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**Health inequity in a Neoliberal
Society: Lifestyle Choices or
Constrained Practices?**

By

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A thesis submitted in partial fulfilment of the requirements for
the
degree of
Doctor of Philosophy in Social Policy

University of Warwick, Department of Sociology
November 2015

TABLE OF CONTENTS

LIST OF FIGURES	V
LIST OF TABLES.....	V
ACKNOWLEDGEMENTS	VII
DECLARATION AND INCLUSION OF MATERIAL FROM A PRIOR THESIS	IX
ABSTRACT.....	X
CHAPTER 1 - INTRODUCTION.....	1
1.1 Background of the research	1
1.2 Aims and Research Questions	4
1.3 Theoretical Framework.....	6
1.4 Methodology	10
1.5 Contributions to knowledge.....	13
1.6 Thesis outline.....	15
CHAPTER 2 - LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK: HEALTH CHOICES ACCORDING TO LIFE CHANCES?	19
2.1 Introduction.....	19
2.2 Literature Review.....	20
2.2.1 Individual responsibility: the behavioural approach	20
2.2.2 Social Determinants of Health: the importance of the social context	31
2.3 Health choices according to health chances: Conceptual Framework.....	40
2.3.1 Social position and the reproduction of social inequality.....	40
2.3.2 Is there space for agency? Analytical Dualism.....	44
2.4 Connecting the Literature to the Research Framework.....	48
2.5 Conclusion.....	54
CHAPTER 3 - METHODOLOGY.....	56
3.1 Introduction	56
3.2 Review of previous approaches and methods used in health-related research	57
3.2.1 The positivist approach and quantitative analysis	57
3.2.2 The interpretivist approach and qualitative analysis	63
3.3 Epistemological approach and research methods: Critical Realism and Mixed Methods	68
3.3.1 Critical Realism: stratified reality and generative mechanisms	68
3.3.2 Research methods: extensive and intensive research as complements	73

3.4	Design, data collection and data analysis.....	77
3.4.1	Chile: case study of a neoliberal society	78
3.4.2	Considering the health gradient: studying middle and lower socioeconomic groups.....	80
3.4.3	Data collection and analysis	86
3.5	Conclusion.....	99
CHAPTER 4 - CONTEXTUAL ANALYSIS: INEQUALITY IN A NEOLIBERAL COUNTRY.....		101
4.1	Introduction.....	101
4.2	Social Policies: the neoliberal experiment and the consolidation of inequality ...	102
4.3	Contrasting realities	110
4.3.1	Chile: A high-income country	111
4.3.2	And a highly unequal society.....	113
4.4	Inequalities in Health-Relevant Dimensions.....	116
4.4.1	Hidden informality and low value of work	116
4.4.2	Unequal educational opportunities.....	120
4.4.3	Residential Segregation.....	125
4.5	Health inequality in Chile: healthcare and health outcomes.....	128
4.5.1	Patterns of health-related practices.....	137
4.6	Conclusion.....	142
CHAPTER 5 - LAY KNOWLEDGE OF HEALTH: HOW MUCH CONTROL DO PEOPLE BELIEVE THEY HAVE OVER HEALTH OUTCOMES AND PRACTICES?.....		146
5.1	Introduction	146
5.2	What does 'health' mean?	148
5.3	What affects health? Lay knowledge of the effect of structure and agency	158
5.3.1	General socioeconomic, environmental and working conditions	159
5.3.2	Social and Community Influences.....	171
5.3.3	Individual or Agency Factors	176
5.4	Conclusion.....	184
CHAPTER 6 - HEALTH-RELATED PRACTICES AND ECONOMIC CAPITAL.....		187
6.1	Introduction.....	187
6.2	The effect of unequal income	188
6.2.1	Commodification of health: 'if you want good things, you have to pay for them'	189
6.2.2	The cost of health-related practices	198

6.3	Employment inequality.....	207
6.3.1	The working conditions of the middle socioeconomic group	207
6.3.2	Labour characteristics from the lower socioeconomic group.....	215
6.4	Conclusion.....	222
CHAPTER 7 - HEALTH-RELATED PRACTICES, SOCIAL AND CULTURAL CAPITAL.....		225
7.1	Introduction.....	225
7.2	Social Capital: neighbourhoods, social relations and health-related practices ...	227
7.2.1	Residential segregation	227
7.2.2	Habitus and 'normality'	230
7.3	Social norms and health-related practices.....	247
7.3.1	Middle socioeconomic group: Moderation and Refinement	248
7.3.2	Lower socioeconomic group: enjoying the moment.....	256
7.3.3	Gender: the construction of masculinity and femininity.....	262
7.4	Conclusion	269
CHAPTER 8 - SUMMARY AND CONCLUSION		273
8.1	Introduction	273
8.2	Conclusions about research questions	275
8.2.1	The consolidation of an unequal structure	275
8.2.2	Lay knowledge of health: the contradiction of neoliberalism.....	278
8.2.3	Unequal economic capital, unequal health-related practices	282
8.2.4	Social and moral boundaries	286
8.2.5	The complete picture	292
8.3	Implications for theory, methodology and policy	296
8.4	Limitations and further research	301
APPENDIX.....		305
BIBLIOGRAPHY.....		319

LIST OF FIGURES

Figure 1: The main determinants of health	33
Figure 2: Analytical Framework.....	50
Figure 3: Chilean population according to socioeconomic groups	82
Figure 4: Higher Education coverage according to income quintile 2003 (%).....	123
Figure 5: Diet Index according to socioeconomic quintiles.....	138
Figure 6: Smoking and alcohol problematic consumption according to gender	141
Figure 7: Agreement and disagreement with the statement that people suffer serious health problems because they behave in ways that harm their health, according to socioeconomic level (%).....	182
Figure 8: Chileans who, in the previous 12 months, did not receive a treatment they needed because the waiting list was too long, according to their socioeconomic level	191
Figure 9: Chileans who, in the previous 12 months, did not receive a treatment they needed because they said they could not afford it, according to their socioeconomic level.....	193
Figure 10: People who belong to an ISAPRE according to socioeconomic level....	197
Figure 11: Preference for FONASA or ISAPRES, assuming that they would cost the same	197
Figure 12: Percentage of monthly income per capita needed to buy the recommended ‘5 portions a day’, according to socioeconomic quintile	202
Figure 13: Gender of the main responsible person to exercise some housework (%)	210
Figure 14: Contradiction between neoliberal values and the consequences of neoliberal policy regime	282
Figure 15: Mechanisms through which economic capital influences health-related practices.....	284
Figure 16: Mechanisms through which social and cultural capital influence health-related practices	288

LIST OF TABLES

Table 1: Gini coefficient according to Chile's regions	81
Table 2: Sample distribution for qualitative interviews	95
Table 3: Evolution poverty rate and Gini coefficient between 1987 and 2011	109
Table 4: Social indicators of Chile and Latin America.....	112
Table 5: Independent income share according to the independent household income per capita decile, 1990-2009	115
Table 6: Salary gender gap 1990-2006 (women's wage as a % of men's wage).....	119
Table 7: Affiliation to health system according to economic and demographic variables	132
Table 8: Risk factors in Upper-middle income countries in Latin America (%)	134
Table 9: Socioeconomic differences in health conditions (probability coefficients)	135
Table 10: Regression models according to health-related practices.....	140
Table 11: Percentage of women who perceived domestic violence from their current partners in the last year according to socioeconomic level.....	175

ACKNOWLEDGEMENTS

I would like to start by thanking my supervisors, Mick Carpenter and Liz Dowler, for their unconditional support and guidance during my PhD. Their constant interest in my work encouraged me to complete my research and overcome the different obstacles that arose during this time. I thank them for giving me interesting and substantial feedback on everything I wrote throughout the course. Their critical assessment took my work to a level that I believe I would not have achieved without them. I will be forever grateful.

I am also grateful to the institutions that provided me with different resources. I would like to thank the Chilean Health Ministry, specifically the Epidemiology Department, Un Techo Para Chile, Ministerio de Desarrollo Social, and Instituto Nacional de Estadísticas, for giving me access to their databases and information. I would also like to express my gratitude for the scholarship provided by CONICYT, which allowed me to pursue my doctoral studies. And finally, I thank the Max Planck Institute for the Study of Societies for the time I spent there as a visiting student.

I want to thank all of those people whom I interviewed. Without their trust and time, this thesis would not have been possible to write. I am very grateful for the way in which they openly shared with me treasured stories and moments of their personal life, inspiring me to work for a more equal society. This work is dedicated to them.

I would like to express my gratitude to all of my friends who helped me in different ways and who were of great support during these years. Many thanks to Eleonora Nun, Sofía Donoso, Mónica Gerber, Juan Ignacio Venegas, María Ignacia Polanco, Osvaldo Larrañaga, Constanza Santelices, Raimundo Frei, Magdalena Gil, Ana Carolina Alfinito, Irina España, Annika Jasse, Divya Sridharan, and Zosia Boni.

I am very grateful for the support and love given by my mother and sisters. In spite of the several kilometres that kept us apart, they were close to me during these 4 years and encouraged me to go on. A special thanks to my mum for teaching me the importance of pursuing what I wish and to my dad for giving me the love for knowledge and research.

Above all, I would like to thank Aldo, my life and adventure companion, for making me happy every day during these years, especially since the arrival of our beautiful Domingo.

DECLARATION AND INCLUSION OF MATERIAL FROM A PRIOR THESIS

This thesis is submitted to the University of Warwick in support of my application for the degree of Doctor of Philosophy. It has been composed by myself and has not been submitted in any previous application for any degree. The work presented (including data generated and data analysis) was carried out by the author.

ABSTRACT

Background: Strong evidence has been provided by several researchers on the influence that structure and social factors have on health. However, there is relatively little information about the mechanisms by which the structure shapes health-related practices and the place there is for agency in this process. Therefore, this thesis explores the mechanisms through which the structure influences the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal economically high-income country such as Chile.

Design and objectives: Following a critical realist approach, this thesis uses mixed methods to answer the research question. The contextual analysis aims to comprehend the wider political and economic forces related to the Chilean neoliberal regime that underlie people's health-related practices. It is based on a bibliographical review and quantitative analysis of secondary data. The extensive analysis focuses on the extension of health-related practices and their statistical association with structural variables. Finally, the intensive analysis explores the meanings and values people give to health and to their health-related practices. It is based on the analysis of fifty-seven in-depth interviews conducted with twenty-nine people living in Santiago de Chile.

Results and conclusions: By combining intensive and extensive approaches with a contextual analysis of Chilean society, this thesis concludes that there are different mechanisms through which the structure influences the space for agency that people have over their health-related practices in Chile. These mechanisms affect people differently according to their socioeconomic level and gender. They are related to people's economic, social and cultural capital, all of which are unequally distributed in Chile. The analysis shows that these mechanisms are a consequence of a structure with high levels of inequalities consolidated by the Chilean neoliberal policy regime.

CHAPTER 1 - INTRODUCTION

1.1 Background of the research

Health inequity is a global phenomenon. Socially produced, unfair and avoidable health disparities (Evans et al. 2001; Blaxter 2010) contrast with the overall increase in life expectancy and reductions in infant and maternal mortality, and fatal diseases. This health gradient occurs in a context where non-communicable forms of ill-health are responsible for 68% of the world's deaths (WHO 2014). The overall improvements in quality of life, improvements in health treatments, health education, and sanitary conditions, have led countries to experience an 'epidemiological transition' in which a higher burden of ill-health is caused by non-communicable health conditions, i.e. so-called 'chronic diseases', whereas communicable conditions tend to decrease (Murray and López 1997; Omran 2005; López et al. 2006).

These forms of ill-health are usually associated with so-called 'risky individual behaviours' or 'lifestyles' (Nettleton 2013); having an inadequate diet and high intake of alcohol, smoking, or sedentary lives. The terms 'risky individual behaviours' or 'lifestyle' are commonly associated with the belief that people 'choose' whether or not to adopt them, focusing the attention 'almost exclusively on its behavioural, volitional aspects' (Frohlich et al. 2001, 783). The emphasis on choice that the term 'lifestyle' implies, overlooks the importance of social structure or life chances, and is especially found in neoliberal societies, i.e. where access to social services depends highly on the market and responsibility for well-being falls mainly to the individual (Harvey 2005).

A range of studies have shown that ‘risky individual behaviours’ are more frequent as people’s position on the social ladder decreases (WHO 2002; Marmot and Wilkinson 2003; Contoyannis and Jones 2004; Chopra 2008; Adler et al. 1994; Doorslaer and Jones 2004; Marmot 2005; Park and Kang 2008; Cutler and Lleras-Muney 2010; Webbink, Martin, and Visscher 2010). Not only do people’s place on the social ladder impact their probabilities of suffering health problems or premature deaths creating a social gradient (Marmot and Wilkinson 2003; Wilkinson and Pickett 2009) the political economy of countries and their overall level of development also influence health outcomes and inequalities (Coburn 2000; Coburn 2004; Navarro and Shi 2001; Raphael 2012). Research has shown that countries with high levels of income inequality which also have a (neo)liberal policy regime have worse health outcomes than more egalitarian societies with a social democratic policy regime (Coburn 2004; Navarro and Shi 2001; Chung and Muntaner 2007; Navarro et al. 2006). This reality reveals the importance that different elements of the social structure have on people’s health ‘behaviours’ and outcomes.

In order to recognise and consider the impact that both life choices – agency – and life chances – structure – have on the way people live their lives, this research adopts the term ‘health-related practices’. Firstly, this concept makes reference to those practices that may or may not have consequences on health outcomes, such as smoking or people’s diet. For instance, not everyone that smokes suffers from lung cancer. Secondly, as it will be explained in more detail in the next chapter, this term implies the belief that these practices are the result of choices taken within certain boundaries – material and social – that are set by the structure. In other words, health-related practices are the result of people’s choices which are constrained by their life chances;

their choices are derived from the interaction between agency and structure. Finally, as a consequence of the nature of these practices, individuals are not aware of the underlying reasons for adopting certain health-related practices. While people experience, for instance, their diet as a result of their personal choice and taste, the constraining power of income inequality or social distinction in shaping or conditioning their decisions remain invisible to them.

While there is evidence on the influence that structure and social factors have on health, there is relatively little research about the mechanisms by which the structure shapes health-related practices and the place there is for agency in this process. In a context where freedom to choose is promoted and personal responsibility for wellbeing is emphasised, to what extent do individuals' social position and economic situation constrain their health-related practices and how far are these the result of deliberate and rational choices?

1.2 Aims and Research Questions

Despite these valuable research contributions, there are still uncertainties about the mechanisms by which the structure impacts health, and the place there is for agency in this process in a neoliberal society. This thesis explores the question:

Through which mechanisms does the structure influence the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal country such as Chile?

This question is divided into the following sub-questions:

- a) In which ways do neoliberal policies on health-relevant issues create inequalities that affect people's daily lives, and how are these related to people's health-related practices?
- b) Which aspects of Chilean society affect how people understand and experience health, and how are these related to people's sense of responsibility for health outcomes and health-related practices?
- c) Through which mechanisms do the unequal material circumstances that men and women from different social groups have affect their power of agency to engage with health-promoting practices, and how are they related to the Chilean neoliberal policy regime?
- d) Through which mechanisms does the social and cultural capital that men and women from different social groups possess influence their health-related practices, and in which sense are these mechanisms related to the neoliberal policy regime?

This thesis takes Chile as a case study of a neoliberal society that presents several contradictions. Chile is a country with a high income per capita according to the World Bank, yet its population suffers from persistently strong income and social inequalities. Additionally, while it may be seen as a country that takes action against social determinants of health (in 2005 the World Health Organization chose its capital for the launching of the Commission of Social Determinants of Health), several years later there are just a few, if any, actions or policies using this approach to reduce health inequalities. More details of the case selection are given in section 4. Taking this case study, the aim of this research is therefore to explore the mechanisms that underlie the health-related practices of men and women who belong to middle and lower socioeconomic groups, and explain how these mechanisms impact the space for choice that people have. These two socioeconomic groups were chosen because they are both affected by health inequalities and have health indicators that may be considered poor (Arteaga et al. 2002; Frenz 2005; Frenz and González 2010; OPS, OMS, and FONASA 2009; Jadue and Marin 2005). By contrasting these two social groups, this thesis will explore how health inequalities are not only suffered by those at the bottom of the social ladder but also by those who belong to the middle class, as suggested by researchers of the social health gradient (Marmot and Wilkinson 2006). Through a critical realist approach and mixed methods as also detailed in section 4, this dissertation explores the material and social mechanisms that underlie people's health-related practices, and argues that they are highly influenced by dimensions that go beyond peoples' individual choices or control, producing health and social inequities.

1.3 Theoretical Framework

When analysing health-related practices in the context of health inequities, two main theoretical perspectives must be considered: the behavioural and the social determinants of health approaches. These theories have specific ways of understanding health inequalities. They each explain in a particular way why different social groups do not have similar health outcomes, leading to a discussion that ultimately rests on the sociological ‘structure-agency’ debate. These approaches, as well as the discussion about the tension between structure and agency will be briefly summarised below and discussed in detail in Chapter 2.

The behavioural approach places most of the responsibility for health-related practices on individuals (Reiser 1985; Minkler 1999). Under this approach, health inequalities are said to be caused by differences in health behaviour which are believed to be caused by lack of information and preferences, without considering the social structure influence. Therefore, attempts to overcome health disparities should be focused on educating people to live ‘healthy’ lives. Crawford, a critic of this approach, has stated that it produces an ‘ideology of individual responsibility’ which ‘promotes a concept of wise living which views the individual as essentially independent of his or her surroundings, unconstrained by social events and processes’ (Crawford 1977, 677). Defenders of this perspective state that ‘the idea of a ‘right’ to health should be replaced by the idea of an individual moral obligation to preserve one’s own health – a public duty if you will’ (Knowles 1977, 59).

As explained in the next chapter, these principles – freedom of choice and individual responsibility – are closely associated with neoliberal policy regimes. Under this type of policy regime, ‘individual success or failure are interpreted in terms of

entrepreneurial virtues or personal failings (such as not investing significantly enough in one's own human capital through education) rather than being attributed to any systemic property (such as class exclusions usually attributed to capitalism)' (Harvey 2005, 65-66). Following this argument, public responsibility is limited to informing people and, if possible, helping them to change their behaviour. In other words, the solution of the health problem is based on individuals and their choices rather than in the structural circumstances that gave rise to it in the first place. This approach implies a strong emphasis on individual agency, i.e. choices, rather than social structure, i.e. chances and opportunities.

The second main approach used to explain health inequity is the social determinants of health approach. In contrast with the behavioural approach, this perspective argues that health inequalities are not primarily a product of the individual's agency, but rather a consequence of the unequal and hence unfair distribution of resources within the social structure (Barker 1991; Wilkinson 1992; Bartley, Blane, and Davey-Smith 1998; Marmot and Wilkinson 2003; Subramanian and Kawachi 2004; Marmot and Wilkinson 2006; WHO - CSDH 2008; Wilkinson and Pickett 2009). Within this approach, there have been debates regarding how social inequalities are translated into mortality and morbidity; how inequality 'gets under the skin' (Wilkinson and Pickett 2009). Three main theoretical explanations have been given: psychosocial theory, neo-materialism, and life-course approach. While defenders of the psychosocial stream argue that health inequalities are explained by the psychosocial burden produced by income inequality (Wilkinson 1996; Wilkinson and Pickett 2009), neo-materialist researchers state that it is essential to take into consideration not only the relation and effects that income and social inequalities have on health outcomes, but also the

structural causes of inequalities, i.e., the political, economic and social context in which they are produced (Navarro and Shi 2001; Lynch et al. 2000; Coburn 2004; Raphael 2012). Additionally, those taking the life-course approach argue that analyses should focus on the presence of social inequality and the exposure that individuals have to potential processes which may affect their health throughout their life-course (Lynch and Davey Smith 2005; Davey Smith 2007). Thus, the position that individuals occupy within the social structure throughout their life-course as well as the characteristics of that social structure would explain health inequalities and the differences regarding health-related practices.

From a sociological perspective, it is possible to understand these two perspectives within the contested 'agency-structure' debate. While the behavioural approach explains health inequalities by making reference to the central role that agency plays on determining health-related practices, the social determinants of health perspective argues that health disparities and differences in practices are a product of people's social location, that is, social structure. As with a multiplicity of social problems, the use of these contrasting approaches does not give a final answer; they do not provide enough information to answer the research question of whether people's health-related practices are deliberately and rationally chosen or if they are influenced by economic and social inequality. In order to explore the mechanisms that underlie health-related practices of men and women that belong to different social groups, I seek in this thesis to combine Bourdieu's theory of the reproduction of the social structure and social practice and Archer's analytical dualism perspective, analysed in detail in the next chapter. This will allow me to understand structural determination without precluding the possibility of agency.

Bourdieu argues that individuals' social location depends on their access to and possession of economic, social and cultural capital (Bourdieu 1986), all of which are influenced in turn by a country's political economy. According to this perspective, people's structural positions or 'habitus' are internalised and translated into practices and tastes (Bourdieu 1977; Bourdieu 1984). When applied to the health-related practices debate, this would mean that they are not shaped exclusively by agency – choices – as argued by the behavioural perspective, but rather by the social structure – chances. Therefore, from this perspective health inequity may be understood as the result of the unconscious dispositions that shape people's tastes and practices according to necessity, i.e. their economic, social and cultural capital. In other words, health inequity would be a consequence of the different positions that individuals occupy within the social structure.

