The Situation of Women's Health in the Context of Health Sector Reform in Latin America

Dr. María Isabel Matamala
The author is a physician and consultant for the Pan American Health Organization's project on Equity, Gender and Health Sector Reform.

It is very exciting to be here to share with people from EPES and with the community committed to health in Chile and elsewhere in Latin America, especially among the neediest and most vulnerable sectors of our countries. It is exciting because even though I am not a founding member of the EPES team, I have watched this dream grow, and I have shared in the utopia that this effort implied.

The invitation that EPES sent out for this event contained a quotation from Galeano explaining that utopia always moves away from us and that we must continue to pursue it. I believe that with each step that it has taken, EPES has somehow slowly caught up with this utopia. What we are sharing today – here in this house, in this room named for Gastón (1) – is part of this utopia first imagined 20 years ago by a group of dreamers to whom we now pay tribute.

My task is to speak about women, and I do prefer to speak of women in the plural because there are so many of us and each experiences health her own way amid the contradictions and discriminations of different health care systems. Since we have to place women in the context of health sector reform, I want to begin by showing you a table that will help us understand why real reforms are necessary. Although the term "reform" means an improvement, in practice this is not always the case, neither in Chile nor elsewhere in Latin America. This table describes the health care model and the crisis that supposedly requires reform.

tabla aquí

As Christina Mills and pastor Lisandro Orlov have reminded us, we must examine the political, social and economic contexts of health and how the sex/gender system influences health through the roles assigned to women and men and the accompanying prejudices and gender-based discrimination. Together with globalization, this socio-political structure, including the sex/gender system, has imposed a model of production and consumption and a type of anti-ecological development that has increased health risks considerably and undermined living standards for most of the population.

Social inequalities of all sorts have grown worse; the benefits of economic globalization are enjoyed by a small percentage of the

population. The great majority have no access to these benefits, and their living standards actually have fallen. We have also witnessed the feminization of poverty: the poorest of the poor are women, especially rural, indigenous and/or elderly woman and young girls.

If we look back in history, we see that under the system of the welfare state, the social contract assumed that the salary of a single worker – more frequently than now a man – would be enough to support the family. Today, even if there is a man in the household who works, he alone cannot meet all the needs of the family. As a result, women and children have also had to join the labor market and contribute to the family's maintenance.

One immediate result of this situation is the double and triple workday endured by women. There has been little, if any, change in the situation of women's productive work within the home: women workers, who thanks to the long hours of labor flexibilization dedicate eight, ten or twelve hours to paid work, must return to their homes to shoulder the tasks they still do not share with the other sex. At the same time and in one of the great gender inequities that still exists in our society, these working women have unequal access to health and social security systems due to gender-based wage disparities and because they often must quit their jobs. We all know that in Chile and throughout Latin America, women are paid 60% of men's salaries for comparable work.

Another effect of what has been called the "modernization of the state" is the tendency to follow the recipes of the World Bank and the International Monetary Fund by lowering state spending on health and education and opening these services to the market through new and "inventive" forms of privatization.

These factors also have had a tremendous impact on women because in addition to the double workday, they also face another extra burden: cuts in government health spending, which mean passing on these costs to the household.

We talk in the abstract about households that have to assume the responsibilities of self-care and health promotion. But these households are not abstractions: they are the women who take on these tasks. Each time a hospital cuts costs, many homes must take in and care for the elderly, the sick who have been prematurely discharged, or the terminally ill suffering from cancer or AIDS. While we may find the humane aspects of homecare to be important, the realities of our countries mean that the tremendous costs of homecare are shouldered by the women caregivers who have neither the time, the means nor the real possibilities to take on these additional responsibilities.

As a result, within the domestic sphere women are making a tremendous, unseen effort: it is not recognized by those around them and much less by the national and global economies. The model of the welfare state has vanished from our countries, and women have become a buffer zone by providing the care no longer assured by the state through what we have termed the "domestic health care system." As a result, despite the whirlwind of reforms, the fact that health care indicators have remained steady in Chile and in the rest of Latin America is largely due to the monumental effort of women in their own homes.

The negative impact of the reform processes are revealed clearly in the behavior, levels of education and, above all, in the civil participation of the general population. For example, in the case of Chile, the first neoliberal health sector reform – the most orthodox proposed by the World Bank – was undertaken in the 1970s, during the Pinochet dictatorship. Even the country's constitution was changed: the "right to health" became the radically different "right to access" which meant a serious setback for civil rights. The very right of Chilean citizens to participate in and determine public policy was put in question by these World Bank-led reforms.

