

## C3 | HEALTH REFORMS IN CHILE: LACK OF PROGRESS IN WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS<sup>1</sup>

### Introduction

The global recognition of the importance of universalism in health has been acknowledged with the commitment, enshrined in the Sustainable Development Goals (SDGs), to ensuring universal access to sexual and reproductive healthcare services by 2030. Calls for universal access to healthcare to address inequalities in health are not new. The Platform for Action emerging from the 1994 International Conference on Population and Development (ICPD) called for universal access to healthcare services, including, specifically, reproductive health services (Principle 8). Yet despite these global commitments and assertions only limited progress has been made towards meeting this objective and many women across the world are still systematically denied access to these services.



**Image C3.1** Health systems often see women as just 'reproducers' (third world health aid)

This has particularly been the case for women in Latin America, where, it has been argued, reproductive health systems are among the largest contributors to gender inequality in the world (UNDP, 2010). Moreover, gender differences in the access to and use of services are not sufficiently factored into debates around universalism (WHO, 2010). Yet universal access goes beyond mere coverage of services. Structural inequalities by gender, as well as by class, race and ethnicity, can reinforce barriers to access and must be accounted for in any discussion of universalism.

The case of Chile can offer some insights into the factors limiting universalism in sexual and reproductive health and rights (SRHR).<sup>1</sup> Chile presents an interesting case study given its status as a middle-income country and its well-developed public and private health sectors. Around 70 per cent of the population is covered by the public system, and in recent years considerable progress has been made towards universal healthcare coverage (Bitrán, 2013). The shift towards universalism began in the early 2000s and studies have suggested that significant improvements have been made towards improving health inequalities (Frenz et al., 2014, pp. 717–31). A central element of the reform is the Plan of Universal Access with Explicit Guarantees, or Plan AUGE as it is commonly known in Chile, which legally guarantees equal rights to both public- and private-sector beneficiaries in terms of accessing timely, affordable and quality healthcare services for 80 prioritized health problems.

Nevertheless, despite the progress towards universal healthcare, there continue to be significant structural constraints within the health system, which remains highly stratified across the public and private systems and continues to prioritize high-income users. Critics have argued that the need to meet the AUGE guarantees has led to a neglect of other health concerns, that overall access continues to be shaped by gender, ethnicity and age, and that the adequacy and quality of care, particularly among low-income users, is a matter of concern (Aguilera et al., 2014). These inequalities are particularly manifested in women's sexual and reproductive health and rights, where there has been a significant lack of progress towards securing better health indicators and outcomes, particularly in the field of SRHR.<sup>2</sup> It is also worth noting that successive Chilean governments have passed extensive legislation advancing gender equality and, indeed, the current president, Michelle Bachelet, has arguably promoted feminist agendas. Yet despite apparent progress in 'pro-gender' policies, particularly in the area of social policy, only limited changes have resulted on the ground. Recently, there has been a push to move the agenda further and there are ongoing discussions in Parliament to approve the de-criminalization of abortion in restricted cases. As Table C3.1 illustrates, there are still a number of significant gaps in women's SRHR health outcomes, which need addressing.

Concerns have been expressed over the lack of progress in a number of areas of women's SRHR in Chile, including the following (CEDAW, 2012):

TABLE C3.1: Some key indicators of women's SRHR in Chile

Indicator	Prevalence
Contraceptive use (2006) <sup>a</sup>	64.2% (Americas: 73.6%)
Births by caesarean section (2010) <sup>b</sup>	37.0% (Americas: 35.6%)
Legal situation re. abortion	Completely criminalized (bill to allow therapeutic abortion in three cases presented in January 2015)
Number of abortions per annum <sup>c</sup>	60,000 to 70,000
Maternal mortality rate (per 100 000 live births) <sup>d</sup> *	22
Estimated deaths per 100,000 (2008) – cervix uteri cancer <sup>e</sup>	4.8
Estimated deaths per 100,000 (2008) – breast cancer <sup>f</sup>	7.3
Estimated deaths per 100,000 population (2008) – ovarian cancer <sup>g</sup>	0.3
Rate of teenage pregnancy (% of 15–19-year-olds who are mothers) <sup>h</sup>	12.3

Sources: a. WHO (2016); b. Ibid. c. See CEDAW (2012); d. UNICEF (2017); e. WHO (2017); f. Ibid.; g. Ibid.; h. United Nations (2017)

Note: \* Regional average 77 per 100,000 live births.



