Beyond States and Markets

The challenges of social reproduction

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8 Reproduction, re-reform and the reconfigured state

Feminists and neoliberal health reforms in Chile

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While women have traditionally taken on a large portion of responsibility for social reproduction worldwide, neoliberal policies heightened the costs of such responsibilities and shifted their weight more dramatically from states to markets, families, and women as individuals.[2] The transnational trend towards neoliberalism began in the 1980s, as advanced industrialized countries (especially the USA and Great Britain) sought to strengthen their economies using new economic principles. In contrast to the previous Keynesian economic model, neoliberalism prioritizes markets and market mechanisms over state intervention. It has been promoted on a global level, and especially in the global South, by international financial institutions such as the International Monetary Fund (IMF) and the World Bank as a means to promote economic and social development. In much of the developing world, neoliberal economic adjustment measures, aimed at stabilizing debt-ridden economies, led to high inflation and unemployment while state services were simultaneously cut. In this phase of neoliberalism state policy-makers relied on women to act as "shock absorbers" for community and family survival (see e.g. Tinker 1990; Benería and Feldman 1992; González de la Rocha 1995). Following economic adjustment, these states began to apply neoliberal principles to their social policies, privatizing significant portions of their social policy apparatus, reorganizing their public welfare systems to act more like markets, and transferring substantial responsibilities for social welfare from the state to women, as women became the permanent "volunteer" health and daycare providers for the neoliberal state (Lind 2005; Ewig 2006a). In the case of Chile, the move to market-based social policies shifted the costs of biological reproduction to women as individuals.

In this chapter I examine Chile's neoliberal health reforms, and how in the early 2000s feminists and their allies attempted to roll back neoliberal policies in the health sector "re-reform" process to claim societal, rather than women's responsibility for one aspect of social reproduction: biological reproduction. Chile was a forerunner in implementing neoliberal social policies, and it applied neoliberal principles in a doctrinaire manner compared to other countries. As a forerunner and as a country that has been

held up as a model neoliberal reformer, Chile is instructive regarding the effects neoliberal social policies can have on the distribution of responsibility for social reproduction. It is also instructive as to the ways in which women, in order to reclaim the state's responsibility for social reproduction, must strategize in the new political terrain of the neoliberal "reconfigured" state (Banaszak *et al.* 2003).

Whereas scholars have argued that Chilean women's movements declined in influence and activity with the consolidation of democracy (see e.g. Waylen 1994: 353; Frohmann and Valdés 1995; Schild 1998; Baldez 2002: Ch. 8), I demonstrate that their lower visibility is due not only to a return to "politics as usual" but also to the reconfiguration of the Chilean state as a result of neoliberal globalization. In the context of neoliberalism, the Chilean state reconfigured itself by downloading essential social services from the central government to municipalities; by lateral-loading key decision-making to non-elected bodies; and by offloading portions of the welfare state either to private sector actors or to women and families. I focus on the consequences of this reconfiguration of the state for the division of responsibilities for social reproduction among women, families, and the state. I show that the reconfigured state has led to new forms of contestation between women's movements and the state, and that the reconfigured state also has led to gendered contestation within the state itself.

I begin by outlining the ways in which the Chilean state reconfigured itself in a context of neoliberalism. I then examine the consequences of Chile's neoliberal health sector reforms of the early 1980s for women, in which the Chilean state off-loaded responsibility for social reproduction to women in families and to private sector interests, and in so doing privatized responsibility for the costs of biological reproduction. The heart of this chapter focuses on the contestation between the women's movement and the state and contestation within the state to make social reproduction and gender equity a central focus of the re-reform of the Chilean health system during the 2000–6 period of centre-left coalition government under President Ricardo Lagos. I conclude with reflections on how the neoliberal state provides both opportunity and obstacle to advances in socializing the responsibilities for social reproduction.

Reconfigured states and social reproduction

Throughout this chapter I use the typology of shifts in state character developed by Banaszak *et al.* (2003), which they term "state reconfiguration." Banaszak *et al.* argue that European and North American states in the 1980s and 1990s underwent significant changes in structure and responsibilities due to conservative economic shifts inspired by neoliberalism. They argue that these changes are critical to understanding the new ways in which states and social movements interact and the changed character of women's movements from radical, autonomous movements to

movements that are more "state-involved and accommodationist" (2003: 2). These authors limited their analysis to women's movements in Western Europe and North America. I apply their framework to Chile, show its importance for questions of social reproduction, and build on it to demonstrate that state reconfiguration also leads to particular forms of gendered contestation within the state itself.