As will be discussed, Bourdieu's approach is criticised for neglecting the role of people's agency, that is, of the meanings or motivations that individuals may or may not have to engage with certain practices (Williams 1995). Following his theory, changes in individuals' health-related practices would only happen within the limits of their habitus, making agency powerless in relation to the social structure. It explains this social phenomenon by making exclusive reference to society and neglects the importance of meanings or motivations that individuals may or may not have to engage with certain practices; it suffers from 'downward conflation' (Archer 1995).

According to Archer, an advocate of the critical realist methodology, structure and agency are separate dimensions that should not be considered simultaneous in time (1995). Under this model of interpretation, known as analytic dualism, both dimensions are interdependent and separate in time. While on the one hand the social

structure ‘pre-exists’ agency and constitutes ‘the (‘macro’) *context* confronted by (‘micro’) social interaction’, on the other agency or people’s actions ‘represent the *environment* in which the (‘macro’) features of systems are either reproduced or transformed’ [author’s emphasis] (Archer 1995, 11). Therefore, health disparities and differences in health-related practices cannot be understood by exclusively making reference to the social structure, it is also necessary to include agency in the analysis.

By complementing Bourdieu’s theory of people’s social location and the relationship between ‘habitus’ and practices with Archer’s argument about the interdependency between structure and agency, this thesis analyses which mechanisms influence the space for agency that people from different social groups have over their health-related practices. After describing the main contributions that this dissertation will make, section V will give an overview of the methodology used to answer this question.

1.4 Methodology

The epistemological approach taken in this research is critical realism. As is explained in depth in Chapter 3, this approach is based on the ontological principles of a stratified, differentiated reality (Sayer 1992; Archer 1995; Bhaskar and Lawson 1998; Sayer 2000; Danemark et al. 2002; Scambler and Scambler 2013). Critical realists argue that reality is independent from our knowledge of it and that it is made of experiences and events, structures, mechanisms and tendencies that people may or may not be aware of (Bhaskar and Lawson 1998), which explains why individuals are not necessarily aware of the underlying reasons for adopting certain health-related practices. Epistemologically speaking, critical realists posit a reality made up by the social structure and human agency, which are interdependent realities temporarily separated (Sayer 1992; Archer 1998; Gorski 2013). The social structure sets the

necessary context and space for human actions to develop, such as health-related practices, whereas these actions are the ones responsible for setting the necessary conditions for structure to continue existing, be it in the same way (reproduced) or in different forms (transformed). It is due to the possibility of human agency transforming or reproducing social structures that critical realists state that society is an open system (Archer 1995).

The stratified nature of reality alongside the openness of the social system, a product of its ‘peopled’ character, makes it necessary to use mixed methods to explore the mechanisms that underlie health-related practices of men and women who belong to different socioeconomic groups. While qualitative interviews allow access to the meanings and values that people give to these practices, extensive analysis, i.e. quantitative research, provides a description of people’s health-related practices and whether or not these are statistically associated with structural variables - income and gender – as well as information about the broader social, political and economic context in which the practices are conducted. These data sources are intertwined throughout the research analysis. The description of the specific research design, data collection and data analysis is developed in Chapter 3.

In terms of the case selection, the political economy of countries as well as their overall level of development have an impact on health outcomes and inequalities (Coburn 2000; Coburn 2004; Navarro and Shi 2001; Raphael 2012). Neoliberalism policy regimes not only have worse health outcomes than more egalitarian societies with social democratic policy regimes (Wilkinson 1996; Wilkinson and Pickett 2009; Wilkinson and Pickett 2015; Lynch et al. 2000) but are also associated with an ideology that implies that practices, such as health-related practices, are individual

choices and responsibilities (Harvey 2005). Chile constitutes a crucial case-study to answer this question, as it will be explained in detail in Chapter 3.

It was in Chile where the first experiment with neoliberal state formation took place after a military coup in 1973, assisted by domestic business elites and the United States (Harvey 2005). This constituted an extreme version of neoliberalism since it took place under severe circumstances of repression, lack of civil rights and government accountability (Taylor 2006). It is said that neoliberalism was implemented under 'laboratory conditions' (French-Davis 2003). After 17 years under a military dictatorship, democracy was re-established peacefully but the neoliberal policy regime remained stable (Taylor 2006, Madariaga 2015). In fact, key features of social policy under democratic governments include the continuity of privatised social services (education, healthcare, pensions) and targeted social policies as well as Chile having the highest income inequality amongst the OECD countries (OECD 2011c). It is also relevant that Chile was categorised as a high-income country by the World Bank in 2013 (Jim Yong Kim 2013). This is important since, as was mentioned in section 1.3, psychosocial theoretical researchers argue that, once countries have reached a basic standard of living, the psychosocial burden produced by inequality is the most important to explain health inequalities. Having a gross national income per capita of 15,230 USD in 2013 (<http://data.worldbank.org/country/chile>) Chile becomes a good case to observe how the psychosocial dimension influences the agency power that people have over health determinants and how it interacts with material factors in a highly unequal country.

1.5 Contributions to knowledge

By answering these research questions, this thesis seeks to contribute to both academic debate and knowledge about health inequalities, to health-related research methodological discussions, and to governments and policy makers who aim to reduce the health gaps in their societies. The different contributions will be briefly described here and explained in more detail in Chapter 8.

Firstly, this dissertation aims to contribute towards the debate between behavioural approach and social determinants of health perspective. By studying the ways in which social structures constrain or enable individuals' health-related practices and how far these are the result of deliberate and rational choices, it will provide evidence that supports the importance that the social dimension has on people's practices, and the place that should be considered for agency.

As a consequence, it aims to add knowledge within the social determinants of the health approach debate by applying the three main theoretical streams of the social determinants of health approach – psychosocial, neo-materialism, and life-course – to a country that has recently been categorised as high-income. It will provide an analysis of the way in which material, social, cultural and life-course factors interact with each other and influence health, testing these different approaches within this case-study for the first time.

Thirdly, this work pursues the examination of a specific area of knowledge about the influence that neoliberalism has on health inequities through influencing the adoption of health-related practices, which may be applied to other societies as well. Chile, a country considered as a landmark case of neoliberalism (Harvey 2005; Taylor 2006),

constitutes a privileged case to study the effect that the centrality that values of individual freedom and responsibility associated to neoliberalism have on people's health-related practices.

In the fourth place, this thesis hopes to add understanding about the Chilean case itself by providing a type of research analysis that so far has not been developed. Even though Chilean health inequalities have been studied in the past (Vega et al. 2001; Gattini et al. 2002; Albala et al. 2002; MINSAL 2003; Hertel-Fernández et al. 2007; Jadue and Marin 2005), none of the previous research has focused on the mechanisms that underlie the adoption of specific health-related practices by different groups.

Additionally, this dissertation aims to contribute to health inequity research by analysing it in terms of the unresolved sociological debate about structure-agency. By combining Bourdieu's theory and Archer's analytical dualism perspective, this research seeks to pose an original theoretical approach to analyse the nature of health-related practices and the reproduction of health inequity.

In terms of its methodology, this research aims to add knowledge about the use of critical realism on health-related studies by applying this methodology to answer the research problem. The combination of intensive and extensive analysis may be seen as an example of how to put into practice the ontological and epistemological principles that characterise critical realism.

Lastly, as a consequence of the previous issues, this research aims to provide useful evidence to policy makers who wish to reduce health inequalities. By concluding the importance that material, social and cultural capital have in relation to the agency people from different social groups have over their health-related practices, this

dissertation seeks to raise awareness about the importance of considering these dimensions on social policies design and implementation. In other words, the research aims to trigger a phenomenon of ‘concientization’ (Freire 2000) – both within policy makers and the general Chilean population – so that they may demand a change to unequal structures.

1.6 Thesis outline

This dissertation is divided into eight chapters. Following this first introductory chapter, Chapter 2 analyses in detail the different theories that explain health inequity and health-related practices which need to be considered to answer the research questions. It examines the behavioural approach, which as was previously described, emphasises agency and choice by placing responsibility on individuals for their practices and analyses how it is closely related to countries that have a neoliberal policy regimes, such as Chile. After considering the consequences of following this approach, the chapter analyses the social determinants of health approach, which argues that the explanation for health inequity may be found in people’s differential access to material and non-material resources throughout their life-course, which is determined by the political economy of the countries they live in. The section continues with the debate between ‘structure/agency’ reflected in these approaches in sociological terms, by discussing Bourdieu’s theory of social location and reproduction of inequity, alongside Archer’s analytical dualism, as a way to consider the interdependency of agency and structure present in health-related practices.

Chapter 3 is focused on explaining the methodology used in order to answer the research question. It analyses how the main methodological perspectives used in previous health inequity research give partial knowledge about the ‘interplay between

structure and agency' (Archer 1995) present in the enactment of health-related practices and argues, therefore, for the need to adopt a critical realist approach for this investigation. Following this discussion, the adequacy of using mixed methods – extensive and intensive approach – to study the research question is analysed and the selection of Chile as a case-study is justified. The chapter concludes with a description of the research design, data collection and analysis processes.

Chapters 4, 5, 6 and 7 are focused on the empirical findings and analysis performed to solve the research problem. Even when these chapters are presented separately for analytical purposes and to facilitate the reading of the results, they make reference to a reality in which the aspects analysed are intertwined and may only be separated artificially.

Chapter 4 carries out a contextual analysis to determine in which ways the Chilean neoliberal policy regime creates inequalities on health-relevant dimensions that affect people's daily lives, and how these are related to people's health-related practices (subquestion a). The chapter starts with a discussion on the national situation, social policies and indicators that characterised three periods of Chilean society (1950-73; 1973-89; 1990-onwards). It analyses how the imposition of a neoliberal policy regime and subsequent stability has created a country with opposing realities. Chile's considerable economic and social improvements compared to its high levels of inequality reflected in different health-relevant measures– income, employment conditions, residential segregation – which are analysed in detail. The last part of this chapter is focused firstly on the description of the Chilean healthcare system and its inequities and secondly on the analysis of the findings from the extensive analysis of health-related practices.

Through an intensive analysis of the in-depth interviews carried out, Chapter 5 examines which aspects of the Chilean social structure affect how people understand and experience health and how these aspects are related to people's sense of responsibility for their health outcomes and health-related practices (subquestion b). In the first place, it discusses the meanings that men and women from different social groups give to health and how they are related to different aspects of the Chilean society, such as in commodified character. Secondly, the factors that people believe affect their health are analysed in relation to the 'structure-agency' debate in order to analyse how responsible people feel for their health outcomes and health-related practices.

Chapter 6 presents evidence about the mechanisms through which material circumstances – economic capital – for men and women from different social groups, affect their agency power in relation to their health-related practices and how these mechanisms are related to the neoliberal policy regime (subquestion c). Specifically, by combining intensive and extensive analyses it shows how people's unequal disposable income and employment conditions create material boundaries that impact their health-related practices positively or negatively. It does so by triangulating the data collected in the interviews with quantitative data that reaffirms and supports people's statements and that provides information about specific aspects of their context.

Chapter 7 analyses the mechanisms through which the social and cultural capital that men and women from different social groups possess influence their health-related practices differently, and in which sense these mechanisms are related to the neoliberal policy regime (subquestion d). Using mainly an intensive approach, it shows firstly

how people's neighbourhoods and social relations (which are related to individual material circumstances – Chapter 6) make them more prone to enact certain practices, and secondly the way in which social norms and expectations may shape individuals' practices.

The concluding chapter returns to the research question and shows how the previous chapters provide evidence to answer it. This chapter also discusses the theoretical and methodological contributions this research entails as well as policy implications with a special focus on Chile. It concludes with an analysis of the research limitations and suggestions for further research.

CHAPTER 2 - LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK: HEALTH CHOICES ACCORDING TO LIFE CHANCES?

2.1 Introduction

This chapter builds the theoretical framework upon which the research is based in order to analyse the data collected and answer the research question. It reviews the main relevant literature and theories that have been used to explain health inequity and the differences in health-related practices or ‘risky behaviours’ that exist between different social groups. Specifically, the chapter analyses the behavioural approach and its relation to the centrality of agency and choice to explain health disparities. It is argued in this section how this approach is closely related to countries that follow a neoliberal regime such as Chile. After analysing the consequences and criticisms of this perspective, section 2.2 focuses on the social determinants of health approach, which argues that the origins of health inequity lie in social structure. This section states how the social context and political economy surrounding health inequities and health-related practices determine the chances of individuals. Overall, the literature review shows that there is no definitive explanation regarding the reasons that underlie the differences in health-related practices between social groups.

This thesis contributes to this discussion by analysing this research problem in terms of the unsolved sociological debate about structure-agency. Therefore, section 3 is focused on the discussion about agency and structure that leads to the construction of the theoretical framework. By adopting Pierre Bourdieu’s theory of the reproduction of social structure and social practice, it is argued that the social structure influences health-related practices through individuals’ habitus, which is determined by their

economic, social and cultural capital. However, due to the fact that this approach reduces social action to social structure, i.e. has a tendency towards excessive determinism, Bourdieu's theory is complemented with Archer's analytical dualism theory. As it is explained, this theory allows analysis of the interdependency of agency and structure in relation to health-related practices, determining how much agency men and women from different social groups have over health determinants in their daily lives. The chapter ends with an explanation of the way in which the theoretical framework was applied to this research, as well as the main definitions it entails.

2.2 Literature Review

2.2.1 Individual responsibility: the behavioural approach

Within everyday language as well as in some policy makers' approach, 'lifestyle' has been adopted under the belief that people 'choose' whether or not to adopt 'risky behaviours', focusing the attention 'almost exclusively on its behavioural, volitional aspects' (Frohlich, Corin, and Potvin 2001, 783). The use of this term is usually related to the increasing importance that has been given to primary prevention of ill-health (Nettleton 2013; Rose 1992), encouraging people to have a healthier life now in order to reduce the risks of having problematic health conditions in the future (Cohen and Henderson 1991). This approach reflects how risk has been associated with 'notions of choice, responsibility and blame' (Lupton 2000, 22) implying that morbidity and mortality derived from non-communicable forms of ill-health or conditions are consequences of imprudent behaviour and the adoption of unhealthy lifestyles. According to Crawford (1977), a critic of this approach, the basic notion underlying this perspective is that people control their behaviour and health choices and that they

are therefore personally responsible for the possible consequences and health outcomes of their choices.

This notion of personal responsibility is consistent with behavioural explanations of health inequity, which will be described in this section. After defining this approach and its central characteristics, this section will establish its relation to neoliberal countries, and will conclude with the main criticisms made of this perspective.

'Lifestyles' and health choices

In a thorough review of different health inequalities theories, Bartley states that under this explanatory model, the clustering of 'risky health behaviours' on the less advantaged groups in society is explained through the assumption that 'people with less money and status are not able to grasp the health education messages put out by government and health professionals, or have not the 'self-discipline' to follow them' (2004, 66). Therefore, health inequalities would respond to differences in health behaviour which is ultimately an individual responsibility. This implies a rational individual who has or should have a thorough knowledge of the risks and consequences of his/her actions and who, at the same time, lives in a free society that does not determine his/her decisions. In Robert Crawford's words:

The ideology of individual responsibility promotes a concept of wise living which views the individual as essentially independent of his or her surroundings, unconstrained by social events and processes. When such pressures are recognised, it is still the individual who is called upon to resist them (Crawford 1977, 677)

This tendency to place responsibility for health on individuals may be observed on the United Kingdom National Health Service (NHS) webpage (<http://www.nhs.uk/livewell/Pages/Livewellhub.aspx>) and its slogan ‘Your health, your choices’. This webpage has several health topics, such as ‘alcohol’, ‘fitness’, ‘healthy eating’, ‘lose weight’ and ‘stop smoking’. Each of these sections has tips and plans for people who want to change their ‘lifestyles’ and enjoy the benefits associated with them. The information provided shows how the behavioural approach may be translated into the belief that health inequalities may be tackled by educating people about the impact that their choices may have on their health outcomes and providing them the correct incentives to behave in a ‘healthy way’. Therefore, the responsibility of public institutions is limited to educating people rather than changing the dimensions of the social structure that influence health-related practices. With expressions such as ‘Quit smoking and you'll be healthier, your skin will look better and you'll have better sex’, this institution aims to encourage people to take the decision to change their habits. Testimonies of people who have engaged ‘successfully’ with different NHS programmes are presented on the webpage and give evidence of the importance of individual responsibility and self-control. Two excerpts from them are presented below:

...I realized that "wine o'clock" had become an automatic reflex that wasn't so much a pleasure as a habit. I didn't find an answer to my question on the internet, but I did find Alcohol Concern's website and a challenge called Dry January. I liked the idea – an opportunity to prove to myself that I had more self-control than a four-year-old who'd been left alone in a Cadbury's warehouse (<http://www.nhs.uk/Livewell/alcohol>)

Following the plan [NHS weight loss plan] all the way through, losing weight and running 10km have all really boosted my self-belief. It feels like such an accomplishment. Over these last 12 weeks, I've turned my life around. No-one can take that away from me (<http://www.nhs.uk/Livewell/weight-loss-guide>)

It may be seen how expressions such as 'self-control', 'self-belief' and 'accomplishment' are central to the narratives of these testimonies. Lifestyles and health outcomes are considered a matter of individual responsibility, a characteristic that has also been observed by research regarding obesity. Through research of the ways in which doctors and patients discuss obesity, Webb observed how it acquires a normative value that reflects the responsibilities that patients perceive for their 'success' – loss of weight – or 'lack of success' – weight gain (Webb 2009). She concludes that 'by indicating their willingness and commitment to listen to medical advice, take new medications, overcome obstacles etc., they display evidence of efforts to master their bodies' (2009, 867), therefore emphasising the centrality that their 'choices' have over their health outcomes.

The belief in the centrality of personal choices to health issues may be related to the rise of a consumer culture. Thus Nettleton argues that 'there is a commercialization of health in that people are constructed as health consumers who may consume healthy lifestyles' with an emphasis on body maintenance that is promulgated by doctors, health promoters, pharmacies and media (2006, 47). The commercialization of the so-called healthy lifestyles may be seen, as she observes, in the widespread influence of the fitness industry, through use of exercise machines, a variety of exercise clothes and accessories, and so forth. The fact of naming people as 'consumers' either of health

lifestyles or healthcare may be also related to a shift of responsibility for health from the state and society onto individuals (Gabe and Calnan 2000).

This shift is seen on people's access to medical treatments and on healthcare public expenditure. Under the belief that no resources should be wasted on 'inefficient behaviour' that is avoidable (Shani 2009, 313), a number of arguments are put forward to defend rationing by responsibility. The first of them, from a more practical perspective centred on future behaviour rather than past behaviour and on the maximisation of the cost-effectiveness in healthcare, is that holding people responsible for their choices and creating positive or negative incentives associated with their behaviour is a good way to avoid individuals engaging in unhealthy practices (Cappelen and Norheim 2005). Secondly, it is argued that irresponsible health behaviour is antisocial; people should lose their right to healthcare when they behave irresponsibly since their voluntary engagement in 'risky' practices means that they are consciously wasting their opportunity to be healthy provided by society (Denier 2005). As a third argument, it is contended that behaving responsibly is a moral duty owed to the state and citizens; 'the idea of a "right" to health should be replaced by the idea of an individual moral obligation to preserve one's own health – a public duty if you will' (Knowles 1977, 59). These arguments are seen in political speeches and governmental approaches to health behaviour and inequalities, as reflected in Tony Blair's speech as UK Prime Minister on healthy living:

Our public health problems are not, strictly speaking, public health questions at all. They are questions of individual lifestyle - obesity, smoking, alcohol abuse, diabetes, sexually transmitted disease (...) They are the result of millions of individual decisions, at millions of points in time (...)These

individual actions lead to collective costs (...) The truth is we all pay a collective price for the failure to take shared responsibility (...) the Government should play an active role in the way the enabling state should work: empowering people to choose responsibly (Blair 2006)

All of these reasons confirm that under the behavioural approach, health disparities between individuals are mainly considered a product of people's behaviours and preferences. This implies the belief that health inequalities are primarily to be tackled through educating people about health choices without necessarily considering the social structural constraints that they face.

Neoliberal policy regime: policies on individual freedom and personal responsibility

This perspective implies an emphasis on choice, individual freedom and personal responsibility in parallel with the withdrawal of the state in favour of the market, suggesting a close relationship with neoliberal regimes. Esping-Andersen has categorised states according to the amount of responsibility they take over societies' welfare by analysing their degree of decommodification, social stratification, and the role of the state, market and family in providing people with economic and social security (Esping-Andersen 1990). He identified three ideal types of welfare regime. In the first place, the social democratic regimes, which may be seen in the Scandinavian countries, are recognised for having universal and substantial benefits alongside a strong and interventionist state. Secondly, in conservative welfare regimes, like Germany, welfare is mainly conditioned by employment and traditional social relations are preserved. Finally, the liberal regime, the US being the clearest example, is made up of nations in which the provision of welfare by the state is reduced to its

minimum, that is, access to welfare depends highly on people's income, benefits are modest and are means-tested. Even when Esping-Andersen's typology has been criticised in theoretical, methodological and empirical terms (Bambra 2007) it successfully reflects the tension between market and state, a central issue when considering liberty and responsibilities.