**Image C3.2** Pro-choice March in Chile, 25 July 2013 (AshokaJegreeo / The Santiago Times; License: CC BY 2.0, <https://creativecommons.org/licenses/by/2.0/>)

- criminalization of all forms of abortion, and the lack of progress on securing safe
- abortions for women
- high number of teenage pregnancies
- high rates of school dropout and expulsion of teenage mothers
- lack of access to contraception.

This creates a highly contradictory situation in a middle-income country such as Chile where, on the one hand, people have access to highly developed health systems but at the same time experience a significant deficit in terms of personal and health rights. Access to SRHR is clearly shaped by class: for example, economic resources guarantee access to safer abortion in private clinics and with the use of the medication Misoprostol. Moreover, 48 per cent of teenage mothers live below the poverty line, with many coming from the poorest rural communities (CEDAW, 2012).

How do we therefore explain the lack of progress with respect to SRHR in Chile, despite the fact that overall health indicators are good and Chile is a middle-income country? The rest of the chapter focuses on three inter-related factors.

### **The marginalization of SRHR in health reform debates**

The role of power relations in policymaking is often overlooked, yet an idea of the nature of power relationships is critical to understanding the ways in which SRHR issues have been neglected in policy debates. Political scientists have shown how, in order to identify the ‘relevant’ actors and understand the power structures inherent in health sector institutions, it is helpful to take a historical view. The work of Paul Pierson (1994) has been central to these debates. He has shown how the establishment of welfare states in the Global North created vested interests and ‘armies of beneficiaries’ that protected it from attack. These historical interests and policies have shaped the politics, including the behaviour of bureaucrats and interest groups, which feed back into contemporary reform processes. These so-called ‘policy legacies’ help us to identify which actors maintain a vested interest in the health sector and seek to shape reform processes accordingly. Policy legacies can also reveal how particular gender, race and class orders become entrenched within policy processes over time. For example, the historical development of the Chilean health sector shows how men’s health needs were prioritized because men were seen as constituting an integral part of the labour force. In contrast, women were seen primarily as mothers whose only role was to give birth and look after young children, and their needs were therefore seen as secondary to those of men. There was no acknowledgement of women having any health issues beyond those directly related to biological reproduction. The replication of this pattern over time has created ‘gendered policy legacies’, which shed some light on subsequent failures to prioritize women’s health needs.

The lack of attention assigned to women’s health concerns is further compounded by the marginalization of women within central decision-making arenas in the Chilean legislature. This raises significant questions over the likelihood of SRHR issues being taken up as matters of serious political concern. This was particularly evident when women’s groups sought to influence the design of Plan AUGE to ensure, for example, that the inclusion of health conditions

reflected women's health priorities alongside men's. In the preliminary phases of the AUGE, 56 health conditions were included but only around one-third specifically addressed questions of gender inequality in health (Vargas and Poblete 2008, pp. 782–92). Moreover, attempts to introduce a more redistributive element to the health system, which would have had important implications for public-sector users (that is, the majority of poor women), were blocked by private insurance companies. This clearly illustrates how particular class and gender interests can be maintained through reform processes.

### **The role of the Catholic Church and other conservative vested interest groups**

The 'policy legacy approach' also underlines the influential role of the Catholic Church in health policymaking. This is particularly evident in the field of women's SRHR where the Church exerts an influence at not only the policymaking stage but also in terms of healthcare delivery, thus impacting health outcomes.

Since the papacy of Karol Józef Wojtyła (1978–2005), the Catholic Church has undergone a conservative shift, and reviews of official papal documents show that it has been increasingly involved in regulating sexuality, reproduction, family structures and gender roles (Casanova 2009, pp. 1–29). Despite there being low popular adherence to the Church in Chile, the Church has successfully maintained a conservative agenda on issues of reproductive rights, precisely because the decreasing attachment of Catholics to the Church has left the latter with the freedom to generate alliances with conservative business and right-wing elites, who are quite empathetic to the Church's moral teachings (Hagopian, 2008, pp. 149–68).

Furthermore, Catholic ideas of women's sexual and reproductive rights in Chile were embedded into the policies and legislation of the military regime in the period 1973–1990, despite the fact that the Church opposed the regime's human rights violation. The influence of Catholicism is also present in the 1980 Constitution; most notably, Jaime Guzmán, a devout Catholic, was one of the commissioners responsible for drafting it. The Constitution set the precedent to criminalize all forms of abortion. Since the return to democracy in 1990, a powerful religious elite has been able to influence policy implementation on sexual education in schools, and access to emergency contraception and abortion. Conservative elites have maintained a close hold over public discussion, and economic elites have stepped in when the government has succeeded in introducing progressive reforms, such as in the case of emergency contraception: conservative mayors stopped access to emergency contraception in their municipalities, based on their own conservative views, even when by law they were mandated to ensure access in all public health establishments. These elites belong to conservative groups within the Church, including Opus Dei, the Legionaries of Christ and the Schoenstatt Movement, and they have successfully penetrated elite educational and health facilities, spiritual groups

and community churches. Groups like Opus Dei are not only successful in their reach but also in their hold over members' work and family life, transforming elite members into committed and active advocates with access to resources and power. Even when leftist governments are in place, such as the current Bachelet government in Chile, real progress in SRHR is unlikely as political leaders are either unwilling or unable to accept the potential political fallout that would result from the adoption of a comprehensive and effective SRHR policy.