Banaszak *et al.* outline three key structural changes in the state: "uploading," "downloading," and "lateral loading," and they point to a significant change in state–society relations that they term "offloading." *Uploading* refers to a shift in powers from the nation-state to supranational organizations. Unlike much of Latin America, where authority has moved decisively up to the IMF in the financial realm and to the World Bank and Inter-American Development Bank in the social policy realm, Chile has experienced minimal uploading. Chile is an outlier among Latin American countries in that it implemented neoliberal reforms before the hegemony of neoliberal thinking. Chile implemented neoliberal economic liberalization beginning in 1974–75, and neoliberal social policies in 1979–82. In many ways Chile was the poster child upon which the "Washington consensus" was modelled.[3] Chile's tenuous democratization in 1990, in which conservative forces were given disproportionate powers, has meant that Chile has not deviated from the global neoliberal economic consensus despite a lack of uploading.[4]

Downloading means the devolution of national responsibilities to subnational units. Also a forerunner in downloading, Chile transferred responsibility for state health services to municipalities in 1979, under the dictatorship of General Pinochet. But since mayors at that time were appointed, downloading was not a devolution of authority. Rather, it was aimed at diffusing responsibility for state services and thus decreasing claims on the central government. For women's movements, downloading multiplies the terrains where state public policies affect the division of responsibilities for social reproduction and where these policies must be contested.

Lateral loading shifts policy-making power from elected bodies to non-elected ones such as courts, executive agencies, and quasi-governmental organizations (Banaszak *et al.* 2003: 5). Exemplifying lateral loading, the decision to implement neoliberal policies in Chile was made by a small circle of advisors to General Pinochet. Even in contemporary Chile, now considered one of the most democratic countries in the region, lateral loading is commonplace. The danger of lateral loading is that issues become invisible to the public, decisions are insulated from civil society, and political questions may become depoliticized.

Offloading shifts traditional state responsibilities to private actors in the market or in civil society (Banaszak *et al.* 2003: 6). In Chile, common to both phases of neoliberalism was an "offloading" of the burdens of social reproduction more squarely to women as members of families and

communities. But other forms of offloading have also been prevalent. Chile offloaded to private sector interests when it introduced private health providers into its previously state-dominated public health system. In addition, following calls from the World Bank for greater participation by civil society (part of the bank's own response to critiques of its top-down approach), Chile offloaded aspects of social service delivery directly to non-governmental organizations (NGOs).

Discourses regarding the role of the state and state–citizen relations have changed dramatically in Chile as a premise for these state reconfigurations. Calls for universal citizenship rights, once frequent, have been replaced by views of the state as a provider of last resort with only limited responsibilities for maintaining the nation's "human capital." The concept of the citizen has been replaced, at least in those areas where market influences are greatest, with the concept of the consumer.

These changes in states constitute a new terrain for contestation over state policies – both inside and outside the state. While each element of change presents new challenges to women's movements, several also bring opportunities. As states have uploaded to international financial institutions, feminist activists have shifted their focus to these, and have had some success. The movement "Women's Eyes on the World Bank" succeeded in making the bank integrate the agreements made at the Fourth World Conference on Women at Beijing into its policies ("Women's Eyes" 1997). United Nations agreements on women's and human rights have served as crucial points of leverage for women's movements, even as states have sought to hide their politics through lateral loading (Keck and Sikkink 1998; Ewig 2006b). Moreover, women's ministries, gender budgeting, and other mechanisms that may provide access points for pushing the neoliberal state in new directions have been publicized through feminist global networks and facilitated by international bodies like the United Nations (see also the Afterword by Govender in this volume).

As states have downloaded to multiple policy centres, feminists have found it much more complex to pinpoint accountability for state policies. Yet in some instances decentralization has opened spaces for women's local influence (Ewig 2006a). When states offload, often the consequences are a shirking of state responsibility. Yet at other times it is women's NGOs that have been offloaded to, presenting unique opportunities for women and womens' movements to shape social policy from the bottom up (Ewig 1999; della Porta 2003; Valiente 2003). Moreover, shifts in social reproductive responsibilities have at times spurred women to contest state policies related to social reproduction (Brenner and Laslett 1991), making the consequences of offloading a potential spark for broader political change. Finally, concurrently with the new discourse of a minimalist state and citizens as consumers, there have emerged global human and feminist rights languages that have served as a powerful discursive counterpoint to the neoliberal discourse (Petchesky 2003).

The rest of this chapter focuses on Chile's health reforms and feminist responses to these, as an example of how the reconfigured state poses limits, but also new opportunities, for feminist interventions in state policies.