Neoliberal regimes could be considered a subgroup within liberal regimes. Chile is a landmark case of a neoliberal society, as will be explained in the next chapter. This regime is characterised by having a political-economic order which promotes deregulation, privatisation, and the withdrawal of the state from the provision of social services and protection in favour of individual liberty. Within these societies people are considered responsible for their own actions and wellbeing, they depend upon themselves for their education, health and pensions. Under the rationality that this regime implies, those individuals who are deemed overweight or 'obese' should inform themselves in order to choose their food appropriately, a similar argument to the one defended by the behavioural approach. Governments are expected to help individuals access this information.

According to Harvey, in neoliberal societies 'individual success or failure are interpreted in terms of entrepreneurial virtues or personal failings (such as not investing significantly enough in one's own human capital through education) rather than being attributed to any systemic property (such as class exclusions usually attributed to capitalism)' (Harvey 2005, 65-66). This rationality is reflected in the way in which neoliberal countries implement health promotion strategies that follow the notion of personal responsibility, encouraging 'the cultivation of self-governing subjects who take an entrepreneurial approach to the management of their health. Such

an approach frames the body as a site of investment, with the investment taking the form of such practices as improving one's diet, avoiding tobacco and excessive alcohol consumption, and engaging in regular physical activity' (Glasgow and Schrecker 2015). By interpreting health relations under economic parameters, the self becomes an enterprise, that is, people's lives are 'understood as a relation to the self, based ultimately on a notion of incontestable economic interest' (McNay 2009, 56; Foucault 2008). Bodies and minds become objects that need to be considered in economic terms, in much the same way as an enterprise would be handled, looking for the maximisation of well-being and happiness. Thus, actions related to health must follow the logics of individual liberty and personal responsibility for the risks that these imply, transforming the body into a space where the socioeconomic order and neoliberal values are reflected (Crawford 1984).

Additionally, controlling bodies and minds under economic principles and a personal responsibility approach strengthen the neoliberal model. By becoming a reflection of this model, 'individual responsibility for health, although not without challenge, proved to be particularly effective in establishing the 'common sense' of neoliberalism's essential tenets' (Crawford 2006, 410). Crawford's research on the meaning of health in the United States of America showed how the tension between self-control and release in relation to health were a reflection of a contradiction of the social system that promoted consumption and discipline at the same time (Crawford 1984). Holding people responsible for their health outcomes and encouraging autonomous actions and privatised solutions helps to emphasise a responsibility discourse, compared to the image of a careless person who is morally judged for his or her unhealthy lifestyle that leads to a need for greater medical care, ultimately paid

for by society in general. These images reinforce the emphasis on individual responsibility and voluntarism, damaging collective duty and obligation, and thus, depoliticise social and political relation (McNay 2009).

Criticisms of the behavioural approach: Blaming the victim?

Several objections and criticisms of the behavioural approach can be made, in practical, moral, and theoretical terms. Firstly, there is a practical objection based on the plausibility of identifying and differentiating the range of factors that cause forms of ill-health. Is it possible to determine that a specific condition has been exclusively created by individuals' imprudent actions? It does not seem possible to argue that the need for healthcare is a consequence of personal activities only, with no other factors, such as genetic or environmental, being relevant (Denier 2005; Cappelen and Norheim 2005). If it is infeasible to be certain about the specific way in which each factor affects health outcomes, then it is not possible to blame people for them.

The second practical objection is also related to the plausibility of identifying causes, not of health conditions themselves but rather of individual choices that are considered responsible for the incidence of ill-health. In order to hold individuals responsible for their actions, it is necessary to have certainty about the free, voluntary and autonomous character of the decision making. However, 'actions only rarely have all the attributes – informed, voluntary, uncoerced, spontaneous, deliberated, etc. – that, in the ideal case, are preconditions for full personal responsibility' (Wikler 2006, 126). The impossibility of being sure that a choice was truly voluntary and autonomous in this scenario, leads to a third objection to this model that has a moral character.

Holding people morally responsible for their health-related practices and health outcomes leads to an inevitable process of stigmatization of those groups that adopt unhealthy practices and are ill (Blaxter 1997; Crawford 1984; Crawford 2006). People that are heavy smokers, do not have an adequate diet or are binge drinkers are considered to be weak, in the sense that they cannot resist the pleasure that smoking a cigarette may give and a moral failure since they cannot fulfil their moral duties. Cornwell's study of women in East London (1984) argued how women's discourses and beliefs denoted a moral attribution given to 'health'. These stated that people who are ill are those that are not able to take care of themselves. Similar findings were found by Blaxter's and Paterson's research (Blaxter and Paterson 1982). Being healthy and not giving up to problems of ill-health was expressed by participants in their study as a moral asset, an aspect that could not be measured through a quantitative approach. The fact of being thin is positively associated with self-control and will power; 'the thin person is an exemplar of mastery of mind over body and virtuous self-denial' (Crawford 1984, 70). The testimony excerpts presented above support the importance given to the individual's characteristics. As a consequence, people that suffer from obesity or are addicted to alcohol become stigmatised as morally unsuitable. Since behaviours that may have a negative effect on health, such as smoking or eating too much sugar or fat, are clustered in disadvantaged groups (Marmot and Wilkinson 2003; Jarvis and Wardle 2006; J.W. Lynch, Kaplan, and Salonen 1997; Nettleton 2013) the stigmatization process reinforces the social exclusion that poor people or those belonging to an ethnic minority may already suffer.

Finally, from an ethical perspective, people should not be blamed nor stigmatised for making choices that are influenced by factors that are beyond their personal control. It

is necessary to consider that ‘what choices one makes depends on what choices one has’ (Venkatapuram 2011, 22) before holding people morally responsible for adopting certain behaviours. Therefore, the behavioural approach implies a morally questionable situation by holding people responsible for situations that go beyond their control. As long as the structural links remain invisible to people’s eyes, so will the injustices that this approach implies, and the low probabilities for the population to demand health justice.

In conclusion, the conception of ‘health behaviour’ or ‘lifestyle’ associated with the behavioural approach and neoliberal policy regimes suffers from important limitations when explaining health disparities between individuals and social groups. This ‘victim blaming ideology’, as Crawford (1977) calls it, considers individual behaviour in a vacuum, ignoring and minimizing the relevance that social, cultural and environmental factors, among many others, have on shaping individuals’ decisions (Crawford 1977; Minkler 1999). It ignores that ‘lifestyles are not random behaviours unrelated to structure but are typically deliberated choices influenced by life chances’ (W. Cockerham, Rütten, and Abel 1997, 325), meaning that lifestyles are mainly shaped by choices that are taken within a context determined by chance. Thus, the possibility that individuals make decisions influenced by their life chances, raises the relevance that social structure has on shaping ‘risky behaviours’, a central aspect defended in this thesis. The following section will be focused on the social determinants of health approach and will argue how social structure influences health-related practices and how health disparities should be explained with constant reference to people’s social context.

2.2.2 Social Determinants of Health: the importance of the social context

The second main approach used to explain health disparities and why people from different social groups engage in different behaviours is the social determinants of health approach. It is characterised by analysing the way in which different social factors, which are determined by the individual's relative position in society, are related to problems of ill-health and differences in mortality between social groups (Sadana et al. 2011, 10). It is an attempt to find the cause of causes, not only the causal relation between certain behaviours and health conditions (Marmot and Wilkinson 2006). This section will firstly explain the meanings of these core arguments and the evidence that supports them, and then to analyse the main theoretical streams that explain how inequalities in social structure are translated into health inequity. It closes with the identification of areas of uncertainty that inform the research question.

Health-related practice and health chances

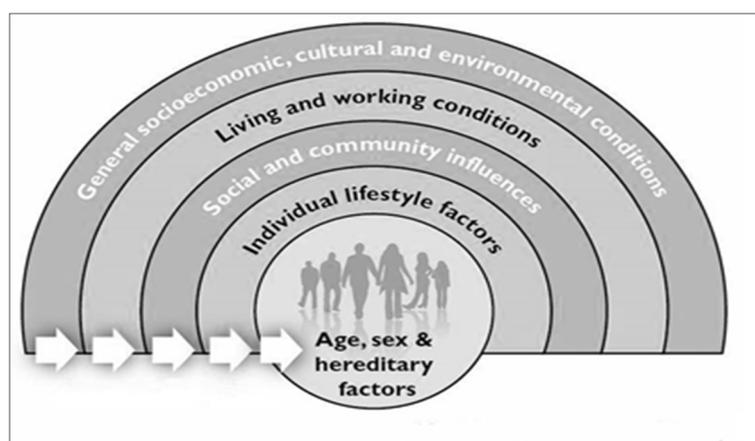
Through the study of the data from the Whitehall study of British civil servants, a social gradient was identified regarding mortality and morbidity, showing worse health outcomes as the social position lowered (Marmot et al. 1978; Marmot 2006). This pattern has been found in other countries as well (Marmot et al. 1991). The main importance of this phenomenon is that 'the social gradient in health is not confined to those in poverty. It runs from top to bottom of society, with less good standards of health at every step down the social hierarchy' (Marmot 2006, 2). Therefore, health inequalities are not only a problem of absolute deprivation but it is also sensitive to the relative positions that individuals occupy within the social structure.

The presence of this health social gradient is explained by the presence of intermediary factors between the social position and the distribution of health and wellbeing which have proven to be related to the health inequity that takes place between social groups. Some of these factors are living under stressful circumstances, working in a stressful place, being unemployed, experiencing food insecurity, living in a country with high income inequality, years of education, experiencing poor early life conditions including prenatal and early postnatal life, being socially excluded, having lack of social support, as well as the exposure – mainly of children – to advertisements for fast-food (Marmot and Wilkinson 2006; Marmot and Wilkinson 2003; R. Wilkinson 1992; R. G. Wilkinson 1996; R. Wilkinson 1997; R. Wilkinson and Pickett 2009; Bartley, Blane, and Davey-Smith 1998; Barker 1991; Subramanian and Kawachi 2004; WHO - CSDH 2008; The Lancet 2003; Hastings et al. 2003; Ashton 2004). While some of these factors make reference to the importance that material living conditions, such as living in poor conditions, have on health outcomes, others point toward a more psychological and social dimension, such as working under stressful circumstances or being socially marginalised. This approach states that ‘it is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatised also matters’ (Marmot and Wilkinson 2003, 9). Thus, health inequalities are not primarily a product of the individual’s agency, but rather a consequence of the unequal distribution of material and non-material resources implied by the social structure and are, therefore, unfair.

Dahlgren, Göran and Whitehead (1991) developed the widely used rainbow model to illustrate the main influences on health and how these are situated in different levels (Figure 1). They state 4 different levels; firstly there are major structural environment

factors, such as economic strategies and tax policies that affect individual's health. Then they identify the material and social conditions in which people live their lives and carry out their daily activities, which are determined by social security, health sector and labour regulation, among other factors. The third layer illustrates social and community relations, making reference to the importance that mutual support has on defending individuals against health hazards. In the fourth place, the authors identify individual lifestyles and attitudes, that is, the actions taken by individuals. Finally, they also take into consideration individual constitutional factors, such as age, sex and genetic history.

Figure 1: The main determinants of health



Source: <http://www.health-inequalities.eu/HEALTH/EQUITY/>

This model reveals the interdependent character of the different layers of the determinants of health, being not only a very good tool for policy planning but also very useful to understand the importance of the broad context. It may be seen that under this comprehension behaviours, such as smoking and diet, should be analysed and considered within the context in which they take place.

Studies have shown that 'lifestyles' are not randomly distributed; they 'cluster together in certain individuals' (Contoyannis and Jones 2004, 966; Marmot and Wilkinson 2003). This clustering is related to factors such as socioeconomic level, gender, and race, implying that 'health behaviour' is influenced by dimensions of social structure. Individuals that are socially marginalised or excluded, have a higher tendency to develop addictive behaviours and inadequate food intake practices as a way to 'numb the pain of harsh economic and social conditions' (Marmot and Wilkinson, 2003, p.24). Social class has been one of the most widely explanatory factors used to understand health inequality and differences in behaviour. Several studies have shown a social gradient regarding health behaviour; as the socioeconomic status of people decreases, individuals present higher rates of smoking and problematic alcohol consumption, lower rates of physical activity, infrequent medical check-ups and unhealthier diets (Adler et al. 1994; Cutler and Lleras-Muney 2010; Doorslaer and Jones 2004; Marmot, Rose, and Shipley 1984; Marmot 2005; Park and Kang 2008; Webbink, Martin, and Visscher 2010). This gradient is accompanied by a health gradient in which the lower the people are located in the social ladder, the more probable it is that they suffer from non-communicable forms of ill-health.

Since 'lifestyles' have proven to be related to people's context and social position, the accuracy of this term is questioned. As it will be discussed in more detail in the next section of this chapter, the terms 'lifestyles' or 'risky behaviours' must be replaced with concepts that are able to reflect the social character these practices have. This research adopts the term 'health-related practices', to make reference to practices that may or may not have consequence on health outcomes (e.g. diet, smoking, exercise), which are socially embedded and dependent both on agency and social structure, i.e. choices and chances.

How does inequity 'get under the skin'?

Within the social determinants of health approach, there are three main theoretical approaches that explain how the unequal distribution of resources implied by the social structure is translated into health disparities.

The first of them is the psychosocial theory, which explains the impact of income inequality on health in biological terms. Its main representative, Wilkinson, states that 'the link between equity and health is largely a psychosocial link [which] means that the scale of income differences and the condition of a society's social fabric are crucially important determinants of the real subjective quality of life among modern populations' (Wilkinson 1996, 5–6; Marmot and Wilkinson 2006). He argues that Wilkinson and Pickett analyse how the most powerful sources of stress, a factor that influences physiological systems, are low social status, lack of friends, and stress in early life (Wilkinson and Pickett 2009). Therefore, the way in which people are perceived and evaluated by others has an impact on their health from the stress and anxiety this evaluation produces.

This approach states that rising income inequality and the way people perceive it through wider social status differences may increase anxiety; 'greater inequality seems to heighten people's social evaluation anxieties by increasing the importance of social status' (Wilkinson and Pickett 2009, 41). As well as generating strong levels of anxiety, income inequality and social status differences deteriorate community life, produce chronic stress, increase rates of obesity and levels of violence, among other negative impacts, all of which affect health through a psychosocial mechanism. The comparisons made by individuals that have different social status, together with low levels of social trust and cohesion, generate a chronic stress through certain biological

responses that finally trigger poor health conditions and death (Wilkinson 1996). This way, social differences that situate some individuals above others in the social ladder would be responsible for generating negative psychological effects on the disadvantaged ones that are finally embodied in physiological responses. Wilkinson states that the psychological burden imposed by non-egalitarian society is translated into a deterioration of the well-being of the whole society as well as an increase in social problems (Wilkinson 1996; Wilkinson and Pickett 2009; Wilkinson and Pickett 2015), which is why health inequity does not exclusively affect poor people.

The second theoretical stream that explains how social inequality is translated into health disparities is the life-course approach, which argues that health inequities are a product of the different accumulation of exposures and experiences that individuals have throughout their lives (John W Lynch et al. 2000; J. Lynch and Davey Smith 2005; Davey Smith 2003). This perspective 'examines a range of potential processes through which exposures acting at different stages of life can, singly or in combination, influence disease risk' (Lynch and Davey Smith 2005, 5; Davey Smith 2007). In other words, it considers the effects that early life conditions and experiences may have in later life health outcomes. What this argument states is that people's present and future health outcomes may be seen as a result of the accumulation of advantages or disadvantages associated with the social context in which biological development takes place, throughout the life-course; 'the social is, literally, embodied; and the body records the past' (Blane 2006, 54; van de Mheen, Stronks, and Mackenbach 1998).

The social context within which individuals develop their lives determine the different types of exposures, i.e., advantages or disadvantages, that they will experience both cross-sectionally and longitudinally (Blane 2006; Lynch and Davey Smith 2005). On

the one hand, advantages or disadvantages are frequently clustered and reflected in diverse spheres; those individuals with lower socioeconomic status, generally have a lower educational level and have access to only poor quality employment, which leads them to have poor housing and develop worse health outcomes. On the other hand, they are also usually preceded or succeeded by similar situations in other moments of their life-course; individuals that are raised and grow up in an affluent environment generally have higher educational levels, which allow them to access secure and well-paid employment, good quality housing and better health schemes. Thus, social inequalities do not only have an immediate effect on health, but also an important cumulative impact.

Finally, the neo-materialist explanations or political economy of health are focused on ‘what affects the social determinants of health’ (Schrecker and Bambra 2015), that is, what produces the different social factors that impact health. Representatives of this stream have criticised the psychosocial theory for focusing too much on psychosocial mechanisms and income inequality, and neglecting the importance of the determinants of relative inequality and social status (Coburn 2004; Coburn 2006; Lynch et al. 2000; Lynch et al. 2004). In other words, neo-materialist researchers state that it is necessary to analyse the social causes which determine the income inequality which in turn produces health inequity as well as the presence of other forms of health-relevant social inequalities stated by the life-course perspective. Through a systematic revision of the empirical evidence regarding the links between income inequality and health, Lynch et al. (2004) conclude that ‘it may not be income inequality per se or the quality of the psychosocial environment that drives population health. Rather, what may be most important is the current and historical links between income inequality and the

levels and social distribution of health-relevant resources and exposures and how these have played out over the life-course of different birth cohorts' (2004, 68). Income distribution is considered a consequence of historical, cultural, and political-economic processes that not only influences how many resources people own but also determines the state of public infrastructure, i.e. education, health services, and transportation amongst others (Lynch et al. 2000). Thus, even when the psychosocial consequences of inequality are relevant to health, it is necessary to analyse what the structural origin of income inequality is (Navarro and Shi 2001; Coburn 2004; Raphael 2012).

According to this approach, 'many other material factors, and their interpretation or imputed meaning, rather than simply income inequality, are central determinants of health inequalities' (Coburn 2004, 53; Lynch et al. 2000). All of these factors are determined by social, political and economic structures, which is why the political economy that a country adopts is a crucial element. According to the data analysed by Navarro and Shi (2001) as well as Coburn (2004), political parties and the policies that governments implement have a direct impact on health equity observed in both infant and adult mortality. They found that societies that have a neo-liberal regime, with high degrees of commodification and market-dependency, have worse health outcomes than social democratic societies, characterised by emphasising citizens' rights and having very low levels of social inequality. Coburn concludes that 'using data from the OECD, in all cases the social democratic nations show better general measures of health than do the liberal nations, although in some instances the differences are small' (Coburn 2006, 74). In this sense, the regime type and political economy of societies have an important impact on health outcomes, not only by determining the degree of

income inequality that is tolerated, but also all the other social inequalities that are relevant for health.

In conclusion, social inequalities may be embodied and translated into health inequalities through different pathways: psychosocially, materially and through the accumulation of advantages or disadvantages throughout the life-course, which are in turn determined by a country's political economy. Even when it is shown how important social context has in influencing health inequalities, it does not provide enough information regarding the real possibilities that people have to choose their health-related practices. More evidence is still required to resolve the tension existing between the behavioural approach and the social determinants of health perspective in relation to these practices. In other words, it is necessary to explore the extent to which people's health-related practices are a product of free choice, and how far are they influenced by aspects of social structure, such as income inequality, life-course disadvantages, and education. This is why this thesis aims to explore the mechanisms through which the structure influences the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal country such as Chile. The comparison between the middle and lower socioeconomic groups allows the observation of the present social health gradient which has an impact not only in the poorest groups, but also those located at the centre of the social ladder. Chile was selected as a case-study due to its recognised neoliberal policy regime (Harvey 2005) which emphasises freedom to choose and individual responsibility alongside its high levels of economic and social inequality, social factors that have proven to have a negative impact on health. The case selection will be explained in detail in Chapter 3.

2.3 Health choices according to health chances: Conceptual Framework

The discussion about ‘lifestyles’ or ‘health-related practices’ and their impact on health inequity is based on the sociological debate about agency and structure. Max Weber’s notion of lifestyle argues that these are mainly shaped by people’s choices which are taken within a context that is determined by chance (Weber 1978). The relevance of this conceptualisation is twofold. On the one hand, by recognising the importance that choices (agency) and chances (social structure) have on people’s practices, it reveals the need to consider both dimensions in order to understand why people engage in different behaviours. As stated by Cockerham et al., ‘it is clear that Weber did not regard lifestyles simply as a matter of choice, nor did he ignore the structural conditions necessary to support a particular lifestyle’ (1993, 417). On the other hand, due to the fact that choices are determined by chances, people’s lifestyles may be considered socially embedded and therefore a social practice (Delormier, Frohlich, and Potvin 2009), which is why the term health-related practices will be used, as explained later in this section.

