

Public Policies and Mental Health in Chile Today

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Abstract

As part of the Chilean Student movement, graduate students in the Masters Program in Clinical Psychology at the University of Chile organized a protest forum on July 13th, 2011. The protest took place on the steps of the University's central building and was entitled "*History, Public Policy, and Mental Health.*" During the protest various academics made presentations and led discussions with the audience (which included pedestrians walking along Alameda Ave in the center of the city). This article is a transcription of one of those presentations. It questions the public health policies which were implemented in Chile during the last several decades and looks at their consequences.

Why are we here today?

The flyer publicizing this event refers to it as a "protest-forum." Why or against what are we protesting? Obviously, this action is part of a larger social movement that drawn attention to the multifaceted crisis facing the Chilean educational system. We are here today to focus on the University and post-graduate programs and we must begin by asking what being a "university" means. We have already frankly discussed how universities have managed to explain away the making of profits, something they are legally barred from doing. It is time therefore to examine how many schools in Chile are really worthy of being called universities.

When compared to Chile's per capita income, our universities are the most expensive in the world. Yet it is no great secret that most are not universities but rather institutions for professional training; this is true across the board. This problem has been relatively neglected in terms of declarations and negotiations, yet it remains of central importance. Superior or tertiary education must not be confused with what it means to be university. The principle work of the university is the production of knowledge. This is not only technical knowledge but also critical thinking. Universities must be socially reflexive. This is why we protest here today: although financing and accreditation agencies deny it, we insist that the fun-

damental work of the university is to ask questions and generate debate.

The student movement has gone to battle in "defense of public education." But what exactly does this mean? Is public education limited to what is provided by state institutions? What defines whether something is public or not? To assume that this is only a question of ownership would be to take a very narrow view of the issue. But we live in a State with a very narrow view. Our protest has to understand this. And for the same reason we also have to elevate the debate a little.

The current structure of higher education was created during the 1980s. This was the high point of neoliberal policies and under a dictatorship which could do as it pleased. Curiously, a few universities survived. Why? Surely there are some who lament that the State didn't privatize its universities. Why, on the other hand did the State not retain INACAP (Technological University of Chile)? In a country that has an imbalance in numbers between professionals and technicians, why are there no state-run technical schools? How can we make sense of this? Moreover, it was during the 1980's that the State reduced its support for superior education; education was seen as an investment for those who studied, while the work of the university was to provide diplomas. Tuition costs shot up. Why didn't the government privatize higher education? Why are the new universities, all private, prohibited from earning profits? This restriction has not been placed on professional institutes and technical training centers. Why are the owners of schools permitted to earn profits and not (at least not openly) the owners of universities? This is not a question of ideology. For example, we have a major housing crisis—the debtors have been incredibly persistent to make this problem visible—and nevertheless, no one questions that the companies that construct subsidized housing are private and earn profits. What is it that the State wants to preserve, although in an unconscious manner, by maintaining certain universities under its ownership? Clearly this had nothing to do with maintaining a regular supplier of professionals nor with ensuring a voluminous scientific production. Personally, I like to think that some vestige of the ideal of the university as a place dedicated to the search and diffusion of the truth must have acted in

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some corners of the minds of those who developed the legal framework for higher education in the 1980s. This trace should be recuperated and brought into the movement and the negotiations. If we don't do this, we can forget about any discussion of the university.

The public and the private

One doesn't have to be a specialist in political analysis to recognize that today's movement—or perhaps malaise—depends upon the relationship of the public and the private. This is the second theme that I would like to discuss today.

The organizers of this forum speak of “public policies,” a concept worth pausing to ponder. Every day—and without much thought—we use expressions like: public opinion, public health, public sector, public transportation, public space, etc. People used to refer to “public order” although the preferred term now is “neighborhood safety.” The police, the sector of the ruling class least inclined to use euphemisms (such as “vulnerable” instead of “poor”) continues to use the language of public order.

The key point, however, is that we function daily as if our lives were divided into public and private spheres. Disputes over the boundaries between these two spheres—as well as over how to reconcile them—are as old as civilization. They are the subject matter for much of political philosophy. Our social movement should examine the public and private spheres, reviewing the social compact implied in the neoliberal development model (although the term neoliberal is certainly a misnomer). Any other approach will lead us to make only to a superficial analysis.

During the 19th century, this question was considered an “economic” matter. Classical economic theory postulated that the tension between the public and private would resolve itself in the marketplace. The 20th century by contrast was a time when private issues moved progressively into the public arena. The state became protagonist in various areas long considered private: health, education, housing, electricity, potable water, transportation, etc. The state became the administrator of “the public.” For this reason, when one reads of certain issues as “public” we should understand this to mean that they pertain to the state. What we have in the final analysis is a demand for state action. But what is the state? For any thinking person, be s/he liberal or “progressive”, the fact that one's birthplace is the most important determinant of one's aspirations and chances in life is simply unacceptable. Yet this is the reality in Chile.