Chilean health reforms of 1979: privatizing reproduction

Before the health reforms begun by the Pinochet dictatorship in 1979, Chile had one of the most universal health systems of the region, with the majority of the population having access to health care services. It was divided, however, into separate but interrelated public systems. The old pay-as-you-go social security health system, the Employee Medical Service (*Servicio Médico Nacional para Empleados*, SERMENA), was designed to serve white-collar workers and civil servants, while the National Health Service (*Servicio Nacional de Salud*, SNS) served blue-collar workers and the poor. Blue-collar workers and the poor relied on the extensive SNS health infrastructure, while SERMENA beneficiaries could choose from SERMENA's limited number of hospitals and clinics, those of SNS, or private providers to whom SERMENA would pay partial subsidies. When created in 1952, SNS was envisioned by its proponents as a universal health system modelled on the British National Health Service (Labra 2002). While this vision was never completely attained, the universal citizen's right to state-provided health care was an important part of political discourse. In the 1970s, SNS supplied health care to about 60 per cent of the population, SERMENA served about 25 per cent of the population, and 15 per cent were either uncovered or covered by the separate medical programmes for the military and police (Cartin 1998: 206).

The major reform of this system took place between 1979 and 1982, a moment in which General Pinochet's regime was most coherent in its advocacy of a neoliberal policy approach (Kurtz 1999; Borzutsky 2002: 166). The reforms involved both downloading and offloading. In 1979 the SNS and SERMENA health systems were fused and restructured to separate their health policy, provision, and insurance functions. The funding portion was split into a new entity called the National Health Fund (*Fondo Nacional de Salud*, FONASA), which was financed by employee payroll contributions and state subsidies. Employer contributions were eliminated. The health provision infrastructure was renamed the National Health Services System (*Sistema Nacional de Servicios de Salud*, SNSS), with its primary care services downloaded via decentralization to municipalities and regional departments. Primary care was financed by municipal funds and fees for services (Titelman 2000).

The separation of the financing from provision cleared the way for greater participation of the private sector in health provision – and the beginning of offloading the most profitable aspects of health care to markets. The top income earners in the state health system were given the option of choosing private providers to whom the state system contracted out (Barrientos 2000:

100). These changes in turn allowed for the legalization in 1981 of Health Provider Institutions (*Instituciones de Salud Previsional*, ISAPREs), for-profit private health insurers with their own private health facilities. Once the ISAPREs were established, individual workers could choose health care coverage from the state through FONASA, or could buy this care through an ISAPRE. (There are two types of ISAPREs, closed ISAPREs that serve one company and are not open to non-employees, and open ISAPREs with whom employees individually negotiate contracts.)

Compared to downloading, offloading via the ISAPREs has caused greater detriment to equity in health care in general, and to gender equity in particular. In general terms, the ISAPREs led to greater segmentation and financial inequity in the health system. Initially, 11 per cent of total state health care beneficiaries moved to the ISAPREs, taking with them 48 per cent of overall health insurance contributions and deepening the financial crisis of the state system (Titelman 1999). As intended, the ISAPREs generated a greater role for the private sector, and in so doing caused greater segmentation along class and gender lines. Beneficiaries can return to FONASA, so Chileans use an ISAPRE during high-earning and low-risk years and return to FONASA when earnings drop and health risks go up. The flight of the best paid workers to ISAPREs at the highest-paying and lowest-risk moments in their lives further impoverished the public system.

The ISAPRE system reflects a strong male breadwinner bias. In order for women to benefit to the same degree that men do from the ISAPRES, women would have to have the same rate of workforce participation and wages equal to those of men. Because this is not the case, women are concentrated in the impoverished public system: 69.1 per cent of women, compared to 63.7 per cent of men, were affiliates of FONASA in 2000 (OPS-Chile 2003). Because only about 34 per cent of women are in the paid Chilean workforce, and even fewer are in the upper earning quintiles, ISAPREs, with presumably better quality of care, are an option for only a small segment of women, unless they are dependents on a spouse's policy. In 2001 women represented 34.4 per cent of ISAPRE beneficiaries (Ramírez Caballero 2001: 1). Women's participation in the ISAPREs drops faster than men's in their later years, signifying women's lesser ability to maintain the cost of the ISAPREs later in life (for figures see Pollack 2002: 26). Moreover, given women's lesser earning power in Chile (on average 40 per cent less than that of men), most women enrolled in ISAPREs are not able to pay for the best quality care, because an increase in quality and coverage requires additional premiums (Ramirez Caballero 2001: 218). The premiums for covering women, even as dependents, are prohibitively expensive.