2.3.1 Social position and the reproduction of social inequality

Social stratification was one of the main dimensions which Weber identified that constrained lifestyles choices; ‘the life chances that enhance participation in health lifestyles are greatest among upper and middle socioeconomic groups who have the best resources to support their choices’ (Cockerham et al. 1993, 418). This implies that the distribution of resources, which is determined by the political economy, has a direct impact on people’s choices by defining individuals’ structural positions. One of the main sociological theories about the importance of people’s social location and its

relation to actions or practices was developed by Bourdieu (1977, 1984). As it will be argued, Bourdieu's social theory on reproduction of the social structure and social practice is a very good approach to understand the tension between choices and chances, i.e. agency and structure, that underlies the research question. Even though Bourdieu did not explicitly analyse health, his theory of capital and the reproduction of social structure has been widely used by researchers of health inequalities (S. Williams 1995; Gatrell, Popay, and Thomas 2004; Carpiano 2007; Singh-Manoux and Marmot 2005; Veenstra 2007; Abel 2008; Pinxten and Lievens 2014; Blaxter 2010; Shilling 2003)

According to Bourdieu, people's location within the social structure depends on the distribution of different types of capital which 'represents the immanent structure of the social world' (Bourdieu 1986, 242). He recognises three types of capital: economic, cultural and social (Bourdieu 1986). Economic capital makes reference to income and wealth; anything that can be converted immediately into money, such as property. Cultural capital, which may exist in the embodied, objectified and institutionalised state, refers to 'long-lasting dispositions of the mind and body (...); cultural goods; (...); and educational qualifications' (Bourdieu 1986, 243) respectively. Finally, social capital is the actual or potential material and non-material resources that people have from the fact that they belong to a network of social relations, and how this belonging may be translated into benefits. These different types of capital are interrelated and may all be converted into economic capital, with varying degrees of difficulty.

A person's social location would define what Bourdieu calls 'habitus', i.e. 'systems of durable, transposable dispositions, structured structures predisposed to function as

structuring structures, that is, as principle which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attend them' (Bourdieu 1990, 53). This means, firstly, that the habitus engenders the dispositions, that is, thoughts and perceptions that give meaning and sense to the existent conditions and practices, in this case, health-related practices. These dispositions are embodied and are experienced by people as 'natural' ways of thinking and acting. Since they depend on the individual's social position, those who share the same habitus, have similar dispositions, thoughts and perceptions (Bourdieu 1984, 173), e.g. similar health-related practices.

Secondly, Bourdieu states that the habitus produces the practices that make sense according to the dispositions, therefore, reproducing itself. This 'structuring structure' 'tends to generate all the 'reasonable', 'common-sense', behaviours (and only these) which are possible within the limits of these regularities, and which are likely to be positively sanctioned because they are objectively adjusted to the logic characteristic of a particular field, whose objective future they anticipate' (Bourdieu 1990, 55–56). The habitus produces practices that make sense within the 'natural world view' and the objective limits, reinforcing or structuring individuals' predisposed dispositions and generates a 'stylistic affinity' (Bourdieu 1984, 173) since they are similar among individuals of the same habitus.

In accordance with this theory, health-related practices are situated in the unconscious of individuals, implying that people's actions do not respond necessarily to a health concern, but rather on what is obvious to them according to their worldviews and perceptions; they follow their own practical knowledge, which reproduces the

structure and dispositions created by the habitus. Bourdieu calls this the ‘feel for the game’ which he defines as ‘what gives the game a subjective sense – a meaning and a *raison d’être*, but also a direction, an orientation, an impending outcome, for those who take part and therefore acknowledge what is at stake’ (Bourdieu 1990, 66). However, this ‘investment’ would be an illusion since it never becomes conscious for the agents involved in the practices. The practical knowledge and belief that guides and gives sense to health-related practices is internalised in such an unconscious way, that it is embodied and is described by Bourdieu as ‘a state of the body’ (1990, 68). This means that the actor’s practices are unconsciously oriented towards the reproduction of his or her conditions and predispositions, and therefore, the social structure.

One way through which Bourdieu states that habitus and practical knowledge orient practices is taste. Taste is considered to be ‘the propensity and capacity to appropriate (materially or symbolically) a given class of classified, classifying objects or practices, is the generative formula of life-style, a unitary set of distinctive preferences which express the same expressive intention in the specific logic of each of the symbolic sub-spaces, furniture, clothing, language and body hexis’ (Bourdieu 1984, 173). People act according to their tastes, to their preferences, which have a symbolic and distinctive character and operate in an unconscious and determined way that they ignore. This would mean that people’s choices are not undetermined preferences, even though they may be experienced as such, but they rather respond to necessities structured by the habitus which is determined by people’s social location or possession of the different types of capital. Bourdieu states that taste ‘functions as a sort of social orientation, a ‘sense of one’s place’ guiding the occupants of a given place in social space towards the social positions adjusted to their properties, and towards the practices or goods

which benefit the occupants of that position' (Bourdieu 1984, 466). An example of this is Bourdieu's observation about the different sport preferences between working class and professional class individuals (Bourdieu 1984). While the first showed a tendency to prefer sports that are popular and accessible to all social classes, such as soccer, the second were more interested in those activities that required investing not only money, but also time and training, such as golf. By engaging with these health-related practices, both social classes reproduced the structure.

To sum up, following, Bourdieu's theory, health-related practices would be determined by the habitus, that is to say, by the social structure that reproduces itself in those actions. Williams defines health-related behaviour as 'a largely routinized feature of everyday life which is guided by a practical or implicit logic' (1995, 583). People are not aware of the meaning or significance of health behaviours since these are embedded into their daily life and, therefore, are not a matter of reflection or questioning. In this sense, health-related behaviour acquires different meanings to individuals, depending on their habitus and taste, all of them 'caught up in struggles for social recognition and distinction' (S. Williams 1995, 599) which remains in the unconscious of individuals.

2.3.2 Is there space for agency? Analytical Dualism

Even though Bourdieu's theory provides powerful insights into the way in which the social structure shapes people's practices, it has been criticised for being over-deterministic. The fact that 'the true explanation for actors' behaviour is seen to reside in the mysterious, murky depths of the habitus and, as a consequence, 'choice' is largely underplayed' (S. Williams 1995, 588) leaves little space for agency, innovation or resilience. Williams argues that according to Bourdieu's theory, 'change' is only

possible within the limits of the habitus, in other words, when people are disposed to do so; when change occurs, it happens in line with the habitus (S. Williams 1995, 591–592). Therefore, it would not be expected for individuals to engage with health-related practices that do not make sense within their habitus.

Understood in this way, this approach implies that social phenomena may be explained by making exclusive reference to society and neglecting the role, meanings, or motivations that individuals may have to engage or not with certain practices, in other words, it suffers from what Archer calls ‘downward conflation’ (Archer 1995). Thus, social action would be subsumed and determined completely by social structure, ‘whose holistic properties have complete monopoly over causation, and which therefore operate in a unilateral and downward manner’ (Archer 1995, 3). The power of agency and the reflexive nature of human beings would disappear under the action of social structure, which is a miscomprehension of human nature and society according to Archer, who argues that the power of agency that human beings have must be included in any social theory since it has the potential to modify social structure:

People are indeed perfectly uninteresting if they possess no personal powers which can make a difference. Of course, if this is the case then it is hard to see how they can offer any resistance, for even if it is ineffectual it has to stem from someone who at least amounts to the proportions of an irritant (and must thus be credited minimally with the personal power of challenge) (Archer 2000, 19)

According to Archer (1995), a strong representative of critical realist approach (discussion in Chapter 3), structure and agency must be considered as different

dimensions. Due to the fact that each of them has autonomous emergent properties, i.e. ‘powers or liabilities which cannot be reduced to those of their constituents’ (Sayer 1992, 199) they cannot be considered simultaneous or co-extensive in time. This implies a relation between these two dimensions that could be described in the following way:

... systemic properties are always the (‘macro’) *context* confronted by (‘micro’) social interaction, whilst social activities between people (‘micro’) represent the *environment* in which the (‘macro’) features of systems are either reproduced or transformed [author’s emphasis] (Archer 1995, 11)

In this sense, both dimensions are different but not independent from each other. In accordance with this approach, structure and agency are interdependent; social structure sets the necessary context and space for human actions to develop, and these actions are responsible for setting the necessary conditions for structure to continue existing, be it in the same way (reproduced) or in different forms (transformed). This would mean that it is people’s actions that have the power to change or reproduce ‘habitus’, rather than habitus reproducing itself. However, this structure influences the possibility of agency by defining the context in which people’s practices are enacted.

Alternative social theories argue that the adoption of health-related practices may be understood as an individual free choice according to the possibilities that people face daily, that is, their ‘capabilities’ (Sen 1999). The possibility to choose a ‘minimally good, flourishing and non-humiliating life’, i.e. the capability of being healthy, would depend on the internal dispositions of the person, and the constraints and autonomies that social arrangements imply (Nussbaum, 2011a, 2011b). Hence, the adoption of certain practices related to health would depend on the freedom to choose that agents

have within the limits of the opportunities guaranteed by societies. However, this theory would not provide an answer to Bourdieu's conceptualization of practices, which as explained previously state that the logic for people's actions remains in the unconscious of individuals and are not a matter of reflexion or questioning (Bourdieu 1990). This is the reason why this research turns to Archer's approach on the structure-agency debate.

Archer's analytical dualism poses a criticism to Bourdieu's conceptualization of practices, which as explained previously state that the logic for people's actions remains in the unconscious of individuals and are not a matter of reflexion or questioning (Bourdieu 1990). Archer's opposing argument states that practice is:

‘the source of differentiation (of the self, subject/object, subject/subject), then the source of thought (the basic principles of logic, namely identity and non-contradiction), and thus makes practice the *fons et origo* of language and the discursive domain in general’ (Archer 2000, 151).

This implies that practices are closely related to human reflexivity and hold meanings which are comprehensible to human beings and are not determined by the context, even though contextual dimensions influence the possibilities of action that people have. This means that even when it would be correct to suggest that habitus has an important impact on agency, it would be a mistake to believe that habitus may only be reproduced by itself. The social structure – habitus – is modified or reproduced by people's actions – agency.

With the conceptualization of structure and agency, the dimension of temporality is useful in order to comprehend their relationship. Since the structure is considered the context in which human action takes place, it is implied that structures ‘pre-exist’

people This does not mean that individuals are determined by the structure, since they are able to modify or reproduce it, but it does set limits to the possibility of actions (Archer 1995, Danemark et al. 2002). This criticises Giddens' theory of structuration which also tries to bring the concepts of agency and structure together. His theory states a duality between agency and structure by arguing that these dimensions are placed in a reciprocal relationship in which neither of them can exist independently from the other (Giddens 1984). Agency and structure would not only have autonomous emergent powers, but they would also have a time gap between them, they would not be simultaneous in time. Therefore, this model of interpretation resolves the tension between structure and agency by recognising their interdependency through the incorporation of time, and states that the proper way to study their interaction is through a social scientific analysis (Danemark et al. 2002).

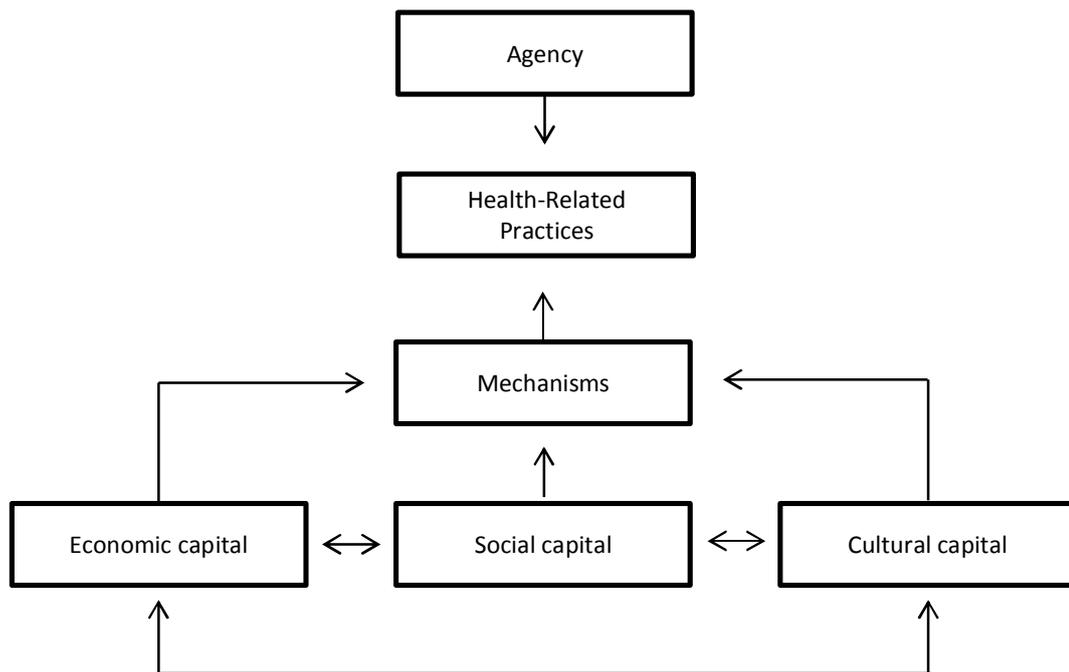
2.4 Connecting the Literature to the Research Framework

Figure 2 illustrates the analytical framework used in this research that emerges from the theory and the main concepts involved. It shows how the ultimate phenomena to be explained are health-related practices, which is why this section begins by defining how this research will define health-related practices.

Health-related practices as a term is preferred over 'lifestyles' which implies a close relationship with behavioural explanations centred on the individual and on agency. This concept may be theoretically understood as the result of the dispositions, determined by people's habitus, i.e. the economic, social and cultural capital, and their reflexive nature, which are translated into practices that may or may not have consequence on health outcomes. Health-related practices are socially embedded and dependent both on agency and social structure, i.e. choices and chances. This implies,

on the one hand, that what may be seen as ‘irrational’ behaviour in certain social circles could symbolise status or strength in others. For instance, the higher presence of behaviours such as consuming alcohol in great amounts among men could be understood as a way to socialise and express their masculinity, i.e. to accomplish social expectations that imply that alcoholic drinks are mainly for men since they are supposed to be biologically stronger. On the other hand, this definition does not reduce the enactment of these practices to structural influence. It recognises the impact that the meanings – which depend both on habitus and reflexion – that people give to these actions are constitutive of health-related practices. This means that health-related practices may reproduce or modify the structure through its interplay with agency. It is important to state that this research is focused mainly on four health-related practices – diet, smoking, exercise, and alcohol intake – since these are ‘usually thought of as most clearly ‘voluntary’, and undoubtedly associated with health’ (Bartley 1990, 113), therefore, the most relevant actions to observe the interplay between agency and structure.

Figure 2: Analytical Framework



Source: Prepared by the author

In turn, people's chances (structure) will be studied as a result of their possession of the different types of capital argued by Bourdieu's theory (1986): economic, social and cultural (Figure 2). Specific dimensions from these forms of capital will be researched in order to identify the mechanisms through which structure influences the space for agency that people from different social groups have over their health-related practices. In this research, economic capital will be understood as those resources that may be 'immediately and directly convertible into money and may be institutionalised in the forms of property rights' (Bourdieu 1986, 242). This dimension also includes people's employment conditions since they are the main source of income that individuals have due to the commodified character and market dependency characteristic of Chilean society. Economic capital will also be called 'material

circumstances' since it is related to the access that Chileans have to material dimensions.

The second dimension studied, social capital, may be considered one of the most contested concepts within Bourdieu's differentiation of capital. The use of this concept differs according to disciplines; for instance, while sociologists usually emphasize its structural variables, i.e. networks and organizations, psychologists emphasize the attitudes involved in it, such as trust and norms of reciprocity (Blaxter 2001). Different aspects and levels of it are emphasized; while some of the definitions are more centred on the utilitarian aspect of it and its relation to socioeconomic status (Bourdieu 1986; Coleman 1988) others put their emphasis on its public and civic aspect (Putnam et al. 1993; Putnam 2000). This research remains close to Bourdieu's definition of the concept, which states that social capital is the resources (actual or potential) to which individuals have access to due to their participation in a 'durable network of more or less institutionalized relationships of mutual acquaintance and recognition' (Bourdieu, 1986, p. 248). Each social network has its own structure, which is mainly defined by the ties, links and ways in which these are arranged. The way in which social networks are composed and the main characteristics of the ties may be understood as their 'connectedness' (Hall and Taylor 2009, 87). This research analyses social capital in terms of social networks' connectedness in two main dimensions: composition and heterogeneity.

The composition of the social network makes reference to the people's contacts, that is, who people consider part of their social networks (Hall and Taylor 2009), e.g. family, friends, neighbours, etc. It also identifies the main actors and the frequency with which their ties are activated. The heterogeneity of the network is understood as

how similar or different the characteristics of the actors included in it are. While some networks are characterised by being exclusive and homogeneous, such as families and friendships, others are more inclusive and heterogeneous, such as voluntary associations. This difference is known as bonding, bridging or linking social capital (Szreter and Woolcock, 2004). Each of these terms makes reference to different types of composition, which mainly affects what type of resources their members have access to. . Those networks that are mainly composed by individuals considered to be similar (e.g. socioeconomic condition, culture, history, practices) are defined as bonding social capital. In turn, bridging social capital is used to describe social networks whose members are different from each other and have heterogeneous backgrounds. Finally, the term linking social capital makes references to networks that are made up by individuals that relate to each other ‘across explicit, formal or institutionalized power or authority gradients in society’ (Szreter and Woolcock, 2004, 655).

The third type of capital analysed in relation to health-related practices is cultural capital. This term makes reference to the possession of symbols and valued information, such as institutional knowledge, cultural goods, linguistic styles, attitudes and behaviour, which are acquired through formal education and socialization (Bourdieu 1986, Abel 2008). The amount of cultural capital that people have is seen on their knowledge of health-related practices as well as the value given to these. Following Bourdieu, cultural capital may be found in three forms: embodied, objectified and institutionalised (Bourdieu 1986). This research is focused mainly on its embodied state, that is, ‘dispositions of the mind and body’ (Bourdieu, 1986, p. 243), analysed through health-related values, behavioural norms, knowledge and skills

(Abel 2008, 2). The values and norms given to health-related practices are essential to understand the mechanisms that underlie these actions.

As Figure 2 shows, the different types of capital are correlated with each other. According to Bourdieu, 'economic capital is at the root of all other types of capital' (Bourdieu 1986, 252). This means that social and cultural capital can be converted, with more or less difficulty, into economic capital. However, economic capital can also be translated into cultural capital such as in the case of a professional degree, which has to be paid for. Additionally, cultural capital may also have impacts on social capital: by attending a university, people create new social networks, thus, increase their social capital. Therefore, this dissertation considers that 'economic, social and cultural resources are correlated and feed on each other' (Abel 2008, 2)

Therefore, Bourdieu's social theory on reproduction of the social structure and social practice, and Archer's analytical dualism theory, are combined to create the analytical framework used to answer the research question about how much agency people from different social groups have over their health-related practices.

Finally, it is necessary to mention the study case upon which this research is based. As will be explained in the next chapter, Chile was chosen as the case-study to answer the research question. In light of the discussion about social determinants of health, this country becomes relevant for different reasons. Firstly, it is a country that presents a social health gradient regarding health conditions commonly associated with health-related practices, such as high blood pressure and obesity (Larrañaga 2005). Secondly, Chile is recognised worldwide for being a landmark example of a state guided by a neoliberal policy regime (Taylor 2002, 2006) as will be seen in more detail in Chapter 4. Therefore, it constitutes an ideal case to study the effect that a neoliberal political

economy and the values of individual freedom and responsibility have on the extent to which people from different social groups choose their health-related practices. Thirdly, in 2013 Chile was categorised as a high-income country due to its high income per capita (Jim Yong Kim 2013; <http://data.worldbank.org/country/chile>). This fact, alongside its high economic inequality (OECD 2011, Ministerio de Desarrollo Social 2011) – a fourth reason for the choice - allows the testing of the three main theoretical approaches of the social determinants of health approach on an emergent economy.

2.5 Conclusion

In a context in which health conditions are related to behaviour, this chapter has discussed the main theories that have sought to explain why individuals from different social groups enact different health-related practices and to what extent they choose these practices. After examining the direct behavioural approach and its close relation to neoliberal values, its flaws in practical, moral and theoretical terms have been shown. One of the main criticisms is the centrality it gives to agency while obscuring the importance of structure, i.e., for considering individuals exclusively responsible for their practices and choices without considering their constraints and chances. Following this discussion, the social determinants of health approach becomes a more satisfactory alternative to answer the research problem, since it recognizes that the chances that people have to behave in a way that protects health or to engage with healthy health-related practices are different. Individuals' practices cannot be understood as a mere product of agency and choices since aspects such as income inequality, living conditions and education level have a strong relation to people's behaviour and health outcomes. People's access to public infrastructure (health care, education, pensions, etc.) as well as the resources they own (economic, cultural and

social capital) and their exposure to media and advertising influence not only their health status but also the practices they enact.

However, as discussed, research conducted within the social determinants approach does not give enough attention to examining the extent to which people's health-related practices are a product of free choice and how far they are influenced by aspects of social structure. This dissertation analyses this tension between choice and chances under a theoretical framework that combines Bourdieu's social theory on reproduction of the social structure and social practice and Archer's analytical dualism. By adopting this conceptual approach to analyse the data collected on Chile, this dissertation aims to contribute to the structure-agency debate that underlies the different health-related practices that individuals from different social groups engage in, and provide evidence that could be used by policy makers when creating programs that aspire to reduce health inequity in Chile and other developed countries.

Having explained the analytical background that is used to analyse the research problem, the next chapter discusses the methods used in this thesis. It explains the ontological and epistemological principles of critical realism on which the analysis is based, and the methodology adopted for this research. It also contains a detailed explanation of the methods used to collect and analyse the empirical data.