The 1980s were years of privatization and the reduction of the “public sector.” After the huge political and economic crises of the 1970s, it seemed

that the State was not the best institution to manage the growing expectations of the country's citizenry. Curiously, in the 1990s, after the country's return to democracy, there was no serious debate about the state and its role. This was due in part to the public assumption (as yet unchanged) that the state consisted of determined goods and services. This explains why the policies of the *Concertación* government (Coalition of left-center parties in Chile) were so mechanical in their efforts to redistribute wealth and reduce inequality. The country grew and the number of poor people diminished. But we continue to be a country strongly segregated; the social classes remain highly compartmentalized.

The redistributive policies of the last few years did not foster social integration. Public education is precisely that which is capable of generating social integration. Are we making ourselves clear now?

Now, let us turn our attention to public policies. What are public policies? In English, the language in which the very notion of public policies was developed, there are two distinct words: *policy* and *politic*; they denote two different concepts. In Spanish we only have the one word (*políticas*) which is the source of both misunderstanding and a certain advantage. Public *policies* are the source of a great deal of *political* mistrust. Whether their orientation is Keynesian or neoliberal, all public policies contain an aspiration to be academic or scientific; in other words they are supposed to be apolitical. This serves to distance *policies* as much as possible from the whims, ambitions, and craftiness of the rulers (the *politicians*). State decisions are supposed to be rational ones. In practice public policies determine that which is a public good, who administers it, who pays for it, and how it is paid for. It is not by chance that economics have become the *lingua franca* of public policy; ultimately public policy has been colonized by economics.

I have no objection to the state making rational decisions or using the best available evidence when designing programs. But this does not suppress much less abolish politics. Lately we have heard the right dig up long-buried concerns about the students becoming politicized. What does this mean? Of course they are political! The entire city has risen up. So we come—inevitably—arrive to the question of democracy. The polls tell us that we face a political crisis which has had a dramatic impact on education. There is nothing unusual about this; education for Chileans is almost synonymous with social mobility. And it has become patently obvious that the current educational system only further increases the gap between rich and poor. There were also uprisings over the environment, and—why not—similar rumblings were also felt in the small business and health sectors. A debate over ISAPRE (Chile's na-

tional health pension system) is on the horizon. Private administrators oversee a public health pension system which forms part of the social safety net. Once again, the public and the private are debated, now in the field of health.

Physical and Mental Health Policies

Health policies are historically part of the effort to manage the “social question.” I must confess that the term *mental health* never seemed right to me. Nevertheless, with the transformation of public health into bio-politics, mental health offers a small escape hatch. Or at least it might. Given the political potential of mental health, the term should not be abandoned. Health in general has been used as a rallying point to promote social justice and well-being. “Healthy” is almost synonymous with humanly reasonable. The workers’ movement, for example, used health concerns to obtain better working conditions, such as having Sundays off and limitations on the work day. As things stand now, in order to have legitimate arguments considered or even heard, they need to be presented in the trappings of science. This is what occurred in the recent debate over the extension of maternity leave to 6 months; this will inevitably come up during the coming debates on gay marriage. Political discussions need to seem like something else.

Other than brief efforts at prevention, public policies on mental health were virtually non-existent prior to 2002. At the end of the 1960s and the beginning of the 1970s, there were attempts made to de-psychologize mental health; these attempts were cut short by the coup. After the restoration of democracy, mental health in the public system was precarious in every possible sense. Medical treatment was essentially concentrated in four psychiatric hospitals and was very traditional. Some psychiatric facilities had become virtual dumping grounds for those patients general hospitals didn’t know what to do with. NGOs did some community promotion work and provided medical attention in popular sectors; this often involved issues of local development, human rights, etc. These NGOs were overwhelmed with the arrival of cocaine; their efforts came to a definitive end when financing for their work was redirected towards the state and Chile stopped being a priority for international aid agencies.

With the arrival of the democratic era, we learned that a large number of medical consultations in the public system were for psychological problems. Chilean psychiatry at the time was still living in the 19th century. Various attempts were undertaken to create alternative psychiatric options; these included the Community Mental Health Centers (COSAM in Spanish) and later, the creation in 1993

of the first National Plan for Mental Health and Psychiatry. Nonetheless, the budget for mental health was—and remains—minimal. This was the context within which the first mental health programs were created. Notable among them was the Program for Detection, Diagnosis, and Treatment of Depression in Primary Healthcare Centers (APS in Spanish) which facilitated the placement of psychologists in local health clinics. These initiatives however were suspended in the health reform plan implemented by President Ricardo Lagos. The new system is known as AUGE (Universal Access with Explicit Guarantees) or GES (Explicit Health Benefits).