Dependent entirely on the market, the costs of health care coverage via the ISAPREs are based on the risk factors of sex and age, a policy allowed under Law 19.381 of May 1995 (Casas 1999: 27). Because women experience greater morbidity, have specific reproductive health needs, and live longer than men, their "risk" of needing health care services is higher. But it

is childbirth that is the primary reason why ISAPREs charge women more than men (Merino 2005 interview). At age 30, during women's peak childbearing years, Chilean women enrolled in the ISAPREs in the early 2000s paid 3.2 times as much as men for the same health care coverage (Pollack 2002: 20). Initially, ISAPREs were to cover the cost of childbirth, the cost of maternity leave, and family leave to care for sick children under one year of age (each being part of Chile's standard family benefits). In an effort to reduce the costs of leaves to the ISAPREs, the state (through Law 18.418 of 11 July 1985) accepted partial responsibility for maternity leave itself and for leave to care for sick children under one, assigning to the ISAPREs only the responsibility for pre- and post-natal supplementary leaves. Yet, even with this state support, and even if a woman were infertile or had no plans to bear children, she would still be classified as high risk, and thus charged higher premiums (López 1999: 8; Ramírez Caballero 2001: 2).

As a result of complaints that it was unfair to charge high rates to women who could not have children, insurers began to offer plans that did not cover childbirth, colloquially known as *planes sin útero* – literally "no uterus health plans." According to insurers, these plans were a benefit for women who had had hysterectomies (Merino 2005 interview). However, they were not marketed to infertile women, but to young women of fertile age, thus entailing the major risk that if they became pregnant they would not have the necessary health coverage (Casas 1999: 23, 25). Even in these health plans that did not provide maternity benefits, women 30 years of age were charged on average 207 per cent of what men were charged for the same health plan (Pollack 2002: 22). The "no uterus health plans" became a symbol of the discriminatory nature of the ISAPREs and their refusal to shoulder any of the costs of biological reproduction.

More evidence of discrimination against women by the ISAPREs was the fact that the differential rates were not confined to women's childbearing years – women paid more from age 20 until age 60, varying from three times as much as men to 1.2 times the men's rate. Only for males under one year old and over 60 years old was the rate higher than that of women (Pollack 2002: 23). Inequality in the ISAPRE system was also evident in exclusions, which were decided separately by each ISAPRE but tended to bar key services for women such as voluntary sterilizations or treatment of complications from abortions (Ramírez Caballero 2001: 2).

By offloading responsibilities for health care to the market, the Chilean state allowed two important aspects of social reproduction, health and biological reproduction, to become the responsibility of individuals, and in the case of biological reproduction, the responsibility of individual women rather than the state or society. Under the Pinochet reforms, women in Chile were afforded high-quality health care to the extent that they could pay for this as consumers. The majority could not pay the discriminatory cost of the ISAPREs and thus were concentrated in the increasingly

under-funded public sector – under-funded in large part because of the "cream-skimming" practices of the ISAPREs (Titleman 1999).

The politics of re-reform, 2000–5

In 1990 Chile underwent a democratic transition, since when it has been ruled in its first four governments by a centre-left coalition, the Coalition of Parties for Democracy (*Concertación de Partidos por la Democracia*), composed of the centrist Christian Democratic party (PDC), the Socialists (PS), the left-leaning Party for Democracy (PPD), the Radical Social Democrats (PRSD), and a handful of independents. Owing to institutional and political constraints on the Concertación governments as a result of the controlled transition to democracy, change in the neoliberal economic model was slow (see note 3). Women's movements in Chile had gained substantial visibility for their role in supporting democratization (Waylen 1994: 353; Frohmann and Valdés 1995; Baldez 2002: ch. 8). As party politics returned to Chile, however, observers argued that women's movements lost strength and visibility with the return to male "politics as usual." In fact, women made advances in traditional politics: voluntary gender quotas by the Concertación political parties raised women's formal role in politics to 15 per cent of congressional representatives, and in December 2005 Chile saw the election of the first female president in Latin America elected on her own merits – President Michelle Bachelet. The low visibility of women's movements was due not just to a return to politics as usual but also to a shift in the terrain of politics itself. As a result, women's movements had to shift their tactics in order to challenge the neoliberal, reconfigured state.

Following Chile's transition to democracy, gender equity in health reform was not a banner of the women's movement as a whole, nor even of the active women's health movement – these were more interested in the specific areas of violence against women and reproductive rights. The relationship between gender equity and health reform was, however, of interest to small groups in civil society, such as sub-groups of the women's health movement, social medicine organizations, and the nursing and midwifery professional organizations (Matamala 2005 interview). When health reform became an agenda item under the government of Ricardo Lagos in 2000, these groups were poised to make gender equity a central issue. By this time, there was a general recognition of a need to regulate the ISAPREs, strengthen the financially weak public sector health system, and better equip the health system to respond to changing epidemiological profiles. The Lagos government promised in particular to overcome the significant inequalities among Chileans with regard to access to care and quality of care.