CHAPTER 3 - METHODOLOGY

3.1 Introduction

This chapter outlines how this research was designed and applied to the research question:

Through which mechanisms does the structure influence the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal country such as Chile?

It discusses the methodological principles on which the research is based as well as the decisions made on how to collect and analyse the data necessary to answer this question.

Initially, it reviews the two most frequent methodological strategies used in previous health inequality research, that is, the positivist and interpretivist approach. Their main advantages and disadvantages are analysed, showing how their ontological and epistemological principles leave areas of uncertainty that remain under-researched: the ‘interplay between structure and agency’ (Archer 1995) present in the enactment of health-related practices. The partial knowledge that each approach provides to this sociological problem not only justifies the research question but also the adoption of a critical realist approach. This epistemological approach argues a stratified and differentiated reality constituted by social systems that are open, due to the fact that they are not only made up of structures, but structures and people, as will be explained later in this chapter (Bhaskar 2008; Bhaskar et al. 1998; Archer 1995; Sayer 1992; Sayer 2000; Danemark et al. 2002).

After discussing the philosophical principles on which critical realism rests, the chapter analyses the adequacy of different social research methods to study social reality in general, and the present research question in particular. Once the advantages of combining an extensive and intensive approach are argued and justified, the case-study is presented and described, followed by a detailed discussion of the research design, along with the data collection and analysis processes.

3.2 Review of previous approaches and methods used in health-related research

The epistemological approach and research methods used in this research will be explained in light of the main methodological limitations observed in previous health-related research. This is why a review of positivist and interpretivist research precedes the analysis of critical realism and explains why it was adopted for answering the research questions.

3.2.1 The positivist approach and quantitative analysis

To date, health inequalities have been frequently researched by using two methodologies: positivist and interpretivist (Wainwright and Forbes 2000; S. J. Williams 2003). Even though there are examples of research that combine both approaches (Blaxter 1990), most only adopt one of them. This section will focus on the analysis of positivist research, whereas the next section will be centred on the interpretivist.

Health inequity has been widely researched under a positivist approach through quantitative methods using a positivist approach. Positivism is an epistemological approach that states that ‘only phenomena and hence knowledge confirmed by the

senses can genuinely be warranted as knowledge' (Bryman 2004, 28). From this perspective therefore, social reality is constituted exclusively by everything or anything that can be observed or measured empirically, seeing natural and social bodies as ontologically alike (Wainwright and Forbes 2000; Gorski 2013). Thus, social research should be focused on measurements and quantified observations; if reality is to be accessed, empirical research based on these methods should be used (S. J. Williams 2003, 46). This means that health inequalities exist as long as they are empirically observable or measurable. Positivist researchers working on health inequalities usually aim towards identifying, describing and predicting statistical relations between variables such as class, income, gender and ethnicity, among many others, and indicators of health and well-being, like mortality, morbidity and health-related behaviours (Williams 2003, 45). This explains the use of the quantitative approach as positivism's main research strategy.

Quantitative research, called extensive research by critical realists, is centred on the extent or quantitative dimensions of social phenomena, giving information about how common it is, what its characteristics are, and so on (Sayer 1992; Sayer 2000; Danemark et al. 2002). The research strategy used mainly by positivist researchers is characterised by its emphasis on quantification – both in the data collection and data analysis – and for stating that social reality is external and objective (Bryman 2012). According to quantitative methods, the variable that is to be explained, such as health inequity, becomes the 'dependent variable' which, as its name implies, is affected by or subjected to the 'independent variables', i.e. variables that are expected to be causing the results obtained.

There are a range of examples of health inequality research that follow a positivist approach through quantitative methods. One of the best examples of this approach, as well as one of the most important within the health inequalities field, is the Black Report published in 1980 (Townsend et al. 1992). This work showed that morbidity and mortality – as quantifiable and objective indicators of health or lack of it – were unevenly distributed throughout the British population and that these inequalities had been widening, instead of decreasing, since 1948. Through statistical analysis, the research argued that health inequalities were caused by social inequalities in health-relevant dimensions, being the first report to acknowledge the importance of health inequalities in the UK (Bartley 2004). Similar findings were obtained by the Whitehall Study of British Civil Servants (Marmot et al. 1991) and studies on the social determinants of health. As previously discussed in Chapter 2, this research states that this reality does not exclusively affect people who live in poor conditions, but society as a whole in the form of a social health gradient (Marmot and Wilkinson 2006, 10). This is shown by the authors through a statistical correlation that shows the lower the socio-economic level, the lower the life expectancy.

Another important study using quantitative methods was done by Wilkinson, whose work combines large-scale survey data with psycho-social theories, introducing the importance that variables such as social gradient, stress and social exclusion have in relation to health inequalities and outcomes (discussed in Chapter 2). Wilkinson bases his arguments on statistical work on cross-sectional data from high income countries according to the World Bank's categorization (Wilkinson 1996; Wilkinson and Pickett 2009). Thus, Wilkinson links health inequality with income inequality and lack of social cohesion by developing a thorough quantitative analysis and theoretical discussion.

Finally, health research following a life-course perspective (discussion on Chapter 2) also uses quantitative measurements, ideally from birth cohort studies, to argue that the accumulation of disadvantage throughout life is directly related to health inequality. Through statistical analysis of various sources, life-course researchers state how problems of ill health such as cardiovascular, diabetes and infant mortality are associated with longitudinal measurements of deprivation, ethnicity and education, among others (Davey Smith 2003; Lynch and Davey Smith 2005).

It may be seen how positivist research using extensive quantitative techniques has offered an important and substantial advance in the comprehension of health inequalities. Not only has it identified the importance of the relation between income distribution and health outcomes (Wainwright and Forbes 2000) but it has also developed significant interpretations of the nature of health inequalities. Amongst the most important ones are: the *material explanation*, which states that low income and its concomitants (e.g. poor diet, housing quality, stressful or hazardous work) are responsible for health inequalities; the *cultural-behavioural interpretation* that argues that health inequalities are the product of different beliefs and norms which lead individuals from a lower socioeconomic background to engage with non-healthy practices such as smoking; the *psycho-social thesis*, previously explained in relation to Wilkinson's work; the *life course perspective*, whose central argument is that social circumstances cumulatively influence health over time, even before birth; and finally *neo-materialist* or political economy interpretation, which explains health inequalities in relation to social policies and political processes that affect people's health and social relationships (Bartley 2004).

Even when this research approach has made significant and valuable progress in the understanding of health inequalities, it suffers from important limitations. In the first place, due to the quantitative approach that positivist research has, their explanations are ‘atomistic’ and ‘de-contextualised’, since they study individuals isolated from their social context and social relationships (Popay et al. 1998; Wainwright and Forbes 2000; Williams 2003). The reality in which individuals' lives are embedded and their power relations cannot be comprehensively measured, so cannot be included in statistical models or analysis. Therefore, even when the nature of the methods used allows the useful and necessary identification of relationships between the survey variables related to health inequalities, ‘that relationship exists in the mathematical world of survey statistics and not in the social world which is determined not by numbers but by human relationships and power’ (Wainwright and Forbes 2000, 264). In this sense, while quantitative research may successfully consider the relation between structure and health outcomes, it cannot analyse the impact that different elements of the social context and social relations have on this relationship. This leads to the second criticism of this approach: the lack of complexity in its explanations.

Again in relation to the data with which this approach works, important factors of social life usually remain absent in their explanations of health inequalities. Large-scale survey data are incapable of accessing or measuring social contexts or meanings, which are factors of high importance when analysing health inequalities and social phenomena in general. (Sayer 1992; Popay et al. 1998; Wainwright and Forbes 2000; Forbes and Wainwright 2001). This type of approach ‘remains profoundly non-social – in the sense that it does not explore the complex interactive relationship between individual experience, social action and the way in which societies are organised at a macro level’ (Popay et al. 1998, 68). For instance, it is incapable of explaining why a

disabled person or someone with a chronic health condition might self-rate their health as very good, since it cannot capture the moral meaning that health has (Blaxter 1997; Blaxter 2010) or to understand how people's explanations for their ill-health depend on the context in which they are talking (Blaxter 1990). Thus, the explanations that statistical models or relations can give to health inequalities lack the complexity and depth that exist in people's real lives due to the impossibility of including meanings and the social context of their lives.

The type of analysis done also neglects the presence and importance of agency, as well as its relation to social structure (Popay et al. 1998). It is not possible to measure individuals' possession of critical reflexivity and capabilities for changing or challenging social structures, which, as previously discussed in Chapter 2, is essential for understanding the reproduction or transformation of societies. Quantitative researchers' desire to identify 'laws' and generate models with possibilities for accurate predictions means that the analysis usually operates as if social reality was a closed system, i.e. under the tacit assumption that objects and their relationships are constant, which is a misconception of the social world (Archer 1998; Sayer 1992; Gorski 2013). Individuals' actions are not fully determined by the structure since people have the power of 'reflexivity towards and creativity about any social context which they confront' (Archer 1998, 190). In this sense, even when statistical patterns may be found between socioeconomic situations and health-related practices, such as smoking, they cannot be understood as necessary or static relations since conditions may also change due to human agency. The open character of social systems will be discussed later in this chapter.

3.2.2 The interpretivist approach and qualitative analysis

It is in response to these limitations that interpretivist social research developed, the second epistemological approach frequently used to explain health inequalities. This approach is characterised by the centrality given to meanings of social action (Bryman 2012). Interpretivists argue that social reality is ontologically different from the natural domain, and that social reality is constructed through language (Gorski 2013). Under this approach, health inequalities are understood and analysed according to participants' perspectives, which are accessed through qualitative methods (Wainwright and Forbes 2000). The move from emphasising quantitative data towards the saliency of discourses is due to this approach having different ontological and epistemological perspectives. Interpretivism is based on an ontological construction of the world which believes that 'social properties are outcomes of the interactions between individuals, rather than phenomena 'out there' and separate from those involved in its construction' (Bryman 2012, 266). Therefore, instead of empirically measuring the characteristics of the social world, the role of the researcher is to comprehend the meanings that social reality and social action have through interpretation of people's discourses (Wainwright and Forbes 2000; Bryman 2012). It should be noted that, as previously said, there are researchers that combine both approaches in order to overcome their limitations.

As a consequence of its epistemological principles, interpretivist research is mostly based on a qualitative research strategy. Qualitative methods are characterised by being centred on language and discourse rather than quantification, and for defining social reality as 'a constantly shifting emergent property of individual's creation (Bryman 2012, 36). Within the medical sociology arena, this line of research has

mainly been concerned with lay beliefs and knowledge, as well as experiences and accounts of health and illness (Williams 2003). In order to be able to comprehend these meanings and discourses, with all the complexities they may entail, qualitative studies use a range of methods. Health-related research has employed in-depth interviews, focus groups and participant observation, among other qualitative methods, to address several concerns (Pope and Mays 2006). Through these methods, the researcher accesses individual's discourses and meanings, seeing the world through the participants' eyes (Bryman 2012).

This approach has provided a significant contribution to the understanding of health inequalities through valuable research, such as Cornwell's (1984) and Blaxter's (1982, 1990) studies, discussed in Chapter 2. The way it acknowledges how people from different social groups rationalise and understand health, as well the insight it gives into individuals' inner experience of health inequalities, may be considered its main contribution to the debate (Wainwright and Forbes 2000). These types of explanation cannot be achieved through a positivist approach. It provides understanding of the meanings given to social action and people's social and power relations, and considers the power of agency, providing a deeper comprehension of why health outcomes vary according to social groups.

However, it is not free of limitations. In the first place, it may be argued that people are usually not aware of their social situation and may offer a misleading account of their realities (Wainwright and Forbes 2000; Williams 2003). An example of this is where Blaxter showed that people from the lower socioeconomic group were not aware or conscious that health outcomes from those who were located higher in the social ladder were better than theirs (Blaxter 1990; Blaxter 1997). When lay knowledge is

given a 'privileged' status to understand health inequalities (Popay et al. 1998, 60), an epistemological relativism arises and the explanations given suffer from what Bhaskar calls a 'linguistic fallacy', i.e. a failure to recognise that reality is more than what individuals express linguistically, and from an 'epistemic fallacy', i.e. there is more to reality than interpretative processes (Bhaskar 2008). In other words, when discourses are considered to be the main source of access to reality, it is common to equate reality with what people say or believe it to be, and neglect the structural dimension of social and human life, an aspect that will be discussed later in this chapter.

The limitation of this approach has been criticised for adopting a uni-dimensional perspective which neglects how the context may affect not only people's actions, but also their opinions and experiences. 'Too often the obsession with 'lived experience' blinds interpretivist researchers to the broader social context in which those experiences are played out' (Wainwright and Forbes 2000, 267; Gorski 2013). Thus, interpretivist research that considers the context solely through people's accounts will not be able to identify social forces or underlying mechanisms that are present within actions and meanings, even when they remain in the individual's unconscious.

As well as the absence of the consideration of the broader social context, there is also a methodological consideration of the nature of people's practices and discourse. Bourdieu indicates a serious problem related to individuals' accounts, which respond to the nature of practice (Bourdieu 1977). As was seen in the previous chapter, Bourdieu argues that actions and practices belong to people's unconsciousness; individuals act according to what is natural or obvious to them according to their worldviews, which are shaped by the habitus (Bourdieu 1984; Bourdieu 1990). It is

precisely due to the unconscious nature of the habitus and of the ‘feel for the game’, that individuals cannot give complete and accurate reasons for their actions.

The explanation agents may provide of their own practice, thanks to a quasi-theoretical reflection on their practice, conceals, even from their own eyes, the true nature of their practical mastery, i.e. that it is *learned ignorance (docta ignorantia)*, a mode of practical knowledge not comprising knowledge of its own principles. It follows that this learned ignorance can only give rise to the misleading discourse of a speaker himself misled, ignorant both of the objective truth about his practical mastery (which is that it is ignorant to its own truth) and of the true principle of the knowledge his practical mastery contains (Bourdieu 1977, 19)

Thus, without contextualising individuals’ accounts within the broader social context, it may not be possible to understand which factors are shaping their world-views and structuring their actions. In this sense, this approach suffers from the contrary limitation of the positivist one; it overemphasises agency and neglects structure (Sayer 2000). By understanding reality as a social construction through discourses and meanings, it neglects the interdependency of structure and agency discussed in the previous chapter; ‘social structures do not endure automatically, they only do so where people reproduce them; but, in turn, people do not reproduce them automatically and rarely intentionally’ (Sayer 1992, 96).

As this section has shown, while these two methodologies and methods have offered significant contributions and important advances towards understanding why health outcomes, practices and conceptions are different according to social position, each of

them has substantial limitations. In order to understand the experience of health and health inequity in a neoliberal country such as Chile, it was necessary to develop a methodological approach which enabled analysis of the mechanisms through which structure influences the space for agency that men and women from different social groups have over their health-related practices in their daily lives. Thus, it was essential to incorporate the close and necessary relationship between empirical data and meanings, as well as the 'interplay' between structure and agency over time (Archer 1995). This is why this research adopts a critical realist approach as being most suited to this task. The next section will explain the key ontological and epistemological principles of critical realism, which then leads into an account of the research methods.

Before proceeding into the next section, it is important to state that even when the previous analysis emphasises the limits that quantitative and qualitative research have in terms of their capacity to illuminate elements of the structure and agency that underlie health inequalities, this is done as an analytical exercise. There are no strict boundaries between these research methods in the sense that while quantitative research is able to reveal some elements of agency, qualitative methods can suggest dimensions of the structure. As stated by Popay and colleagues (1998, 636), lay knowledge 'could provide invaluable insights into the dynamic relationships between human agency and wider social structures that underpin inequalities in health'. The unclear boundaries between these two research methods may be seen in different studies of health inequalities centred on the relationship between place and health inequalities and the use of multi-level modelling (Duncan et al. 1993; Pickett and Pearl 2001; Popay et al. 2003; Elliot et al. 2015).

3.3 Epistemological approach and research methods: Critical Realism and Mixed Methods

Following the analysis of the limitations present in the most frequently used methodologies in health-related research, this section argues that critical realism is the most appropriate epistemological approach to answer the research question. The first half is centred on the analysis of the ontological and epistemological principles that characterise this approach and how they have been applied in earlier research focused on health. The second half argues how these principles imply the need to combine intensive and extensive analysis and, therefore, use mixed methods to analyse health-related practices and social phenomena.

3.3.1 Critical Realism: stratified reality and generative mechanisms

Critical realism starts with a question about the nature of reality and how is it related to our knowledge of it (Danemark et al. 2002, 18). Through an analysis of the practice of science, Roy Bhaskar, one of the main proponents of this approach, identified that in order for experiments to be possible, reality must be made of not only experiences and events, but also structures, mechanisms and tendencies ‘by aspects of reality that underpin, generate or facilitate the actual phenomena that we may (or may not) experience’ (Bhaskar and Lawson 1998, 5). This means that reality is viewed as independent from our knowledge of it; our knowledge of the world has no relevance to the way the world actually is. The difference between the objects of science, i.e. the phenomena that we study, and our knowledge about it, i.e. theories and discourses that indirectly connect science with reality, is what Bhaskar calls the intransitive and transitive dimensions of knowledge, respectively (Sayer 2000; Bhaskar and Lawson 1998; Bhaskar 2008; Danmark et al. 2002). In Bhaskar’s words,

Any adequate philosophy of science must find a way of grappling with this central paradox: that men in their social activity produce knowledge which is a social product much like any other (...) This is one side of 'knowledge'. The other is that knowledge is 'of' things which are not produced by men at all: the specific gravity of mercury, the process of electrolysis, the mechanism of light propagation. None of these 'objects of knowledge' depend upon human activity. (...) Let us call these, in an unavoidable technical neologism, the *intransitive objects of knowledge*. The *transitive* objects of knowledge are Aristotelian material causes [author's emphasis] (Bhaskar 2008, 11)

The identification of these two dimensions of knowledge implies that reality is not the same as – and should not be equated with – our experiences and perceptions of it (Sayer 2000), which leads to the statement of a stratified reality. Bhaskar recognises three levels of reality: the real, the actual and the empirical (Bhaskar and Lawson 1998; Sayer 1992; Sayer 2000; M. S. Archer 1995; Danemark et al. 2002; Scambler and Scambler 2013). The *real domain* is made of causal or 'generative mechanisms', which may or may not be activated depending on the conditions in which they work. This means that they exist independently of their effects or activation. When these mechanisms combine and generate phenomena, these become manifest in the *actual domain*; within this strata of reality events take place independently of our experience of them. According to Bhaskar,

The world consists of mechanisms not events. Such mechanisms combine to generate the flux of phenomena that constitute the actual states and happenings of the world. They may be said to be real, though it is rarely that they are actually manifest and rarer still that they are empirically identified by men (Bhaskar 2008, 37)

It is only in the *empirical domain* that we may experience and identify events produced by the mechanisms. This means that it is only in this domain that health-related practices may be empirically observed. In this sense it becomes clear that knowledge cannot be equated with direct experience, which is why studying health inequality and the mechanisms that give place to health-related practices by making exclusive reference to people's accounts may lead to incomplete or mistaken answers. As was previously argued, the mechanisms that shape health-related practices remain invisible for individuals.

However, this does not mean that mechanisms that underlie practices are incomprehensible to people. Causal powers and generative mechanisms 'are not unknowable, although knowledge of them depends upon a rare blending of intellectual, practice-technical and perceptual skills' (Bhaskar 2008, 37). This implies that they are not visible to people in their daily lives, but that they may be observed by analysing social reality with appropriate methods. According to critical realists, events outcomes cannot be deduced or predicted within social sciences (Scambler and Scambler 2013), which is why it cannot aspire to develop or formulate causal laws, i.e. universal empirical regularities, since mechanisms may or may not be actualised. Instead, causal laws should be analysed as tendencies since these are 'potentialities which may be exercised or as it were 'in play' without being realized or manifest in any particular

outcome' (Bhaskar 2008, 40). Lawson goes further and states that empirical relations in the social world are not random and unsystematic, and that it is common to see partial regularities that are relatively stable, such as the health social gradient analysed in the previous chapter. These partial regularities are what he calls 'demi-regularities' or 'demi-regs', which are 'precisely a partial event which *prima facie* indicates the occasional, but less than universal, actualisation of a mechanism or tendency, over a definite region of time-space' (Bhaskar and Lawson 1998, 13; Danemark et al. 2002). Therefore, this research will identify the demi-regularities regarding the difference in health-related practices between social groups in Chile, and explore explanations of the social processes through them.

It is possible to find significant examples of health-related research projects that follow a critical realist approach in the literature. The first of them is Scambler's work on the production and reproduction of health inequality (Scambler 2007; Scambler 2009; Scambler 2012). Through a critical realist approach to class power and the command relations of the state, this author develops the Greedy Bastards Hypothesis. This theory states that 'Britain's widening health inequalities can be seen as largely unintended consequence of the voracious, 'strategic' appetites of a hard core or cabal in its strongly globalised capitalist-executive, backed by its more weakly globalised power elite' (Scambler 2012, 137). Through their influence in the command relations of the state, these capitalist executives create material, social and health inequalities by creating, for instance, new forms of work related to job insecurity and low wages (Scambler 2012).