In the 1990s the Chilean state updated its health policies to bring them in line with what the WHO was promoting as the state of the art: a community approach to mental health. Ironically, this approach had already fallen out of favor elsewhere. It remains a mystery exactly what health professionals—even those directing the program—meant by “community.” It is worth pondering this a moment because this confusion ended up creating all sorts of unfortunate feuds between those who called themselves “communitarians (or “psychosocial”) and the more traditional clinicians (considered “biomedical”).

As things stand now, “community focus” has become something of a garnish on the intellectual salad composed of health economics (cost-effectiveness and cost-benefit), evidence-based medicine, and the ontological conception of disease which is the necessary link between the two. The true policy is not to be found in the public discourse but rather in the ways that resources are assigned and results evaluated. The true policy is not found in the documents, but in the records, the statistics, the management contracts, etc. These documents tell the full story and everyone is free to draw his or her own conclusions about the real health policy of the Chilean State.

The 2000 National Plan for Mental Health and Psychiatry made a notable effort to insert mental health into health policy, an arena which has always seemed refractory to such concerns. Nonetheless, the Plan remains a document full of contradictions. On the one hand, it adopts a community focus. In its first pages the Plan literally states that health—and in particular mental health—does not depend “only” on biological factors, it also concerns one’s life conditions. The Plan also promotes a series of principles and values like universal access, cultural diversity, and social participation. Yet the Plan is also focused and standardized. It uses criteria of biomedical effectiveness and performance indicators that clearly places management concerns above those of the

clinic, in other words, over the concerns of the patients.

This Plan was adopted during the years of absolute domination by the so-called Washington Consensus. It was a time when health economics promised to resolve the problems of public health and the World Bank emerged as the new leader in global health. In 1993 the Bank had published the now famous report *Investment in Health* which became the new bible of policy makers. The report introduced two key ideas: the need for governments to define clinical packages calculated in economic terms and a new way to measure health: the DALY (Disability-Adjusted Life Year). What is behind all of this? Management considerations trumped not only clinical concerns but also politics. Political debate was now restricted to the definition of objectives, goals, and indicators; ethical debate was limited by making efficiency the ruling imperative.

During the period of the *Concertacion* everyone accepted an almost reverential fear of macro-economic disequilibrium and the need to strictly follow the instructions produced by think tanks in Washington. We need to point out the everywhere—that after decades of increases of spending on health—the principle focus now appears to be cost containment. This implies more focused policies and the setting of priorities. In a few, short years we went from “health for all” to limited health packages. The result has been program like AUGE-GES. Chile sets priorities based on specific diagnoses. This brings us again to the question of public goods. Why does the State prioritize some diseases and not others? The political right would ask: “Is this part of a program of state control?” The left could ask: “Why are health priorities dominated by economic considerations?” But the truth of the matter is that almost no one questions AUGE as a policy. This underscores the dearth of debate and critical thought in Chile today.

Under the health reform, specific services are guaranteed for specific illnesses. This is why diagnosis is the starting point for everyone. It is the certificate of diagnosis that indicates that there is an illness and this is why anyone entering the GES has to “have” a determined illness. In the case of the so-called mental disorders this is not a trivial issue. As has been demonstrated by North American insurance companies, diagnosis is an issue of accounting and management. As a result, the existence of illness as a sort of Platonic Ideal becomes an article of faith – something unquestioned. Without it, the policy scaffolding falls to the ground. The tangle that we have of co-morbidity and the problems with multiple diagnosis patients are treated as an externality within this way of doing things.

I should clarify that I am not anti-diagnosis. But

the exercise of making a diagnosis does not occur in a vacuum – it is always *for* some purpose. And what we see is that diverse experiences and diverse ailments from diverse persons are collected under one definition in order to facilitate accounting and management. For those who have a certain fondness for psycho-pathology, the manner in which these definitions are made is actually very poor. The illness becomes an entity in itself. The patient is just the backdrop where illness occurs. As a result the personal significance, the narrative of the patient, ceases to be a relevant concern.

In the last 40 years, the number of diagnoses in the DSM rose from 26 to more than 300. We know the role that pharmaceutical and insurance companies have played in this. The idea that the diagnostic categories represent something that exist in reality is purely an article of faith. This is not something new; we had seen it coming. It is the outcome of a approach to medicine that was established two centuries ago. As I have already stated, the AUGE has been celebrated by the left and the right. It is interesting that the defenders of the psycho-social model have been converted into the best guarantors of the bio-medical paradigm. The bio-medical dream is to identify the illness; everything else is secondary. This leads to the paradox of classifying psycho-education as the community mental health intervention *par excellence*; its object is limited to raising awareness of the illness and fostering adherence to treatment. All of this contradicts the emancipative character of the original community movement.