The discussion and formulation of the health "re-reforms" took place in two parallel spheres: one in public forums and working groups initiated by then minister of health Michelle Bachelet (for a full discussion see Celedón and Orellana 2003), and the other in a closed technical commission led by a personal appointee and friend of President Lagos, Hernán Sandoval. Both the health ministry and the technical commission constituted areas of "lateral loading," in that neither was an elected body. But Bachelet's forums and working groups attempted to open up some space for dialogue, while the technical commission, which ultimately had the most influence over the reform process, remained closed. One women's movement activist described the latter commission as "absolutely technical" and commented that it "never discussed its plans with any type of organization" (Espínola 2005 interview). According to its leader, Sandoval, the commission's role was only to elaborate reform options for policy-makers to consider, and it was subordinate to the minister's authority ("Ministra Bachelet" 2001). In practice, parallel discussions took place and the technical commission had more weight and authority.

Organized feminists and their allies interested in gender equity in health sector reform had access to state health reform discussions via the forums and working groups established by Minister of Health Bachelet, but these were low on the policy reform process hierarchy.[5] Members of women's organizations participated in the civil society working group (Matamala 2005 interview). In addition, Bachelet also created a special commission on gender and health sector reform. In January 2001, this commission published a document that outlined a number of ways to make the existing health system more equitable. The document reflected the long-term interests and issues of the women's movement, such as reproductive health and violence against women, but it also began to move beyond these important issues to recommend financing based on ability to pay rather than risk, and shared responsibility for the costs of social reproduction – including maternity and childcare leaves and the cost of childbirth (MINSAL 2001: 34). The document was an important first attempt to integrate gender into the reform process.

When Bachelet left the health ministry and Dr Osvaldo Artaza took over, the document on gender was pushed to the side and the participatory discussion process was halted (Matamala 2005 interview; Gómez 2005 interview). "Lateral loading" decision-making to ministries leaves input from civil society dependent almost entirely on the goodwill of particular ministers to engage in dialogue and to take gender equity seriously. Bachelet was willing to do both of these, but the new minister was not; as a result, the spaces gained for intervention in the reform process were abruptly closed.

The technical commission was even more insulated from direct pressures from civil society, and from the political issue of gender inequity in particular. A former member of the technical commission reported that it was very difficult to get gender onto the agenda of this committee. For example, the idea of unpaid work remained marginal to the discussion, despite her efforts to incorporate this concept (Larraín 2005 interview). Testament to the greater powers of the technical commission was that its head, Hernán Sandoval, was also the representative of the ministry of health on the

interministerial commission on health reform. Whereas the role of the technical commission was to develop a range of potential reform proposals, the inter-ministerial commission was the place where these proposals were vetted and formulated into bills to be presented to the Congress. The inter-ministerial commission was particularly important because it included a representative from the ministry of finance (*Ministerio de Hacienda*), which holds higher authority than any other ministry in that it evaluates and approves the financial viability of any major policy decision.

A key member of the inter-ministerial commission reported that the gender mainstreaming document developed by the Gender Commission and the proposals by the working groups organized by Bachelet had no influence over interministerial commission decision-making (Anonymous C01 2005 interview). To these influential decision-makers, the reform process was confined to the technical commission, the interministerial commission, and the Congress (ibid.).

Thus the re-reform process demonstrates a politics of contestation between women's movements and the state *and* a process of gendered contestation within the state itself. Although the reform debate as a whole was contained to lateral spheres of decision-making, Minister Bachelet's more participatory and gender-conscious approach was contested by other lateral spheres with a more decisive influence over the reform process.

At about the same time that Bachelet was replaced, an "uploading" opportunity appeared that was favourable for advocates of gender equity in health. In 2002, the Pan American Health Organization (PAHO) had been funded by the Ford Foundation to commence a project on gender equity and health sector reforms in Chile. Financial support from Ford and technical support from PAHO allowed key figures from the women's health movement to continue the work begun by Bachelet's gender commission, under the auspices of the PAHO "Gender, Equity and Health Reform Project."

One of the first steps of the project was to create a road map of the reform process, identifying the key decision-makers and decision-making spaces, and interviewing informants to identify the obstacles to gender mainstreaming the health reforms (Matamala 2005 interview). The interviews exposed a need for research and public education on gender and health reforms. The project commissioned research, and each time a document was published it was released with high levels of publicity and presented to the ministry of health, the parliament, and other key decision-making centers.[6] In this way, the project attempted to raise public consciousness of the discriminatory nature of the existing health system. For example, on 21 May 2002, just before President Lagos' annual address to the nation, women's groups published a newspaper ad that outlined ten key agenda items for a gender equitable reform, with many signatories, so that the president would feel compelled to respond (Matamala 2005interview). They followed this with a meeting of 400 women on 28 May 2002, led by

PAHO and several key women's organizations, to define proposals for a gender equitable health reform ("Las Mujeres" 2002; "Mujeres" 2002).[7]