All of this supposes that what is happening in health today cannot be addressed as it once could have been under the welfare state. The paradigm shift, the cultural change of globalization, has led people to live in a context of competitiveness and anguish, which in turn transforms the type of illnesses suffered by the population. Today, at least in the Southern Cone, people are not as afflicted by transmissible diseases which were the primary cause of mortality and morbidity in past decades. We now find that mental health illness, the so-called "ills of the soul," are more prevalent. However, the system does not diagnose these fundamental problems, and therefore no responses are offered.

As an example, let us look at a situation in Chile that has recently caused a great deal of controversy. The mayor of Santiago decided to dismantle the city's first treatment center for gender-based violence, founded over ten years ago by the municipality and the National Women's Service (SERNAM). The mayor made this decision because the center costs 60 million pesos (about US$86,000) each year. Evidently, there is still not a clear perception of the fundamental problems of violence faced by women and men – who were also treated at the center. Centers like these for the treatment of violence represent an effort to change our health care responses.

To use the terminology of the health profession, what we are proposing are "new epidemiological profiles." These profiles imply a change in the ways in which the general population lives, becomes ill and dies. However, we continue to measure health with the same indicators as before.

In Uruguay, for example, every eight days a woman dies as the result of domestic violence, and yet we continue to measure health in terms of maternal or infant mortality. At the same time, infant mortality will tell us very little about the situation of girls who have been raped. They didn't die during their first year of life, so it can easily be claimed that the status of girls' health is excellent because infant morality is down. But it so happens that one out of every four or five girls aged one to five are victims of abuse or rape, especially in the most vulnerable sectors, and nothing is being done about it. This is an example of the defenselessness of the elderly and the young, especially in the case of women. Meanwhile, our countries continue to emphasize health services which are really "illness" services: they are not focused on the community; there is no real participation by the community; and the services are unable to effectively respond to the health crisis.

Health sector reforms should aim to resolve this issue, but the debates, discussions and new recipes proposed by the World Bank in response to the failure of the health sector reform implemented in Chile under the dictatorship are all focused on resolving the problems of health system financing. The new reforms seek to guarantee the continued coexistence or "collaboration" between the public and private systems, with one dealing with the poorest and most dispossessed sectors while the other concentrates on profits. Until now, this has been the recipe of the so-called "second generation" of health sector reforms.

The Colombian attempt at reform has been in place for some ten years, the longest of all the efforts in our region. Recently, we heard the opinions of a Colombian physician visiting Chile who shared his opinions on this undertaking. I'll cite just one example: when the Colombian reform was first implemented, 14% of the population had no health coverage, but now, ten years later, 40% of Colombians have no health coverage. We call this "evidence," and in the medical profession, it is very "in" to talk about evidence-based medicine. So we are seeing evidence that as long as the reforms in Latin America do not meet the needs of the population – and fundamentally, the needs of women who are the most affected by the reforms – we will not be able to resolve the real health problems of the population in general and of women in particular.

In conclusion, I wish to emphasize why we insist that women must be a priority in the planning and design of the reforms. First of all, women are the mainstay of the domestic system of health care. As a result, they make the greatest contribution to the production of health services. In addition, they have an added value that we have never been able to evaluate: their work is based on emotional bonds. When an aide, a nurse or a midwife places her hand on your forehead, it does not have the same soothing effect as the hand of your grandmother, sister or mother, and this cannot be measured.

Another aspect that we often talk about when we examine these reforms from a gender perspective is financing. You want to talk about financing? Okay, but we have to describe the economy of health in its totality and not just the mercantile aspect, and this means placing value on women's contribution to the health of the general population through the system of domestic health care.

The women's movement is defending this contribution throughout Latin America. We want women's unpaid work to be recognized in the national accounts, the Gross National Product and the Central Bank of every country so that the entire population is aware of this reality. We believe that this recognition of women's contribution would restore some justice on a macroeconomic level and in the overall panorama of reform policies. This would have positive repercussions for women's health both in terms of self-esteem and social and civil identification. Above all, we do not want any elderly woman to be bereft of health care after a life of caring for others simply because her husband dies or because she has no social security or independent means of support.

I am thrilled that we are working with EPES on this topic in the reform process. And I believe that we must invite all the women and men of Chile to take part in these civil initiatives that will most assuredly facilitate greater justice in health not only for women, but for the entire population.

Finally, I would like to thank you all for giving me this opportunity to speak, in particular the EPES team and the entire community with whom I've collaborated for so many years: among them, Mónica, Valeria and the many other women from the El Bosque neighborhood with whom I worked when I first returned from exile and who have been an example for us all during these many years.

Note: Gastón Toledo, a long-time member of the EPES team, died November 20, 2001.