006). Reca and colleagues (2002) found that primary care-givers spent on average nine hours per day carrying out caring responsibilities. The most time-consuming duty was 'keeping the patient company' and also covered observing the patient,

identifying their needs and making sure they were comfortable. The women interviewed in the study spent around 310 minutes per day doing this. Similarly Medel and colleagues found that the most time-consuming tasks were often those most invisible to policymakers, such as organising the patient's routine, taking the patient to appointments and organising their living space. At the same time these kinds of activities are critical to the wellbeing of patients and other research has highlighted the importance of 'tender loving care' in caring for the sick. Reca *et al.* (2002) found that the other most time-consuming activities were domestic labour and support followed by specific professional care activities such as administering medicine, help with rehabilitative exercises and giving injections, inserting catheters and dressing wounds.

In many cases, women working as primary care providers also have full-time employment outside of the household and spend up to eight hours per day in their place of work, plus additional travel time. This was particularly the case for women in the middle and lower income groups and in many cases they were the primary breadwinners. Women in the lowest income groups worked on average up to 94 hours per week carrying out paid and unpaid work whereas for women in the highest income groups this figure was on average 65 hours per week (Medel *et al.* 2006). Often the women also slept in the same room as the patient – either with them or near them – and so this has clear implications for their ability to have a full night's sleep (Reca *et al.* 2002). The toll of this unpaid care work on women's health cannot be underestimated, particularly in relation to stress levels. Indeed research from Canada has shown that time spent on this kind of care work induces far higher stress levels in women than other types of unpaid work within the household, and that on average women experience a far greater degree of stress than men do (MacDonald *et al.* 2005). In the Chilean study many of the women interviewed reported feeling stressed, and experienced stomach ailments, insomnia and depression as a result of their caring roles, yet very few had consulted a doctor about their own health (Reca *et al.* 2002). While some male carers also participate in paid work outside of the household Medel and colleagues found that only a small number of men played this role compared to the number of women and that women took responsibility for unpaid care work throughout their adult lives whereas men often only

did so where a close relative needed specific healthcare. Moreover, women talked about their caring roles in terms of family responsibilities and obligations whereas men did not.

The gender division of labour can severely impinge on women's ability to access their right to healthcare since women's 'double burden' limits their possibilities of moving freely into the labour market. As a result, they may be forced to take lower paid jobs or take on informal work which may lack a contract and therefore deny workers the possibility of belonging to an insurance system, thus linking to broader issues of social exclusion. Given that women are more likely than men to be located in informal work (Chen *et al.* 1999) these processes are clearly gendered.

6 Women's participation and agency around health sector reform

Another important issue is the question of participation and agency around health. As argued earlier and demonstrated in other articles in this *IDS Bulletin* (see, for example, Chakravarti and Wilson) citizen participation is a central tenet of the current neoliberal development orthodoxy. In 2002 the Chilean Government created several new participatory mechanisms and women's organisations and NGOs were invited to join the debate around the proposed health sector reform (see Gideon 2006a for a full discussion of this). The women's health movement was highly active and organised a series of nationwide meetings in which large numbers of women were invited to come and discuss the proposals and develop a 'Women's Proposal for Health Sector Reform in Chile' to be presented to the government. Several annual Women's Parliaments, organised by the women's health movement, were also held to debate the reform further and ensure that there was as much input as possible from women's groups across the country. Central to women's demands were the importance of women's reproductive rights and the need to include women's health priorities in any basic package of services (or the services included in the Plan AUGE).

The experience of the Plan AUGE suggests that unlike the private sector, the public sector does offer some (limited) space for women's participation around health. Although in the final instance the debate around the Plan AUGE was relatively top-

down and many women's organisations complained about their exclusion (Dannreuther and Gideon 2008) they were at least invited to the table. Moreover, subsequent advocacy by the women's health movement has resulted in the inclusion of mental health problems, including schizophrenia and depression in the Plan AUGE as well as the inclusion of pregnancy and birth-related services, resulting in the abolition of 'plans without uterus' in the ISAPRES (OEGS 2006).

However, the most important omission of the reform has been the failure to fully address women's reproductive rights. Despite the strength of women's demands as expressed in their proposals emerging from the Women's Parliaments successive governments have maintained an active pro-life policy. Many women's groups have complained about the large gap between the government-defined gender equity agenda and the needs and priorities of women, particularly working-class women, as expressed by themselves (Schild 2002). Some limited gains were made when women secured the right to emergency contraception but abortion remains illegal.

7 Conclusions

This article has reviewed the changing nature of rights and entitlements in the Chilean healthcare

system and it is clear that the recently introduced Plan AUGE does offer some potential for overcoming the gender bias in access to healthcare and guaranteeing women's right to health. Following the privatisation of healthcare provision as part of broader neoliberal reforms, gender inequalities in accessing health worsened and for many women the burden of unpaid care also increased. While it is too early to provide a full assessment of the Plan AUGE the process does also suggest the critical role of the public sector in guaranteeing women's rights. The gender bias inherent in the ISAPRES clearly illustrates that the private sector has little or no incentive to work towards ensuring gender equality.

Clearly the Plan AUGE alone will not transform gender inequalities within the health sector and as discussed above critics have argued that it has failed to address the embedded gender inequalities around the division of labour in healthcare. More significantly the AUGE has also avoided the contentious issue of reproductive rights and the question of abortion, which remains illegal in Chile and poorly performed illegal abortions remain one of the central causes of maternal mortality (Casas 2006). Once this issue is addressed women can begin to be really confident that their right to health is guaranteed.

Notes

1 Much discussion has been focused on producing a typology of welfare regimes in the region (Mesa-

Lago 1994) but for reasons of space this will not be reviewed here.

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