With bio-medicine—and I understand bio-medicine as the dominant medical paradigm that began in Europe at the beginning of the Nineteenth Century—diagnosis became the central medical act and was more than treating illness. This went hand in hand with the need for new methods of governing and managing populations, making health a matter of public interest. The individuality of the patient was seen as a problem. The clinic went from being a place of practice to one of observation; over time this observation would limit itself to those indicators that could be objectified, measured and compared with population parameters. That is to say, public health was converted into a matter of quantification.

This brings us to the concept of evidence. One of the ideological pillars of public health is Evidence Based Medicine (EBM). There exists a hierarchy of evidence according to this method. The King of Methods is the randomized clinical trial. Putting aside for today the necessary epistemological discussion that EBM requires, I will mention instead EBM’s organizational and clinical consequences. The authorized discourse presents itself now as a kind of mediator between evidence – truth – and

healthcare professionals. This generates a system highly tailored to the interests of healthcare insiders. There are some who think and others who execute. For a long time, the super-specialization of professionals has divided up the therapeutic process. But today, it is necessary to add the tendency to standardize interventions. That is, interventions have become like Fordist assembly line. Creativity and innovation are inhibited so that, over time, all patients are treated in the same way.

The everyday experience of the clinic is disqualified as a source of reliable evidence. Health policy is uni-directional, from top to bottom. Yet it is the professionals in the trenches who should be the eyes and ears of authority! If we use an organic metaphor for these policies, we might say that the Health Minister is the brain, the professionals the hands, and the systematic reviews and meta-analysis are the reality. The authorized discourse no longer speaks of its own beliefs but rather in the name of evidence that is by definition anonymous. Debate is no longer possible. Health professionals are looked at in the same way as professors: lazy, resistant to change, looking out for their own interests. I am not saying that that this viewpoint is entirely wrong. But if we focus on the disappointing results of all the education reforms that have been conducted in Chile in the last several decades, it seems strange to insist on replicating in the health field those reforms which have not worked in education. It would be better to listen to the complaints of the professionals and those who use their services.

Several years ago there was a very-well matched marriage between EBM and the nascent field of health economics. The calculations of cost-effectiveness are both a logical consequence and an intermediate step towards the standardization of treatment. It is a pure instrument of rationality to weigh the costs of means and ends. But for this calculus to work, it is necessary to greatly simplify the ends or results. Those of us who work in this area know that the relationship between results and means are much more subtle and complex than they first seem. It is very easy to nullify in practice that which is proposed in theory if one does not have a clear understanding of these difficulties. We are left only with a discussion on cost-utility. There is much to deconstruct here. What is it that we mean by utility? How is it quantified? Utility for whom? Etc.

And now we arrive at President Lagos. This is not a coincidence because he is the one who best embodies the genuine modern spirit of those *Concertación* leaders (the first to dare to use the discredited word “equality” as a political slogan during the transition). As a result, it is not surprising that he would promote standardized health policies. The

problem is that the world changes, the population is no longer the same, and neither are the social ills. The challenges of underdevelopment add to the imperatives of individuality, the loss of social networks, and the breakdown of traditional cultural references, leaving humanity in a more precarious situation. We are unable to respond to life’s challenges and more prone to anxiety, isolation, and depression. Economic globalization and the enormous technological changes of recent decades make life more uncertain every day. These processes have become virtual and acquired a rhythm that blocks the possibility of experiencing life. It is necessary to rethink social protection and welfare practices and, in particular, health policies. A welfare program that is deaf to the narrative of those seeking help only makes the problem worse. With this in mind, public policies should create—at least—the minimal conditions for each person to explore and build their subjectivity. At a minimum public health should not inhibit the exercise of subjective reasoning.

Despite the fact that we have today seemingly unlimited coverage for certain psychological problems, psychiatric leave has increased consistently and is now the leading cause of worker absenteeism. Despite this, no one does anything about what is often referred to as mental health at work. Nor does it occur to anyone to consider mental health during urban planning, let alone when designing public transportation systems. This is evidence of a lack of global view, a lack of sensitivity towards the emerging culture, towards the “new social question.” These are the holes which make up a State converted into a machine that solves problems, i.e. a policy vacuum.

I know that I have said many things, some unconnected. My intention has been to provoke a dialogue—nothing more, and nothing less. I only would insist that, given what is occurring today, given the calls for the State to get its act together, there is now a window to debate the distinction between public and private. This debate is about more than the financing of specific services or the domains of certain institutions. I have insisted that the University has a role which citizens should demand it perform. Arrogance and technocracy have been a staple of Chilean governments in the last few decades and those of us in the University have been complicit in this. There have been some scholars who have raised their voices. Sometimes events have to occur before people are able to risk questioning certain dogmas, so that – and I say with some shame – we can rethink that which for years seemed indisputable.