An example of the potentially positive aspects of state reconfiguration, funding from an outside, international organization gave the movement for gender equity in health reform a level of legitimacy it did not have before. At one point, the project even solicited proposals for funding gender and health projects – funds for which the ministry of health applied. Also key to the success of the women's health reform movement were its ability to make inroads into lateral spheres such as the ministry of health, even in times in which the leadership was opposed to dialogue; its ability to build a base of support around the issue of gender equity and health in civil society; and its ability to develop research that matched the requirements of state technocrats in terms of data and technical language. In other words, women had to enter the political playing field on the terms of the state technocrats. This was a long process, however, much of which took place after the re-reform proposals were passed and had moved to the implementation stage. In the next section I discuss the reforms that were debated and passed and their implications for gender equity, before returning to a discussion of the role of the women's movement during implementation.

Re-reform and social reproduction

The Lagos government began discussion of re-reform of the health sector in its first year in office, and in 2002 sent a full reform proposal to the Congress. Two of the five proposed health-reform laws would have had important consequences for gender equity. By this time enough public emphasis had been placed on the discriminatory nature of the existing system (in part through pressure from civil society via the women's movement) that ending gender and other forms of discrimination became one of the primary motivations behind these two reforms (Anonymous C01 2005 interview).

One of these proposed reforms was to create a universal package of health services that each health insurer/provider would be obligated to provide to each of its clients. This was termed the Plan for Universal Access with Explicit Guarantees, or "Plan AUGE" (*Plan de Acceso Universal con Garantías Explícitas*). The plan was envisioned as standard in its components, universal in its coverage of all Chileans regardless of insurance type, integral in that it would apply to any stage of the disease in question, and total in that it would encompass curative and preventative care. To rectify long waits for care, especially in the public FONASA system, Plan AUGE outlined timelines within which care would be guaranteed. The plan would also guarantee a standard level of quality (Biblioteca del Congreso Nacional 2002; Anonymous C01 2005 interview). AUGE had important gender implications. By requiring that all health plans, private and public, offer a uniform set of minimal services, all of which included basic reproductive health services, the AUGE essentially (without directly saying so) outlawed

the infamous "no uterus plans" of the ISAPREs and required that any basic health plan cover childbirth.

The other proposed reform key to gender equity was to create a compensatory, universal health fund, the Solidarity Compensation Fund (*Fondo de Compensación Solidario*), intended to make financing of the health system more solidaristic. Under this proposal, rather than pay their ISAPRE or FONASA directly according to individual risk, individuals would contribute from their salaries to a national fund. Each consumer would pay the same percentage of salary, while the fund would pay the insurers according to risk. In this way, the fund would serve as a cross-subsidy between the rich and poor, the healthy and the sick, between the high- and the low-risk, and between the private and public sectors – thus alleviating the disproportionate costs of health care that have fallen on the Chilean public sector. Moreover, the fund would address one of the main discriminatory effects of the health system: the higher prices for insurance charged to women and the elderly (Biblioteca del Congreso Nacional 2003). Thus, the fund was designed explicitly to address gender and age discrimination.

Of these two key reforms, only Plan AUGE passed through the Congress into law. As a result of the strength of the political right in Congress, and of lobbying against the measure by the ISAPREs themselves, the fund was modified to create only a compensatory fund among the ISAPREs, rather than a fund that would bridge risk between the public and private sectors. Thus the law that did pass defeated the main objectives of the reform. Yet women's groups did gain with the passage of AUGE, which challenged many inequities. Moreover, the women's groups that organized as a result of the legal debates continued their work and sought to influence the implementation of the reforms.

Implementation and perseverance

In the implementation stage of reforms, access points to areas of "lateral loading," such as ministries, become even more important. The implementation stage, by its very nature, is not a process of debate. Yet it is the stage which has the most direct influence on people's lives, and in which policies can become remoulded on the ground. When a more sympathetic vice-minister of health took office, the women's movement was able to make three key inroads. One was its successful insistence that the effects of violence be covered by the health system. This area had been left out of reform discussion altogether, but through simultaneous pressure, women's movements and the Chilean state's executive women's agency (*Servicio Nacional de la Mujer*, SERNAM) were able to place this on the health agenda post-facto (Lamadrid 2005 interview, Matamala 2005 interview).[8] Attention to violence began on a pilot basis in some health facilities in 2004, and was required throughout the system in 2005 (Matamala 2005 interview). The

women's health reform movement also succeeded in negotiating with the ministry of health for the PAHO project to train ministry health professionals in gender sensitivity over a three-year period, beginning in 2005, part of the ironic "uploading" discussed previously (Matamala 2005 interview). A final focus was to account for women's unpaid contribution to health care. The PAHO project developed a methodology for accounting for this work, and began lobbying for this unpaid work to be calculated into the national health accounts system put together by FONASA (Matamala 2005 interview).