The second example worth mentioning is Williams' analysis of chronic illness and disability under a critical realist perspective (Williams 1999). He analyses the different

accounts that have been given to the contested nature of body, specifically in relation to chronic conditions and disability, and argues how a critical realist approach may overcome the limitations of postmodern and post-structural definitions of the body and disability. Williams' research states firstly that the body cannot be reduced to the social or vice versa, and secondly, that disability is an emergent property located in the interplay between 'the biological reality of *physiological impairment, structural conditioning* (i.e. *enablements/constraints*), and *socio-cultural interaction/elaboration*' [author's emphasis] (Williams 1999, 810). Thus, his work constitutes a theoretical contribution to medical sociology from a critical realist perspective.

This thesis aims to add knowledge within the field of critical realism methodology and health inequalities and health-related practices. It seeks to contribute to previous health-related research by showing how useful and appropriate the ontological and epistemological principles of critical realism are when understanding and explaining the interplay and tension between agency and structure that underlies health inequity. In other words, one of its objectives is to be an example of how to put into practice, both in terms of research design and analysis, the critical realist approach within the study of health disparities. Additionally, by choosing this approach, the research aims to activate the emancipatory potential of the social sciences. As was previously seen, the reasons that people give for their own actions or the way they experience reality does not always correspond to reality. Acting upon ideas which are not true may have an impact on people's reality, for example, the belief that health inequity is natural rather than socially produced, unfair and avoidable may lead people to see disadvantaged groups' poor health as something that is also natural. It is for this reason that a critical realist analysis of society has an emancipatory potential: 'if one can

demonstrate a systematic connection between inaccurate beliefs and oppressive social structures, then one has not only explained the beliefs but also supplied a motivation for changing the structures' (Gorski 2013, 666–7; Sayer 1992). Through a critical analysis it is possible to make people aware of the inaccuracy of their ideas and beliefs and develop or trigger a phenomenon of 'concientization' that aims to change unequal structures by making people aware or conscious of their oppressive character (Freire 2000).

To sum up, this thesis follows a critical realist approach which is based on the ontological principles of a stratified and differentiated reality, where the social system is made up by the social structure and human agency, which are interdependent realities temporarily separated. The stratified nature of reality and the presence of generative mechanisms that underlie health-related practices bring several challenges regarding research methods that need to be considered. The following section will be focused on this task.

3.3.2 Research methods: extensive and intensive research as complements

Critical realism is not a research method; it is the philosophical basis that sustains the choice of methods for specific research according to the ontological and epistemological principles that it states. However, as a consequence of these principles it is possible to observe the advantages and disadvantages that the main methods used in social sciences, i.e. quantitative and qualitative, have. In this section, these methods will be analysed from a critical realist perspective, in order to then explain how the principles and techniques were applied in this research.

The purpose of social research is to understand and comprehend social phenomena, how and why they change between social groups, and through which processes. This implies a causal analysis that would aim to answer questions such as what ‘produces’, ‘determines’ or ‘enables’ certain social phenomena. In the case of this research, which mechanisms produce health-related practices or how are they shaped. In Sayer’s words,

... on the realist view, causality concerns not a relationship between discrete events (‘Cause and Effect’), but the ‘*causal powers*’ or ‘*liabilities*’ of objects or relations, or more generally their ways-of-acting or ‘*mechanisms*’ (...) a causal claim is not about a regularity between separate things or events but about what an object is like and what it can do and only derivatively what it *will* do in any particular situation [author’s emphasis] (Sayer 1992, 105)

However, the identification and comprehension of the causal mechanisms that give place to health-related practices cannot be understood exclusively by using quantitative or qualitative methods. As was seen earlier in this chapter, neither of them is able to provide the necessary knowledge about the processes that lead to the reproduction, modification or creation of social phenomena by itself, which is why the combination of both methods seems the appropriate approach to answer the research question.

Qualitative methods are generally characterised by being focused on meaning and understanding, case study design, ‘thickness’ of explanations and the importance of studying the cases in their natural environment (Danemark et al. 2002). They are based on individuals’ accounts and discourses, which is a central aspect of reality due to the intrinsically meaningful character of social phenomena stated by critical realism;

‘human society is an inherently meaningful world, and people form their practices and direct their activities in accordance with the varied significance they allocate to their world’ (Danemark et al. 2002, 33; Sayer 2000). Thus a qualitative component, i.e. intensive research, is necessary in critical realism social research.

The primary concern of the intensive approach - to understand what causes things to happen under specific circumstances (Sayer 2000) - does not imply that it can achieve a comprehension of reality by itself. Acknowledging the stratified nature of society implies awareness of the fact that the accounts individuals give of their reality do not necessarily correspond to overall reality; the ‘empirical’ and the ‘real’ are different and separate domains. It is necessary to contextualise people’s discourses:

Everyone knows that good interpretive work always involves various forms of ‘contextualization’. And rightly so, because the reasons for what people do can be different not just from the reasons they *do* give but even from the reasons they *could* give. We are not fully transparent to ourselves, nor is the social world fully transparent to us [author’s emphasis] (Gorski 2013, 662)

As was already discussed, human agency takes place within a pre-existing social structure that delineates the possibilities of actions, without necessarily determining them (Chapter 2). This means that health-related practices take place within a context that cannot be ignored; the meanings of these phenomena are related to material circumstances and a practical context, which may or may not be present in individuals’ accounts. It is necessary to understand where actors are speaking from, and on which material reality their discourses are constructed. Additionally, the ‘tendencies’ regarding the enactment of health-related practices between social groups is also central to the comprehension of the mechanisms underlying them. Thus, a contextual

analysis based on an extensive approach is a necessary complement to the interpretative analysis developed by intensive research.

In conclusion, from a critical realist perspective the combination of extensive and intensive methods seems to be the most appropriate way to answer the research question. Extensive research might be used to describe how many Chileans engage in specific health-related practices such as carrying out physical exercise or smoking, as well as describing the population in relation to these practices i.e. it may identify demiregularities regarding health-related practices in Chile. However, in order to understand why some people engage in these practices while others do not, e.g. what causes some individuals to smoke while others have ceased or never started, it is essential to adopt an intensive research approach. This approach may reveal the reasons underlying the tendencies previously identified; it is necessary to know the reasons and meanings that people give to their actions in order to comprehend the causes of their actions. Nevertheless, these narratives have to be accompanied by a contextual analysis of the overall structure that reveals the mechanisms that underlie health-related practices. Only then will it be possible to comprehend the real reasons for health-related practices and the space for agency Chileans have over these practices.

3.4 Design, data collection and data analysis

The theoretical and methodological principles used to design the research have already been explained. The design process, the data collection and its analysis will now be described and explained.

As was previously discussed, this research combines an extensive and intensive approach in order to answer by which mechanisms the structure influences the space for agency that men and women from different social groups have over their health-related practices determinants in their daily lives in a strongly neoliberal country such as Chile. As discussed in Chapter 1, this question is divided into four sub-questions (see Chapter 1, section 2). Answering these questions implies a causal analysis of health-related practices, i.e. what causes people to engage with certain health-related practices and not others, how are these practices shaped. From a critical realist perspective, combining an intensive and extensive approach seemed the best way to develop this research. Therefore, an extensive approach and an extensive approach were applied together. The extensive approach considered the extension of certain health-related practices according to two different socioeconomic groups and gender within a neoliberal context was applied. The intensive approach centred on the meanings and reasons that people give to health and their perceptions of health-related practices. This parallel approach allowed understanding and explanation of the tendencies found. This was framed by a contextual analysis, i.e. the social-political-economic context in which the meanings and actions were developed and took place.

3.4.1 Chile: case study of a neoliberal society

As it was seen in Chapter 2, countries characterised by having a neoliberal ideology, due to the emphasis placed on individual liberty and privatisation of social security, have the highest inequalities regarding health (Navarro and Shi 2001; Coburn 2004; Coburn 2000). The coexistence of inequality and the emphasis on liberty in these societies leads to the question of how much space there actually is for free choice. Are people actually able to freely decide the health-related practices they engage in, or do they face constraints, psychosocial or material, that influence their practices? The chosen research method will analyse Chile's overall structural context and its potential implications for health-related practices. In critical realist terms, it will focus on the generative mechanisms of these practices.

Chile is a hallmark of a neoliberal society, having served as a laboratory where this model was implemented for the first time in 1973 under a military coup (Harvey 2005). The imposition of this model, which had the support from the domestic business elite and the United States, meant a strong reduction of social and overall state expenditure, changing universal social policies to ones targeted only at the poorest segment of the population, the privatisation of social services, such as health care and pensions, implementing a pro-business environment, and openness to foreign trade and investment (Arellano 1985; Illanes and Riesco 2007; Taylor 2002; Taylor 2006; French-Davies 2007; Larrañaga 2010). Most of the earlier state social responsibilities, such as providing health care to all the population, were left to the dynamics of the market.

As will be seen in detail in the next chapter, the economic and political transformations consequently led to high and persistent levels of inequality along with substantial

service improvements to upper income countries, creating a strong segmentation of society between those who could afford private-sector services (which are, by and large, good quality services), and those who have to rely on public-sector services (Illanes and Riesco 2007; Larrañaga 2010). Even when democracy was regained, with economic growth and significant increases in public expenditure, the neoliberal model remained almost untouched this segmented and unequal situation remains today. According to OECD data, Chile has the highest income inequality within its member states, and the third highest relative poverty rate after Mexico and Israel (OECD 2011c).

At a first glance, government authorities may be considered to have a social determinants of health approach. In the year 2005, the World Health Organization decided to launch the Commission of Social Determinants of Health in Santiago, Chile. This Commission aimed at creating social change and a debate to tackle health inequity by providing evidence about effective interventions, its relation to politics and the need to place health in all policies (www.paho.org). Three years after this launching, Chilean authorities presented a report giving evidence about the health gradient and recommendations. International countries took this as a sign of Chile being a country committed to tackling health inequalities and a model to be followed by other countries. However, seven years after the dissemination of this report, research in this area has been postponed, the webpage of the Chilean Commission is outdated and health inequality measures remain the same.

Alongside its neoliberal traits, further relevance for Chile to be the case-study choice is that Chile has been a high-income country since 2013 (Jim Yong Kim 2013). As was discussed in chapter 2, the psychosocial theory argues that once countries have

reached a certain level of a basic standard of living, the psychosocial burden produced by inequality is the most important explanation of health inequalities. Having a gross national income per capita of 15,230 USD in 2013 (<http://data.worldbank.org/country/chile>), Chile is a good case to test how social dimensions influence the agency power that people have over health determinants, and how it interacts with material factors in a highly unequal country.

3.4.2 Considering the health gradient: studying middle and lower socioeconomic groups

Chile's estimated total population is 17,402,630, being 50.5% women and 49.5% men; approximately 40% of the population lives in Santiago, the country's capital, and only 13% of Chileans live in rural areas, which shows its highly urbanized character (Instituto Nacional de Estadísticas Chile 2012). The country is divided into 15 administrative regions, with the Metropolitan region populated by 40.3% of the total population (Instituto Nacional de Estadísticas Chile 2012). This regional distinction is the best example of the tension between development and inequality experienced by Chile; while the Metropolitan region has consistently presented the highest Human Development Index within the different regions of the country, as shown in Table 1 (Barozet et al. 2009), it is also the one that presents the highest Gini coefficient. This is a measure that ranges from 0 (perfect equality) to 1 (perfect inequality) and which is exclusively related to income (Haughton and Khandker 2009) Santiago, Chile's capital, was therefore chosen as the place to study.

Table 1: Gini coefficient according to Chile's regions

Regions	Gini Coefficient 2006
Metropolitana	0,528
La Araucanía	0,495
Bío-Bío	0,488
Los Lagos	0,475
Maule	0,470
Coquimbo	0,468
Magallanes	0,466
Valparaíso	0,461
O'Higgins	0,447
Atacama	0,445
Tarapacá	0,445
Antofagasta	0,432
Aisén	0,423
País	0,509

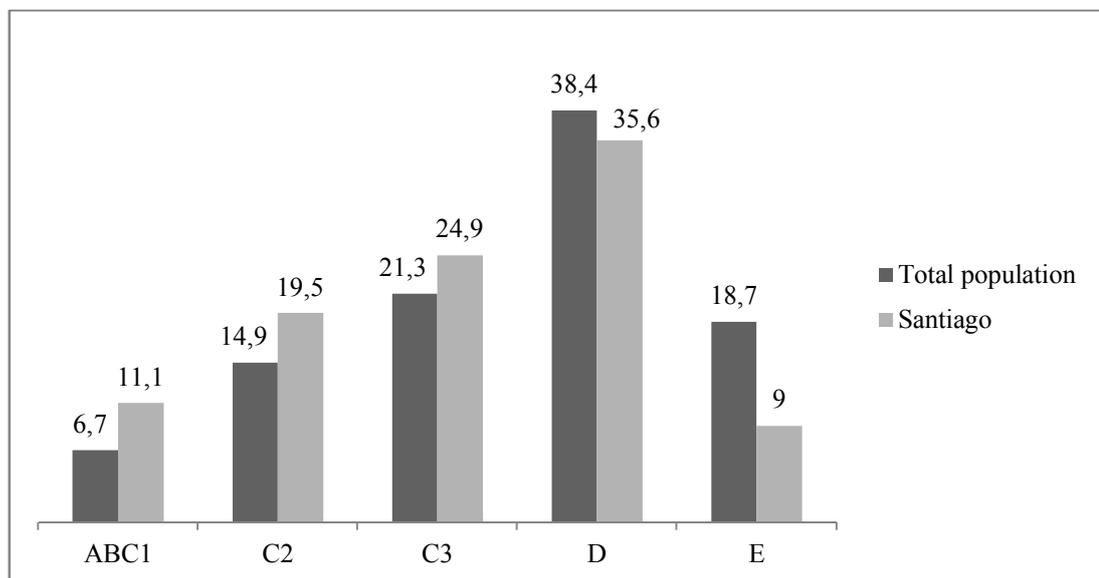
Source: Barozet et al. 2009

* This was the political administrative division prior to 2007 when two new regions were created (Valdivia and Arica y Parinacota)

In relation to Chile's socioeconomic distribution, the population is usually divided into 5 main groups. The Association of Market Researchers (AIM in Spanish) has developed standardized methodological criteria to classify people according to their socioeconomic situation through the construction of an index based on the possession of goods and the educational level of the head of household (AIM 2008). According to the index developed, five main distinct socioeconomic groups are identified; these can be seen in Figure 3.

These groups are primarily distinguished by, among other variables, years of total education, living in specific neighbourhoods and being in particular jobs. Therefore, it is possible to have a good expectation of a person's socioeconomic level by knowing the head of household's educational level, address, employment situation and key goods owned.

Figure 3: Chilean population according to socioeconomic groups



Source: AIM 2008

The present research's aim to observe the interplay between agency and structure present in health-related behaviour with a focus on social gradient meant choosing individuals from different socioeconomic groups. Even though in the quantitative analysis it was possible to consider all five groups, in the qualitative work, due to time and economic restraints, only two of them were considered: the middle and lower socioeconomic groups. As will be seen in the next chapter, individuals from both of these groups are affected by health and social inequalities (Arteaga et al. 2002; Frenz 2005; Frenz and González 2010; OPS, OMS, and FONASA 2009; Jadue and Marin 2005), which is why they were chosen as comparative groups and not upper and lower, or upper and middle. Although these last two comparisons might have been useful to see differences between the groups, they would not have offered the opportunity to compare social groups whose health indicators are poor. Each of the socioeconomic groups according to AIM (2008) and Adimark (2004) will now be briefly described, emphasising the middle (C3) and lower (E) groups since they were more closely studied.

ABC1: This group represents 7.2% of the total population and 11.3% of Santiago, being composed by the high sectors of the Chilean population. The head of household has an average of 16.2 years of education; many of them have postgraduate education, either from Chile or abroad. They live in the exclusive neighbourhoods within Santiago and a 100% of them have domestic service. Their household income ranges from 3,100 USD (1,700,000 Chilean pesos) to 6,350 (3,500,000 Chilean pesos) or more.

C2: Around 15% of Chileans and 20% of Santiago's inhabitants belong to this socioeconomic group, which represents the middle-high population. The education of

the head of household is an average of 14 years, meaning that they usually have a technical profession or an incomplete university education. They live in traditional neighbourhoods in Santiago and some of them have domestic service. Their household income is between 1,100 USD (600,000 Chilean pesos) and 2,200 USD (1,200,000 Chilean pesos).

C3: This group is known to be the middle-class or socioeconomic group. It represents 21% of the Chilean population and 25% of Santiago. The head of household usually finished secondary education but did not continue studying (11.6 years of education on average), which is why they frequently work in non-manual occupations (Espinoza and Barozet 2009) as public or private sector employees with no professional qualifications. Individuals from this group usually live in popular neighbourhoods within Santiago, in modest houses with no luxury appliances and in some cases cars. They hardly ever have domestic service since their total income does not allow it; household income ranges from 730 USD (400,000 Chilean pesos) to 900 USD (500,000 Chilean pesos). For the same reason, their children usually attend schools that are subsidized by the State. It is interesting to note the importance given to a good quality education by this group. For the Chilean middle-class, children's education is considered to be a central priority since it is believed to be the main mechanism of social mobilisation. People tend not to place their children in public-sector schools which is why an important part of the family income is oriented towards it (Barozet and Fierro 2011).

D: The lower-middle class is situated within this socioeconomic group, which comprises 37% of the Chilean population and 35% of those who live in Santiago. Frequently, the head of household has completed primary education but not secondary

(7.7 years of education on average). They live in big popular neighbourhoods that lack green areas and have high density levels. They never have domestic servants; actually many women from this socioeconomic group provide this type of service to better-off social classes. Their household income is between 350 USD (200,000 Chilean pesos) and 550 USD (300,000 Chilean pesos), which explains why they make use of all the public services and subsidies, mainly in health, education and housing.

E: This sector represents the lowest socioeconomic group and comprises 20% of the country's population and 10% of those who live in Santiago. Their precarious situation is reflected in the head of household's educational level, which is usually 3.7 years of education, meaning incomplete primary education. This leads to them being in insecure, poorly paid work, such as occasional jobs, being self-employed because they find it difficult to find a job, or other non-specialised and badly paid work such as cardboard collectors or informal 'watch-cars'. This socioeconomic group lives in overcrowded conditions in what is considered to be poverty. Their insufficient household income, which is less than 290 USD monthly (160,000 Chilean pesos), makes them dependent on the State or civil society (NGOs, Church, etc.) to cover their basic needs. Their children attend public-sector schools and sometimes night school in order to be able to work during the day to contribute to the family's income. These families live in poor neighbourhoods, with unpaved roads and poor quality urbanization; many live in '*campamentos*' – in 2011, 83,863 persons lived in this type of settlement (MINVU 2013). A '*campamento*' is 'a group of 8 or more families living on a small piece of land under an irregular legal situation, and which lacks at least one basic service, such as electricity, water or sewage system' (Techo, n.d.). These settlements are usually located in the suburbs, which marginalises their inhabitants

from the city centre and leads to increased expenditure on public transport, lower quality of life, and experiencing urban ghettos of poverty, with high vulnerability because of low social capital (CIS - Un Techo Para Chile 2005).

3.4.3 Data collection and analysis

As has been previously stated, the use of quantitative analysis follows two main objectives; firstly to describe the extent and tendencies of health-related practices in Chile, and secondly to provide a context within which individual discourses can be analysed. The way in which each of them was designed and developed will be presented separately in this section.

Extensive design: measuring health-related practices and contextual analysis

In order to understand to what extent and how macro dimensions, individuals' economic, social and cultural capital shape, cause or influence health-related practices of individuals from different socioeconomic groups, ages, and genders in Chile, it was first necessary to analyse these practices among different social groups. This was done with an extensive approach by analysing the frequency and statistical probability of people from different social groups engaging in particular health-related practices, that is, with practices that have a potential impact on health outcomes, where an interaction of choices and chances takes place, and whose generative mechanisms remain invisible for people. This statistical analysis was done with the database from the Chilean survey named 'National Survey Quality of Life' (Encuesta Nacional de Calidad de Vida – ENCV), which was carried out in 2006 by the Chilean Ministry of Health in collaboration with the National Institute of Statistics and the Catholic University of Chile. It had been developed as a second phase of a quality of life survey previously

carried out in 2000. Both of them aimed to gather systematic, reliable, and timely information about the quality of life and health of the Chilean population in order to improve the design, development, and evaluation of health policies and interventions (Departamento de Epidemiología - MINSAL 2006). However, the differences in questions developed and phrasing of the questions made it impossible to develop a longitudinal analysis that could describe how the extension of the phenomena had or had not changed over time.

The survey was based on face-to-face interviews and it used a probabilistic random sample to assure that the results were representative of the total population at national, regional, urban and rural levels. The sample selection was made in three stages: random selection of geographical area, then of households, and then of individuals. A Kish table was used to select the 6,228 individuals who were interviewed, who had to be 15 years of age or older and a member of the selected household. In total, 6,160 cases were analysed, since cases with missing information were excluded. The sample error was 2.5% at a 95% confidence level.

It is important to state that the statistical analysis of this database did not seek to formulate predictions, but rather to identify the tendencies and ‘demi-regularities’ that may have been present in Chilean health-related practices.