### **The role of medical professionals**

The 'policy legacies approach' also reveals how the medical profession has been able to maintain its power as a professional body during successive reform periods. Moreover, its inherent gendered nature has meant that the medical profession has failed to prioritize women's own definitions of their health, and it has continued to essentialize women as reproducers. In Chile, the development of the medical profession was closely aligned with nineteenth-century ideals of hegemonic masculinity, and the evidence of this policy legacy is still apparent in the profession across much of the Latin America. Present-day maternal healthcare services are often organized around medical professionals (that is, doctors), rather than 'semi-professionals' (that is, nurses and midwives). This has important implications for decision-making processes with regard to childbirth, where power tends to lie with medical professionals rather than the women themselves (Gamble et al., 2007, pp. 331–40). Moreover, in the context of the privatization of, and 'professionalism' in, healthcare, medical professionals such as obstetricians are becoming increasingly accountable to 'the market' rather than the state (Sandall et al., 2009, pp. 529–53). This is particularly evident in the context of reproductive healthcare services, especially childbirth. In Chile, where the medical profession was one of the main beneficiaries of the public-sector reforms of the 1980s, medical practitioners acquired the possibility of a 'dual practice', that is, a stable public-sector job coupled with private-sector responsibilities and revenue. This has exacerbated inequalities, as private patients in the Chilean system are often given preferential treatment over public-sector patients, particularly in the matter of childbirth (Murray and Elston 2005, pp. 701–21).

Yet it is also necessary to understand how 'gendered policy legacies' shape opportunities for medical professionals to exert power at the policy implementation stage. A recent systematic review highlighted the growth of the micropractice model as an important constraint in implementing health policies (Gilson, Schneider and Orgill 2014, pp. iii51–iii69). Health workers frequently use their own discretion to determine whether or not to offer women family planning services and, moreover, whether or not to restrict women's contraceptive choices. In the case of Chile, private clinics and private university hospitals decide what reproductive and sexual health services to offer, despite national

regulations and guidelines. This means that some Catholic health services do not provide access to contraception or voluntary sterilization; there is also anecdotal evidence of medical professionals marking the files of women who are suspected of having undergone an abortion.

While it is important to recognize that discretionary power is not always used to undermine and subvert policy, there is a clear need to understand how power relations shape outcomes so that it is possible to move towards better ‘policy ownership’ by implementers (Lehmann and Gilson 2013, pp. 358–66). In Chile, health and medical workers maintain power and control over women seeking healthcare services, a situation that has arguably been reinforced in the context of the privatization of health services.

### Conclusion

The foregoing discussion on universal access to healthcare has focused attention on the importance of SRHR and its centrality to the wider development process. Yet if governments are serious about their commitment to overcoming inequalities and meeting development goals, it is essential that SRHR issues are fully addressed. The case of Chile clearly demonstrates that even in the context of universal healthcare systems in countries where economic development has occurred and income levels have been raised, women’s sexual and reproductive health rights are frequently ignored or even deliberately kept off the political agenda. We therefore advocate the importance of employing a broader approach: governments must not only commit to promoting women’s health concerns but must simultaneously address the deeply embedded gendered norms within the society and healthcare system, and in the daily practice of health professionals. If not, policies will fall short at the implementation stage.

### Notes

This chapter draws in part on an earlier article by the authors: ‘What is hindering progress? The marginalization of women’s sexual and reproductive health and rights in Brazil and Chile’, *Journal of International and Comparative Social Policy*, vol. 31, 20 Oct. 2015.

Although sexual and reproductive rights have not been explicitly included in the SDGs, we believe that they are an integral part of sexual and reproductive healthcare and must be taken into account.

The definition of SRHR in the ICPD Programme of Action includes family planning; antenatal and postnatal care; prevention of abortion and management of the consequences of abortion; information, education and

counselling, as appropriate, on human sexuality and reproductive health and prevention; and prevention of violence against women (UNFPA, 2008).

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