One of the leaders of the efforts to integrate attention to gender equity into the health system put it thus: "SERNAM has been our best ally" (Matamala 2005 interview). The very existence of national women's machineries is a result of uploading – acquiescence in the UN Convention on the Elimination of All Forms of Discrimination against Women, which encouraged the creation of state women's agencies. Chile was the first country in Latin America to establish an executive level women's agency (in 1991), a move which carried through with the CEDAW accords, but which also represented the Concertación government's attempt to meet feminist demands in the democratization process (Matear 1995).

But state women's agencies are also a form of lateral loading; they are points of access for civil society only if upper-level authorities are open to these interests. The relationship between SERNAM and the Chilean feminist movement has been highly uneven, fluctuating in its degree of support of feminist objectives dependent on the minister (Franceschet 2003; Ríos Tobar 2003). In the health reform political process, the women's minister made the political decision not to become involved (Lamadrid 2005 interview). By contrast, the subsequent minister, in the implementation process, chose to work closely with women's organizations to monitor the implementation of the reforms.

Beyond the commitment of the minister, what matters for the effectiveness of women's executive agencies is the degree of real authority these have over other ministries (Stetson and Mazur 1995). In the case of Chile, SERNAM in 2002 gained special authority over other ministries through a programme begun by the ministry of finance, called the Programme to Improve Management (*Programa de Mejoramiento de Gestión*, PMG).[9] A programme unique in the Latin American region, under the PMG, SERNAM is charged with assuring that each ministry meets specific criteria for integrating gender into its programming. If a ministry does not do so, it is penalized by budget cuts enforced by the ministry of finance. While the ministry of health began a number of projects to integrate gender more carefully in its programming, its efforts in many respects fell short of SERNAM standards. As a result, in 2004, the ministry of health did not pass its evaluation for integrating gender, and was faced with budget cuts. Since 2005, it has been forced to be more responsive to questions of gender equity, and this facilitated many of the recent inroads described above made

by the women's movement.[10] The PMG give the women's movement, via SERNAM, important indirect access point to the politically influential ministry of finance which controls the national budget.

Conclusion

Chile under Pinochet was among the most neoliberal nations in terms of its social policies, relying almost entirely on the market to determine costs. Health reforms under Pinochet created a two-tiered public/private health system. The flight of the best paid and healthiest individuals to the private system left the public system – in which women were concentrated – underfunded, while those women who were able to access the private system faced blatant discrimination. The private sector shifted the costs of biological reproduction to women as individual "consumers". The fight over health reform under the presidency of Ricardo Lagos was in large part a struggle over whether the responsibility for social reproduction should rest with individuals or whether this was also a collective responsibility. In the re-reform process, organized feminists and their allies in the state sought to socialize the costs of social reproduction, in particular biological reproduction, while private sector interests, in the interest of profit, and more neoliberalist parts of the state sought to maintain the neoliberal status quo of individualizing this cost.

In the period of health policy re-reform, of the two policies key to improving gender equity in the health system, only one passed. The AUGE plan, which guarantees reproductive health care for all – in private and public sectors – and seeks to equalize the quality of care among institutions, can be viewed as a major advance for gender equity. But the solidarity compensation fund, which would have pooled health care "risk" between rich and poor, men and women, young and old, and the private and public sectors, did not pass. Important reasons why it did not are the entrenched powers of the private-sector ISAPREs as a result of 20 years of growing economic and political strength; the strength of the right in Congress in 2002; and lateral loading to the technical and inter-ministerial commissions where organized feminists and their allies had limited influence.

In the implementation stage, however, the women's health reform movement developed both more powerful points of access within the state, and new modes of communicating with the neoliberal state. First, the movement used the power of "uploading," via the support and influence of the Pan-American Health Organization, to obtain greater legitimacy and to develop more concrete data and evidence of gender inequity in the existing health system. This data in turn allowed the movement to speak more directly to the state technocracy, and explain, often in quantitative terms, the discrimination that existed in current policy. In addition, via the lateral sphere of the state women's agency (SERNAM), the women's movement gained a new access point within the state. The PMGs used by SERNAM to demand

that the ministry of health implement gender mainstreaming or face budget cuts proved especially effective. This tool gave SERNAM power over other ministries, and gave the agenda for gender equity an upper hand in the ongoing gender contestation within the state.

The experience of Chilean health reform demonstrates that the reconfigured state poses both limits and opportunities for women's movements to challenge the current neoliberal social policy paradigm from within. The reconfigured state itself is a space of contestation – in which different parts of the state often have competing agendas and objectives as well as shifting degrees of power. Because much of this contestation takes place in competing lateral spheres, it is particularly demanding for women's movements to identify not only access points, but also the centres of power at any particular point in time.