The health-related practices analysed with this approach were diet, physical activity, tobacco consumption, and alcohol consumption deemed problematic, which are considered amongst the most essential in relation to health outcomes (WHO 2004). Additionally, these actions are usually considered to be an exclusive product of choice and agency (Bartley 1990). The specific questions used to construct the indicators are presented in the appendix.

Specifically, diet for the purposes of the quantitative extensive analysis was assessed through a 'diet index', which was constructed using the World Health Organization and the Chilean Ministry of Health standards (WHO 2004; MINSAL and INTA 2004). Respondents were asked how often they ate particular foods, and a point was assigned for the respondents who ate enough vegetables, fruit and milk (3 times a day), legumes and fish (twice a week), and avoided eating fried food. These variables were used to construct a crude diet index that went from 0 to 6 points, where 6 indicated the healthiest diet. Physical activity was measured according to a binary variable, which was constructed for this research, in which those respondents who reported doing physical exercise for 30 minutes, 3 or more times a week, were categorised as having enough physical activity and the rest as 'not enough', according to WHO guidelines (2004) and MINSAL (2004). Tobacco consumption was also analysed in terms of a binary variable: (self-reported) smoker and non-smoker. Although other factors such as the number of cigarettes smoked daily and years of being a smoker are also relevant to understanding practice, these data were not available. Finally, an indicator of 'alcohol consumption deemed problematic' was constructed using guidelines of the 'brief scale of problematic drinking' (*Escala Breve de Beber Anormal* - Orpinas et al. 1991), which identifies people who have what is termed 'a way of drinking which is considered problematic'. After the construction of this scale, a new indicator was built in which the population was separated into those who have problematic alcohol consumption and those who do not.

As for the characteristics of the individuals observed, the analysis considered age, gender, area of living (urban or rural). It also incorporated the socioeconomic level of the respondent, which is a variable that the Chilean Ministry of health's research team constructed using the data obtained following the socioeconomic classification of

homes used by the National Institute of Statistics (INE). They did this by using a group of variables such as sociodemographic characteristics, housing characteristics, and goods owned. These allowed the creation of an index which classifies the socioeconomic level and welfare of each of the homes studied into quintiles, which does not coincide precisely with the categorization presented earlier in this section but is, nevertheless, a good and reliable proxy.

Specifically, two sets of analyses were carried out for the present research. In the first place, a descriptive statistical analysis was carried out in order to observe the distribution of the population according to the health-related practices described. This allowed comparison of the means and proportions of these practices across the different social groups to be studied, giving a first impression of the variation of health-related practices across socioeconomic groups. i.e. ‘demi-regularities’. Secondly, multivariate regression models were used to examine the mathematical magnitude of association that variables presented with health-related practices. Even though this analysis cannot show the process through which these variables are related, it allows us to examine whether or not they are related at all. Linear regression was used to explain people’s diet, whereas logistic regressions were used to model people’s physical activity, tobacco consumption and problematic alcohol consumption, since these were all binary variables.

The second use of quantitative methods aimed to analyse the contextual framework from which discourses would be analysed, according to the critical realist perspective adopted. As was previously stated, individuals’ accounts must be complemented by a contextual analysis that helps us understand where those discourses come from. In order to fully comprehend the production and reproduction of health-related practices,

it is crucial to analyse meanings and context together. This analysis used different datasets from diverse, reliable sources as well as data presented by previous research. Five dimensions were considered relevant in relation to the research question: income inequality, labour situation, education system, housing situation and health-care system. The description of these different components necessitated the use of data from OECD, ECLAC (UN), Chilean governmental institutions (Ministry of Health, National Institute of Statistics), and Chilean think-tanks (Fundación Sol, Centro de Estudios Públicos). A variety of data present in the literature was also used in order to give a thorough account of the Chilean context, specifically Santiago which was where the intensive part of this research took place.

Intensive design: understanding the meaning and process of health-related practices

The use of quantitative analysis followed the main objective of comprehending the causes of health-related practices and the processes through which they are shaped. As has been discussed, meaning plays a central role in social reality and needs to be understood in order to comprehend the generative mechanisms underlying social phenomena. Thus, this research also applied an intensive approach to interpret the meanings that people gave to health-related practices and health, as well as the reasons they gave for engaging in some of these practices and not in others.

The intensive approach followed a semi-structured interviewing process (Bryman 2012), meaning that an interview topic guide was produced (see appendix) with the main topics I wanted to discuss with the respondents, but that at the same time, participants were free to add new topics, skip questions that made them feel uncomfortable, and answer the questions as they wished. There was no fixed order for

the questions; interviews were conducted more as a conversation than a question-answer dynamic.

I constantly reviewed the interview guides. At the start of the research there was only one topic guide, which I tested and piloted in my first interviews; at the end of these first conversations, I would also ask the participant for feedback related to the instrument itself. This evaluation process led me to adapt the guides for the different socioeconomic levels since there were questions or topics that were essential for one of the groups but senseless to the other. I also had to add some different questions regarding age, especially in reference to future study plans.

Participants were interviewed on two different occasions whenever possible. This had two main objectives: to create a relationship of confidence and trust between the respondents and myself, and to avoid interviewing people for very long periods of time. In relation to the first objective, it was thought that meeting people on more than one occasion would improve the possibilities of moving from their 'public' to their 'private' accounts (Cornwell 1984). According to Cornwell, 'public accounts are sets of meanings in common social currency that reproduce and legitimate the assumptions people take for granted about the nature of social reality (...) [whereas] the opposite of public account is the "private account" [which]... springs directly from personal experience and from the thoughts and feelings accompanying it' (Cornwell 1984, 16). This seems to have been achieved on some occasions, mainly with women. The first interview was based on people's life-histories or biographies; we would talk about their lives from childhood until the present, stopping at topics such as education, employment, starting their own families, and social life. Usually, once we had done this first part, a positive relationship had developed, where I already knew the main

aspects of their past and present life, putting us on a more familiar footing. Some respondents would also ask about my life once the first interview was done; I answered all the questions they posed me as a sign of reciprocity. The second interview was exclusively centred on health and health-related practices, which was my main interest for this qualitative element, which is why it was important for people to feel comfortable in the interviewing process.

As for the second reason for dividing the interviews in two, as may already be apparent, doing the two parts together would have taken up too much of the respondent's time, which they did not always have to spare. It made sense to split the interview into two. However, in practice this division was not always necessary or desirable, especially in the case of men who were less willing or interested than women to talk for a long time. In those cases, I would do the two interviews on the same occasion, but with at least five minutes break in between the two main sections.

The final sample was different from what I had planned at the beginning of the research. When I first started the research design, I intended to interview three families from the upper, middle and lower socioeconomic groups. I wanted to explore the mechanisms influencing health-related practices throughout the complete social ladder. I had chosen three families per socioeconomic group as a minimum to observe variety within each social group. However, during the upgrade examination of my research design (at the end of the first year) the examiners suggested to study only two socioeconomic groups instead of the three. Their argument was that I could achieve a level of complexity that would make it hard to do deep research on the groups as well as complete my work. Having finished my work, I appreciate their suggestion.

Therefore, I changed my sample to interviewing only two socioeconomic groups: middle and lower. I chose these two in order to explore groups that were affected by the health gradient. Since I was going to research less groups, I considered increasing the number of families I would interview to five. This purposive sample (Barbour 2008) would allow me to observe more variety within each group in terms of characteristics that have proven to be related to health inequities, such as gender, household situation, labour market position and educational status. However, this design also suffered some changes when I started my fieldwork. At the beginning of this research stage, I realised that it was too complex to interview families. Not only because sometimes relatives were not willing to take part in the research, but also because in some cases sensitive information was shared and the interviewee did not feel comfortable about their relatives being interviewed. At this point, I decided to focus on individuals rather than families. Thus, I would interview 15 individuals from middle class (5 women, 5 men, 5 teenagers) and 15 individuals from lower class (5 women, 5 men, 5 teenagers).

The final number of interviews was also dictated by saturation, that is, when new interviews were not adding information (Checkel 2005, 367). This started to happen by interviewee number 5 of each category when no new information or concepts arose. This was a sign that I had reached the saturation point and that I did not need to increase the amount of people being interviewed. In the case of teenagers, the final number of interviewees was lower, not only due to the fact that I had reached the saturation point but also because it was difficult to find teenagers willing to be interviewed.

In total, I carried out 57 interviews with 29 people who lived in Santiago de Chile. As may be seen in Table 2, the sample was distributed almost 50/50 between the middle

and lower socioeconomic groups in order to capture evidence of any health gradient as well as the diversity of realities. Although I also aimed at an even distribution between men and women respondents, in practice 17 of the respondents were women and 12 men; this partly reflects a slight difficulty in approaching men to take part, which will be discussed later in this section. Ultimately, the diversity searched through the purposive sampling was conditional upon the researcher's contacts and individuals' willingness to participate in the study. Adults' ages were between 31 and 65 years old, which meant that they had had time to study for a professional or technical career, but that at the same time were still economically active. As for the teenagers, ages varied between 15 and 19 years old, implying that they had completed secondary education but had not yet started any further or higher education.

Table 2: Sample distribution for qualitative interviews

		Adult (31 to 65 years old)	Teenager (15 to 19 years old)	Total
Middle socioeconomic group	Men	5	2	7
	Women	5	2	7
Lower socioeconomic group	Men	4	1	5
	Women	7	3	10

Source: Author's elaboration

It is important to state that this sample was not intend to be representative of any of these groups. Even when the sampling aimed to increase the variety of interviewees, because of the nature of the study its aim was not representativeness. However, as will be observed throughout the data analysis, in some cases I argue about the relative salience of particular responses in different groups. This does not mean that I carried out a quantified analysis of my qualitative sample. These statements respond to the amount of times a certain aspect was named within each interview and among interviewees as well as the emphasis with which this aspect was stated. Therefore, statements such as ‘the majority of men...’ or ‘most of middle class interviewees’ does not imply a statistical analysis and does not intend to suggest a representativeness of that opinion.

The procedure for contacting people was different according to the socioeconomic group, as well as by gender. Participants from the middle socioeconomic groups were contacted through my own acquaintances; I directly asked my social circle if they knew people that lived in certain neighbourhoods (those known to be middle class), who had completed secondary education but not higher or further education, and who had jobs characteristic of the middle class (group C3), or who were still in secondary education if teenagers, whom they thought would be willing to participate in my research. Once I was given the contact, I would phone them or write them an email explaining what the research was about, what the interview would be like, and assuring anonymity and confidentiality. From this, if they responded positively, we would establish our first meeting. On some occasions, men were contacted through their partners or wives who had been already interviewed, in order to provoke a positive answer, even though in the middle socioeconomic group men seemed more open to taking part in the research.

As for the lower socioeconomic participants, contact was made through 'Un Techo Para Chile', a Chilean NGO working with families that live in *campamentos* to organise themselves to get better and more reliable housing. Therefore, the lower socioeconomic group is represented here by *campamentos* residents, one of the most deprived populations within Chilean society. I was able to contact them since I had worked with them in the past. This avenue of contact assured my security and also increased people's willingness to participate in the research, since residents from the *campamentos* have a very good relationship with this NGO. The procedure was as follows: I gave workers from the NGO a letter addressed to the resident of the *campamentos* where I introduced myself, explained to them the overall purpose of the study as well as the interview I wished to undertake, and assured anonymity and

confidentiality of our conversations. In response to that, the NGO would contact me with those people who had expressed an interest, and they would usually introduce me personally for the first interview, so as to increase the confidence of the participant in me, as well as helping to assure my personal security. In these cases, almost all the men interviewed were partners or husbands of women I had already interviewed, since that seemed the only way to reach them; men from this socioeconomic level were, as anticipated, less willing to participate and talk to me.

It is important to mention that I obtained consent to interview minors from the adults responsible for them. Whenever I interviewed teenagers who were younger than 18 years old, the interview would take place at their house or, in a few cases, in a neighbour's house with adults present in the house. Most of the time their parents would open the door when I arrived and would be present when I introduced myself and explained my research. I would ask them if they authorised their child taking part in my research.

The main challenges of this part of the research were related to men's occasional unwillingness to participate and express themselves, and to the socioeconomic difference between me and respondents, which was sometimes experienced as a power imbalance. In relation to the first aspect, as was already mentioned, I tried to contact men through people who had already been interviewed, usually their wives, partners or children. This way, they knew directly from their family what the interview was about, which I hoped would make them more inclined to trust me. Once in the interview situation, the conversation was easy and relaxed. As for the second challenge, I tried to minimise differences where I could, such as my personal presentation and language, by wearing simple clothing and avoiding using expressions

characteristic of higher socioeconomic groups. There was no way to eliminate this imbalance, but it tended to become less visible during the conversation as the participant became more comfortable in the interview situation.

All interviews were digitally recorded with the explicit consent of the respondents, who were reassured that everything they told me was and would remain confidential and anonymous. Afterwards the interviews were transcribed by me and imported into the qualitative software NVivo, which was used to organise the information and to facilitate the analysis. The data were analysed in Spanish and the extracts quoted in this research were translated by me. All names presented here are fictitious as a way to protect participants' identity and confidentiality.

The analysis proceeded through many stages. The transcriptions of the interviews were imported into NVivo, where a thematic analysis of the interviews was developed. The texts were codified into different topics; some of these were considered relevant from the start of the research while others emerged in the conversations. Once the first round of thematic coding was made, a preliminary description of results was developed in order to get a general picture of the important points, and to observe the main and clearest meanings and reasons that people gave in relation to their practices. After this description, interviews were re-read and re-codified as a way to look for unnoticed relevant topics or dimensions present in the discourses, as well as to identify underlying or implicit discourses within the interviews. Here, the contextual circumstances considered in the contextual description were introduced into the analysis to understand what the material, political and social bases of the discourses were, and why people thought and acted in similar or different ways, particularly in relation to the social group to which they belonged.

3.5 Conclusion

This chapter's first part discussed how health inequalities have been studied from different perspectives and with a range of methods. By analysing their advantages and disadvantages it was seen that while research exclusively using the positivist approach emphasises the structural dimension of health inequalities, that conducted within the interpretivist perspective focuses on actors' voices and agency, often neglecting the importance of the context from which they speak and act. The need to consider both dimensions, i.e. structure and agency, and the interplay between them in health-related practices, justifies the adoption of a critical realist approach.

The ontological and epistemological principles that constitute critical realism justify the combination of intensive and extensive methods in this research. While the intensive analysis allows accessing the meanings and understanding the reasons of people's engagement in health-related practices, the extensive approach gives information about how common these are across the population, as well as describing the context from which people speak. The combination of both analyses aims to identify and analyse the interplay between structure and agency in relation to health-related practices as well as to add knowledge to the use of critical realism in health-related research.

The chapter's second part discussed why Chile constitutes an interesting case to research the agency power that men and women from different social groups have over health determinants, due to its neoliberal traits, high inequality, and high-income country status. It also justified why the thesis is focused on individuals who belong to the lower and middle socioeconomic groups, as well as why Santiago was chosen as the place to carry out the qualitative data collection. The final section provided a

detailed description of the research design, along with the data collection and analysis procedures.

The next four chapters are dedicated to the description and analysis of the results. Chapter 4 is focused on the analysis and presentation of the context from which respondents speak and where their health-related practices take place, as well as on the extensive analysis used to identify the tendencies regarding the enactment of health-related practices between social groups. Chapter 5, 6 and 7 present the findings obtained through the qualitative interviews conducted, and the intensive analysis that allowed accessing the meanings people give to health and health-related practices, as well as to the differences that exist between social groups. As will be seen, the analysis of the interviews is triangulated with quantitative data and is constantly making reference to the broader context in order to visualise the interplay between agency and structure. Chapter 8 considers the research question in light of the findings and discusses the theoretical, methodological and policy implications that these have.

CHAPTER 4 - CONTEXTUAL ANALYSIS: INEQUALITY IN A NEOLIBERAL COUNTRY

4.1 Introduction

The previous chapters have discussed the relevance of studying the mechanisms through which the structure influences the space for agency that men and women from different social groups have over health determinants in their daily lives in a strongly neoliberal society. They have discussed why Chile, a neoliberal country where personal freedom and individual responsibility are highly treasured values, is a good case-study for researching how health-related practices are shaped and which mechanisms underlie these practices. These chapters have also discussed why a critical realist approach is the most appropriate methodological perspective, as well as the decision to combine extensive and intensive methods to answer the research question. This chapter will focus on the analysis of the contextual reality in which Chileans' health-related practices take place.

In order to understand from a critical perspective why individuals from different groups may adopt different health-related practices as well as the reasons they give for this, it is necessary to understand the context from which their discourses emerge, as well as the wider political and economic forces that shape this reality (discussion in Chapter 3). Specifically, this chapter firstly develops a brief description of Chilean social policies in the 20th century and the political pathway that turned a socialist model into a neoliberal one. Secondly, it shows how the imposition and stability of the neoliberal policy regime, defended by domestic business groups through their close relationship with political power, favours aspects such as choice, competition and

privatization in social policies and how this produced a country with two faces: a developed and high-income country vs. an unequal and segmented society. The chapter analyses the contrasts between the considerable improvement of social indicators, economic growth and peaceful return of democracy, with a stable high income inequality, unequal labour conditions, inequity of education opportunities, and residential segregation. The two final sections are focused on the Chilean health situation. Section V analyses the structure of the healthcare system and the inequalities reproduced through programs that emphasise individual responsibility for health outcomes and practices. The last section analyses the frequency and statistical probability of people from different social groups engaging in certain health-related practices; this identifies the demi-regularities and tendencies regarding the enactment of health-related practices between social groups.

4.2 Social Policies: the neoliberal experiment and the consolidation of inequality

Throughout the different phases of development in Chilean history, inequality has always been present, either as an explicit concern, as a government aim, or as an outcome of policies and models. The unequal distribution of resources and benefits was already a political and social concern at the beginning of the 20th century, Chile being one of the first countries of Latin America to develop social security policies. However, the problem of inequality became stronger, more severe and more permanent with the introduction and establishment of a ‘pioneer’ neoliberal policy regime in the early 70’s that took place under a military dictatorship. Even after some modifications, this policy regime has been preserved despite the ending of military rule and reintroduction of democracy (Taylor 2006; Madariaga 2015).

Between 1924 and 1950, Chile went through what has been described as the Welfare State era, which was segmented according to occupational category and social class (Larrañaga 2010). During these years, urbanization grew from 46.4% of the population living in urban areas in 1920 to 60.2% in 1950 (Arellano 1985), partly in response to the attempts at industrialization that followed the import substitution industry model. These attempts were encouraged by an increased international demand for copper during the Second World War, which was seized by the upper class to control the economy (Navarro 1974, 98). This meant a more than four-fold increase in the number of salaried workers which needed new services, as well as new social policies (Arellano 1985; Illanes and Riesco 2007).

Within this social scenario, the first coordinated social policies took place. These policies were mainly concerned with workers, regarding their labour conditions as well as their health and social security, ‘because they [the upper class] wanted to build up the economy, it was to their advantage to have a healthy work force, particularly in the industrial sector’ (Navarro 1974, 98). As a result of the increased percentage of the GDP dedicated to public social expenditure – in fact the percentage rose by a factor of 5 during this period (Larrañaga 2010) – social indicators such as life expectancy and literacy rate showed significant improvements (Arellano 1985). However, an important part of the Chilean population was still considered poor, and the access to social services was far from universal and equitable (Illanes and Riesco 2007). By the end of this period, income inequality increased significantly giving place to worker and peasant revolts (Navarro 1947).

The second period of social policies (1952-1973), named the ‘Exhaustion of the Corporatist Welfare State’ [*Agotamiento del Estado de Bienestar Corporativo*]

(Larrañaga 2010) took place against what was widely considered to be an influential international background. On the one hand, the end of the Second World War meant a higher demand for Chilean copper, leading to increased production and promotion of the industrialization controlled by the oligarchy. On the other hand, the Cuban revolution that took place in the 1960s aggravated the agitated internal atmosphere by giving an example of a socialist revolution against oligarchy and imperialism (Boeninger 1998). This example made the workers' demand for inclusion more legitimate and stronger than before.

The first measure taken in this period to promote social inclusion was the creation of the National Health Service [*Servicio Nacional de Salud*] in 1952 (Law 10,383) during the right-wing administration of Jorge Alessandri. This state organ unified the main preventive and healthcare services into a single healthcare authority. Between 1950 and 1975, infant mortality rates fell by one third and adult mortality by half alongside a considerable improvement in infrastructure, sanitation services and general life conditions of the population (Larrañaga 2010).

In turn, Eduardo Frei's administration (1964-1970) approved a group of social reforms that aimed to make social policies more inclusive and universal, income redistribution being one of the primary objectives (Arellano 1985). Some of the most important reforms implemented were: an education reform that increased the mandatory years of education (Act 27,952); a law that approved peasant labour unions (Law 16,625); the 'chilenization' [*chilenización*] of copper (Law 16,425); and the agrarian reform (Law 16,640). Through these centre-left measures, Frei's government aimed to institutionalise class struggle and avoid wider and stronger conflicts (Boeninger 1998).