The neoliberal, reconfigured state reflects two major currents of the transnational globalized age: the economically oriented technocracy that has dominated the state since the economic adjustment period; and the women's machineries that have emerged as a result of pressure from the transnational women's movement. Women's machineries can provide a foothold for women's movements only if these are given significant powers over other parts of the state, and only if these lateral spheres, as with all lateral decision-making spheres, open themselves to collaboration and participation with movements in civil society. Neoliberal technocracies such as Chile's ministry of finance are much more difficult points of access for women's movements. Yet, to some degree, by speaking on their "terms" of evidence-based positions and through innovative mechanisms such as the PMG, women's movements can also make some advances in this arena.

Notes

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2 See the Introduction to this volume for a definition of social reproduction.

3 Williamson (1990) coined the term "Washington consensus" to refer to the informal agreement among dominant international policy-makers in the 1980s on the economic reforms necessary for improving faltering national economies.

4 With the democratic transition, the right was designated nine seats in the senate and the open list electoral system was replaced with a binomial system in which the winning slate has to win two thirds of the vote; otherwise the second seat goes to the second largest vote-getter. This system has favoured rightist party

candidates. The military was also given budgetary and political autonomy. Recently the designated seats were eliminated, and reform of the binomial system is now a point of debate. For the first 10 years following democratization, these measures and a general fear of a repetition of the economic and social chaos experienced under the presidency of Salvador Allende (overthrown by Pinochet in 1973) led democratic Chile to stick closely to the neoliberal economic model.

5 There were four working groups: (1) academics, professional associations, and public health clients; (2) ISAPREs, service providers, and unions and clients of the private system; (3) civil society; and (4) municipalities (Celedón and Orellana 2003: 16).

6 The project's research papers can be found online at www.paho.org/Spanish/DPM/GPP/GH/ChileReform.htm

7 This was called the "Parlamento de Mujeres," or Parliament of Women, to which key government policy-makers were invited. The meeting has been organized for four consecutive years by the women's organizations Foro Red de Salud and Derechos Sexuales y Reproductivos.

8 SERNAM is not precisely a ministry. It is housed in the Ministry of Planning and Cooperation (MIDEPLAN) but the head of SERNAM has the status of a minister of state (Franceschet 2003).

9 The PMG programme began in 1999, but the gender measure, carried out by SERNAM, was added in 2002. For a full explanation of the mechanics of the PMG, see Pérez (2006).

10 It is important to note that organized women in Chile have rarely made advances in the arena of reproductive rights, where conservative forces, including the Catholic Church, have been vocally opposed to feminist positions. In these areas, even when the ministry of health has been willing to make changes, outside conservative forces have made limited advances. This dynamic could be seen in early 2005, when the ministry of health was ready to make emergency contraception available in state health clinics, but conservative politicians prevented this.

9 Working women, the biological clock, and assisted reproductive technologies

Wendy Chavkin[1]

Louise Brown, the world's first test tube baby, is now 30 years old. In the two and a half decades since she was born, births such as hers have increased at a dizzying pace. In 2002, some 33,000 American women delivered babies as a result of assisted reproductive technologies (ARTs) – more than twice the number who had done so in 1996. Additionally, more than double that number used ARTs unsuccessfully. The use of ARTs is even more common in Europe. At least a million, perhaps 2 million, babies have been born worldwide as a result of these technologies (Zegers-Hochschild 2004; OECD 2005). Over the same time, there have been dramatic changes in the way people in the highly developed world are leading their most intimate lives. Women now participate in paid employment; divorce and single parenthood have escalated; and women have fewer children and at significantly later ages, often postponing childbearing until salary and career are established (Fox 1994; Orloff 1996; McDonald 2000). This delay truncates their period of opportunity to become pregnant and successfully carry to term. A rapidly increasing number are resolving the discordance between employment trajectories and the biological reproductive clock by defaulting to the technological fix of ARTs. In the context of these demographic and social trends, this chapter will examine how technology is transforming the basic conditions and capacities of one aspect of social reproduction – biological reproduction – for an increasing number of women.

Why do ARTs serve as the path of least resistance, and is this good for women – for their health, and for gender equity? To answer these questions, we must revisit several critical insights of second-wave feminism regarding the centrality of social reproduction to gender equity and the related dilemma of separate or equal treatment of maternity, as well as the concepts of gender underpinning variations of the welfare state. In the last three decades, there have been dramatic changes in demographic patterns, the shift from a bipolar to a unipolar political world, the rise of "globalization," and the rapid-fire dissemination of a host of new technologies. I argue here that the delay in childbearing and falling birthrates is one consequence of these three entwined issues. I further argue that the technological solution