Even though there were improvements in relation to previous social policies, inequality was still a strong reality (Illanes and Riesco 2007). In a context of radicalisation of both political left and right parties, in 1970 the anti-oligarchy and anti-imperialist left coalition – *Unión Popular* – won the elections under the figure of Salvador Allende, leader of the Socialist Party. In this year, ‘the executive, though not the other branches of the state, changed hands and passed partially into the control of the working-class-based parties’ (Navarro 1974, 103) in a highly tense political atmosphere. Right-wing politicians and the entrepreneurs viewed this scenario with suspicion and fear. Following the ‘Chilean road to socialism’ [*vía chilena al socialismo*], Allende’s government accelerated Frei’s agrarian reform, nationalized copper, and implemented economic measures to reduce inequality through income redistribution, such as nationalization of industries. Additionally, he created the Single Health Service [*Servicio Único de Salud*] that unified the National Health Service created in 1952 with the National Medical Service for Employers [*Servicio Médico Nacional de Empleados*], which served white collar employees (Illanes and Riesco 2007). Under this new health service, almost all the population had access to vaccination and other sanitary measures as well as healthcare. Allende encouraged a revolutionary economic and social program that would construct Chilean socialism (Boeninger 1998).

Even though the period between 1952 and 1973 meant social policies which were more inclusive and led to further improvements in social indicators in health and education (Larrañaga 2010; Banco Central de Chile 2001), it did not end on a positive note. This period ended with strong macroeconomic imbalance, a general economic decline and an increasingly confrontational relationship with the traditional oligarchies and middle

classes, who formed alliances against more progressive reforms in defence of institutional order and private property (Boeninger 1998; Illanes and Riesco 2007).

In 1973, the political and economic deterioration led to a military coup promoted by the domestic business elite and supported internationally by the United States – the Central Intelligence Agency (CIA) and US Secretary of State Henry Kissinger. After the coup, Chile was governed by a military junta headed by General Commander Augusto Pinochet under strong neoliberal principles. With the suppression of civic and political rights, the state of military repression, and the strong reformist will of the military's civilian allies – the technocratic cabinet of the government was composed of liberal young rightist economists trained at the University of Chicago under Milton Friedman, i.e. 'Chicago Boys' (Valdés 1995) – Chile became the 'laboratory' in which neoliberalism was implemented for the first time (Ffrench-Davies 2003; Harvey 2005; Taylor 2006).

The new reforms led to significant economic, political and social policies and transformation that is still largely present in Chilean society today. Market categories such as choice, competition, and privatization were introduced for the first time in the social security system, and produced a stronger segmentation of society (Larrañaga 2010). The period of the Residual Welfare State [*Estado Bienestar Residual*] that took place between 1973 and 1989 (Larrañaga 2010) saw significant cuts to social public expenditure – from 25.8% of GDP in 1972 to 14.3% of GDP in 1981 – , a shift of social policy away from universalism to selectivity, and privatization of social services (health care, education and pensions), along with the adoption of a favourable pro-business environment and openness to foreign trade and investment (Arellano 1985; Illanes and Riesco 2007; Taylor 2002; Taylor 2006; Ffrench-Davies 2007; Larrañaga

2010). These measures meant that ‘the market was presented as the realm of freedom and equality and, concurrently, the competition between service providers who would react to consumer choices was suggested to create an optimal allocation of resources throughout welfare provision’ (Taylor 2006, 87). There was a move away from the previous state-centred model towards a model based on the market, transforming the market into the key social driver.

This new economic and political reality provided impressive and significant service improvements for upper income groups, the main supporters of the neoliberal dictatorship, who were the only ones that could afford them. The private social protection scheme adopted by Chile during the military government only benefited the richest 25% of the population (UNDP 2002a; Illanes and Riesco 2007). The public sector was depleted due to the lack of investment and financing which provided inadequate resources for the significant proportion of the population in considerable need. Pinochet’s period ended in 1989 with a situation of social inequality worse than that experienced in the previous decades, with an worsening of the distribution of income and a stagnation of poverty (Ffrench-Davis 2003; Larrañaga 2010).

After 17 years of dictatorship, democracy was regained peacefully in 1990 through a plebiscite. The democratically elected governments that followed tried to mitigate some of the previous inequity by adopting an approach of ‘continuity and change’ (Ffrench-Davies 2007, Taylor 2006). This meant that while a social policy structure continued to rule that supported choice, competition and privatisation, the state increased its intervention through social policies and programmes aiming to reduce the ‘social debt’ created during the dictatorship – high unemployment rates, deterioration in healthcare and education infrastructure, and housing shortages for the working

classes, among others. The main measures taken by the democratic governments between 1990 and 2005 to reduce this 'social debt' were programs to overcome poverty; high investment in social sector infrastructure, health reform (AUGE), a social protection system for the population in extreme poverty (Chile Solidario) and a considerable increase in public housing (Raczynski and Serrano 2005). As Table 3 shows, the result was a reduction in the number of Chileans living under the poverty line, i.e. the number of people who did not have the necessary income to cover basic needs was less. However, income inequality remained stable and high as seen in the evolution of the Gini coefficient (measure explained in Chapter 3).

Table 3: Evolution poverty rate and Gini coefficient between 1987 and 2011

Year	Poverty (%)	Gini
1987	45.1	0.58
1990	38.6	0.56
1992	32.6	0.56
1994	27.5	0.56
1996	23.2	0.57
1998	21.7	0.58
2000	20.2	0.58
2003	18.7	0.57
2006	13.7	0.54
2009	15.1	0.55
2011	14.4	0.54

Source: Prepared by the author using data from MIDEPLAN 1998 and Solimano and Torche 2007

The persistence of high inequality in a context of democracy and neoliberal policy regimes – a characteristic shared by almost all Latin American countries – has been explained by Schneider and Soskice (2009) as the result of a form of capitalism which they call ‘hierarchichal market economy’. Schneider (2009) argues that this production regime is characterised by having diversified business groups, i.e. large domestic business groups that specialise in highly profitable economic sectors. Even when these

groups are small in number, they constitute a large share of the economic activity and are generally owned and managed by families, a factor that introduces more hierarchies according to Schneider. Some of these diversified business groups have partnerships with multinational companies, mostly from the United States, which have a big presence in Latin America. The strong domination that these families' groups have over the economies, in this case the Chilean, relates partly to the 'symbiotic relationship between the groups and the political system' (Schneider 2008 in Schneider and Soskice 2009, 38). The economic and political powers are very close in these democratic countries, which means that business groups invest in legislators and political parties in order to have influence on government regulations. In fact, recent Chilean politics has experienced collusion, when private companies have illegally and secretly financed political candidacies as a way of having power over politics – the 'Penta Gate' case (Engel, Ferreiro, and Ríos 2015; El Mostrador 2015; Montes 2015b; Montes 2015a). This form of capitalism may be one of the generative mechanisms that causes continuing health and other inequalities in Chile and for the continuation of the almost unaltered neoliberal policy regime.

4.3 Contrasting realities

The neoliberal policy regime that has ruled Chile since the dictatorship period has caused significant numbers of the population to be left behind on a range of indicators and dimensions. As stated by the UNDP throughout the analyses done for each of the Human Development Reports in Chile (1998; 2000; 2002b; 2004; 2006; 2009; 2010), while there is an explicit acknowledgement of the improvement that the country has experienced, there is also a statement of the urgency of incorporating the whole of society in the development process. Some groups within society have been excluded

from the opportunities and benefits related to development, while other groups seem to be living in a country that is very similar to more developed ones. This section will focus on how Chile's neoliberal policy regime has delivered both considerable improvements in economic and social terms, as well as high levels of inequality of income, labour, education and neighbourhoods, all of them health-relevant dimensions, as will be discussed.

4.3.1 Chile: A high-income country

The end of the military dictatorship and the new social policies implemented by the new democratically chosen Christian Democrat president – Patricio Aylwin – were accompanied by significant economic growth, which was translated into an increase in real incomes and an increase in public expenditure on social policies. Between 1990 and 2000, public expenditure on education increased by 178% and in health by 166%, which reflects not only the increasing commitment to social development, but also the economic prosperity in Chile (Larrañaga 2010), past and present. In 2011, Chile was among the Latin American countries with higher levels of social expenditure (more than 1,000 USD per capita), mainly due to a constant increase in public social expenditure (ECLAC 2011).

As a consequence of all this, Chile's social indicators improved considerably during the 1990s. There was an increase in secondary and higher education enrolment, real wages increased significantly, unemployment decreased, poverty rates were reduced by more than half (table 3), and the country moved up several positions in the human development index, reaching a 'high' level similar to developed countries and the more advanced countries in the region: Argentina, Uruguay, Cuba and Mexico (Illanes and Riesco 2007; Raczynski and Serrano 2005; Mesa-Lago 2002). The country also

experienced further significant reductions in birth rate and both general and infant mortality, as well as an epidemiological profile where non-communicable conditions became more responsible for mortality than communicable ones (OECD 2011a; Banco Central de Chile 2001; ECLAC 2011). All of these indicators (table 4) led to Chile being incorporated in the OECD in 2010.

Table 4: Social indicators of Chile and Latin America

Social indicators	Chile	Latin America
Life expectancy (average years)*	79,3	74,4
Infant mortality (per 1,000 live births)*	7,8	16
Mortality rate (per 1,000 adults)*	87,5	140
Fertility rate (birth per woman)*	1,8	2,2
Literacy rate , adult total (% of people ages 15 and above)*	98,6	91,3
Years of education (average)*	9,7	7,8
Poverty (% population)** , ***	11	29,4
Human Development Index (HDI)*	0,819	0,741
HDI adjusted by inequality *	0,664	0,55
Gini coefficient**	0,516	0,52

Sources: *UNDP 2013

** ECLAC 2011, 2012 (PS)

*** Poverty rate calculated according to the poverty line of each country

Despite the changes made under democratic governments, these results have been achieved with the overall preservation of the previous economic development strategy. Within Chile, dominant ideology dictates that the neoliberal policy regime is still the best way to achieve development, to reduce poverty rates and to improve social and economic indicators. According to a Minister from the right-wing government elected in 2010 – Cristián Larroulet – the consensus that states that Chile has changed for the better in the last 25 years is based on:

First, an economic model where the main drive of economic progress relies on the initiative and strength of the private sector (...) with large degrees of economic freedom (...) Second, a social policy focused on the most vulnerable people, and where the public services are generally provided by both public and private agencies, so that beneficiaries can have the freedom to choose among different competing alternatives. Third, a representative democracy (Larroulet 2013, 2)

In this sense, neoliberalism is seen as the main factor responsible for the positive outcomes that the country has experienced during the democratic governments. The defenders of this model argue that it is because of the institutions consolidated under neoliberalism that Chile's considerable improvement in social factors has been achieved. This would mean that the domestic business groups' interests would benefit the whole population. As will be explained in the next section, this idea differs to Chilean reality.

4.3.2 And a highly unequal society

The successful figures recognised by both the OECD and World Bank hide a less prosperous reality. Income inequality has remained significantly high and relatively stable since the 1990s, with very little variation (table 3). When Chile is compared to the rest of the OECD countries, Chile's 0.5 Gini coefficient is the highest among the group (OECD 2011c). According to the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) classification of countries according to their inequality level (2004), Chile has remained in the 'high' level of inequality cluster – Gini coefficient between 0.52 and 0.58 – for the last two decades. This means that the economic growth experienced by Chile is not distributed evenly throughout

society, even though social indicators have improved significantly and poverty has decreased considerably.

Another way of observing income inequality is through the distribution of total income in the population. According to the OECD (OECD 2011a), the average income of the richest 10% of the Chilean population is 27 times that of the poorest 10%, which contrasts negatively with the 9 to 1 average in OECD countries. The following table (5) shows that during the period 1990-2009, the richest 10% income per capita represents 40% of the total national income. This situation has been examined in more detail by López et al. (2013) through an analysis of what they term the 'super rich'. They show that the income concentration is highly accentuated within the richest 1%, 0.1% and 0.01%, in that between 2005 and 2010, these groups received 30%, 17% and 10% respectively of the total personal income in Chile. They also state that when compared to other countries (e.g. USA, UK, South Africa, Singapore, Canada, Ireland, Australia, France, Spain, Norway, Sweden, Denmark), Chile occupies the first place in the ranking of participation of the 1% and the second place in relation to the 0.1% and 0.01% behind the USA. All of these data reveal the acute situation of income inequality within the country that contrasts with its high rates of economic growth.

Table 5: Independent income share according to the independent household income per capita decile, 1990-2009

Decile	1990	1994	1998	2003	2009
I	1,4	1,4	1,2	1,2	0,9
II	2,7	2,7	2,5	2,7	2,7
III	3,6	3,5	3,5	3,6	3,7
IV	4,5	4,5	4,5	4,7	4,6
V	5,4	5,6	5,3	5,4	5,6
VI	6,9	6,4	6,4	6,6	7,1
VII	7,7	8,1	8,3	8,2	8,5
VIII	10,4	10,6	11	10,7	11,1
IX	15,2	15,4	16	15,3	15,6
X	42,2	41,8	41,4	41,5	40,2
Total	100	100	100	100	100

Source: Ministerio de Desarrollo Social 2011

In summary, Chile has experienced significant improvements in social and economic indicators from 1952 to today, leading to a social profile that seems closer to developed countries than to its regional neighbours. Nevertheless, its main challenge remains the persistent elevated levels of income and social inequality that derive from the neoliberal policy regime defended by business groups and most politicians. In other words, even when Chileans chose democratically to end the dictatorship and the suffering related to it, the mechanisms and structure responsible for generating inequality and for benefiting a minority at the expense of the majority has remained stable and protected by the economic and political powers.

4.4 Inequalities in Health-Relevant Dimensions

The inequality produced by the neoliberal policy regime is not only reflected in income distribution, but also in other dimensions that influence health outcomes. As exposed by Dahlgren and colleagues' (1991) rainbow model, different dimensions of society influence individuals' health (discussion in Chapter 2). These factors are situated on different levels, all of which interact with each other and produce different effects on health. Through a contextual analysis, this section focuses on how the Chilean neoliberal policy regime creates inequality specifically in the labour market, educational opportunities, and residential segregation, and how these interact with each other generating a long chain of structural health determination.

4.4.1 Hidden informality and low value of work

The Chilean productive structure suffers from a problem of 'structural heterogeneity', i.e. an 'unequal mapping in terms of the enterprise's sizes, geographical location, degrees of technological development, capitalization level, markets to which they are directed to and the creation of employments' (Assael et al. 2009, 25). This diversity in Chile, reflected in its previously explained variety of hierarchical capitalism, is characterised by the coexistence of highly profitable transnational corporations oriented towards exports, with numerous informal, small and medium size enterprises that have low levels of productivity and which focus on the internal market (Assael et al. 2009; Infante and Sunkel 2009). Small and medium size companies with low productivity levels absorb most of the labour force, while big enterprises are very few in number, have a low number of employees, and offer the highest levels of productivity and wages. This creates a situation where a few produce the most, and earnings or profits become concentrated among them; the individual gross

remuneration of the high productivity enterprises' employees is five to six times higher than those of the small or medium-sized enterprises' workers (Infante and Sunkel 2009).

This means that as the productivity of the economic sector decreases, the informality of employment increases (Sunkel 2003), an aspect that has been related to worsening physical and mental health outcomes (Bartley et al. 2006). High informality is related to another inequality regarding the labour market, i.e. differences in employment conditions and security. Chile is one of the countries with the lowest labour informality in Latin America. According to ILO, in a context where labour informality is very frequent, Chile presents the lowest rates in the region – 32.3% in 2006 – and has contributed to the decrease in Latin America's labour informality average over the 1990s (ILO and WTO 2009, 29). However, the formality figure hides an important omission. Several organizations have shown that actual informality rates are much higher. For example, according to Fundación Sol (2011; 2013), only 54.9% of employees have a 'protected employment', which means that they have a written permanent employment contract, a salary statement, and pension, health and unemployment insurance contributions. Around 18.1% of employees work as 'independent subordinates', that is, employees that face all the norms and control systems of dependent employment, but do not have a salary statement and are not part of the protection system of labour rights (pension and healthcare). Therefore, being an employee is not necessarily associated with having good quality employment, access to social security, or acquiring good levels of economic capital. This means there is a large proportion of the working population that have informal, unprotected and unstable jobs.

Formal workers' salaries must be equal to or more than the minimum wage (for 45 hours per week) according to a law that is reviewed each year (Law 20.763 for 2015). The minimum wage agreed for 2015 is 241,000 Chilean Pesos (approximately 230 pounds) which corresponds to 1kg of bread per day, one return bus/underground ticket to commute to work, rent for a room – not a house or flat –, and to pay social contributions (health, pensions) (Durán and Kremerman 2015). These numbers reflect a reality in which work is highly undervalued and the minimum wage is not enough to meet basic needs. According to Durán and Kremerman (2015), 24.5% of workers – salaried workers, self-employed, and employees – receive this remuneration, which is 37.2 times lower than what parliamentarians earn – 9.3 times in OECD countries and not higher than 6 times in Portugal, Germany, United Kingdom and France for comparison.

The problem of informal work and low salaries is worse in the case of women. While 15.9% of male employees work as 'independent subordinate', 21.2% of women are in this category (Fundación Sol 2011; Selamé 2004). This disadvantage adds to the inequalities between men and women regarding salaries when women enter the labour market. Even though the salary gap between genders has decreased in Chile since the 1960's, the average income of men still exceeds that of women regardless of education level, confirming gender discrimination (UNDP 2009). As table 6 shows, this gap is wider among men and women who have higher levels of education, meaning that the salary gap is not caused by a difference in education level (Selamé 2004; Ministerio de Planificación 2008).

Table 6: Salary gender gap 1990-2006 (women's wage as a % of men's wage)

	0-8 years of education	9-12 years of education	13 or more years of education
1990	68	77	59
1992	78	79	57
1994	76	79	62
1996	78	80	63
1998	80	84	67
2000	86	80	65
2003	86	85	69
2006	81	81	73

Source: UNDP 2009

With salary discrimination there is also occupational segregation, which may be defined as the unequal distribution of occupations between men and women. When the sectors of economic activity are analysed according to gender composition, it is possible to see firstly that women tend to be more concentrated in fewer occupations than men and secondly, that these occupations correspond to community, social and personal services, as well as domestic service, which represent an extension of the household responsibilities that are considered to belong to women (Selamé 2004; UNDP 2009). This phenomenon means that women are not only excluded from certain types of employment, but also that they are concentrated in sectors that have lower value and salaries than those where men work; the more 'feminine' the occupation, the lower the salary (Ministerio de Planificación 2008; UNDP 2009).

The probability of improving wages and working conditions also remains low due to the low proportion of workers who belong to unions and the unions' weak power, aspects that have been related to hierarchical market capitalism (Schneider 2009). In

1979, during the neoliberal military dictatorship, a Labour Bill (DL 2,756 and 2,758) was approved that aimed to restore the order defended by domestic business elite and military forces through the opening of the economy and a high flexibility of the labour market (Narbona 2015). Under this bill, several measures that took power away from workers were approved. These included; collective bargaining only being allowed within enterprises and not beyond them (e.g. national level), striking workers being allowed to be replaced, and workers with short time contracts or product-based contracts not being allowed to participate in unions (Durán 2013). Even after the return to democracy, the Chilean Labour Code still reflects the main principles of the labour relationships established during the dictatorship, and rates of unionization remain low, showing the power that business groups have over politics in Chile.

4.4.2 Unequal educational opportunities

The equity of educational opportunities is another area which is essential to decrease social and health inequity: ‘education is a key factor for the generation of higher levels of income, social mobility and welfare’ (Contreras et al. 2005, 61). Different researchers have shown that an increase in years of education is associated with positive health indicators such as a decrease of mortality (Lleras-Muney 2005), decrease of the probability of suffering poor mental health (Currie and Moretti 2003) as well as an increase of the probability of being physically active, a non-smoker, and drinking ‘moderately’ (Ross and Wu 1995; Cutler and Lleras-Muney 2006; Cutler and Lleras-Muney 2010). The neoliberal character of the Chilean education system, explained below, implies not only that the quality of education varies according to people’s purchasing power, but also that certain sectors of the population cannot access the highest levels.

During the 1980's, the military government modified the structure of the education system according to the new socio-political model orienting it towards competition based on incentives (Contreras et al. 2005, Aedo and Sapelli 2001). In 1980, the education system became a mixed system with three types of school: municipals, subsidised private, and private schools (Law 3.166). The public schools that used to depend on the state were transferred to local governments, giving rise to the 'municipalisation' of the education. Conversely, the subsidised private schools were private schools that committed themselves not to charge enrolment in order to receive some funds from the state. From 1993, the subsidised private schools receive an extra funding resource that is called 'shared funding', which allows parents to make financial contributions to the school so that it has more resources to improve its education quality (Aedo and Sapelli 2001). Both types of schools were and remain financed mainly by the state through a system of education support in the form of vouchers as a demand subsidy. The state gives the school a monthly subsidy for each student that attends it, which is why it is a voucher associated with the student and not the education establishment, even though the state pays it directly to the school.

This voucher system, introduced in 1982, responded to the neoliberal principles of increasing competition between schools and, therefore, their quality. However, it did not in fact result in better schools or higher equity (Contreras and Elacqua 2005). Even when a number of reforms were made to the system once democracy returned, deficiencies in quality and unequal access have remained. On the one hand, when Chile is compared internationally, the educational achievement of students seems poor. The PISA (Programme of International Student Assessment), a survey that evaluates the performance of education systems in different countries, has included Chile for several

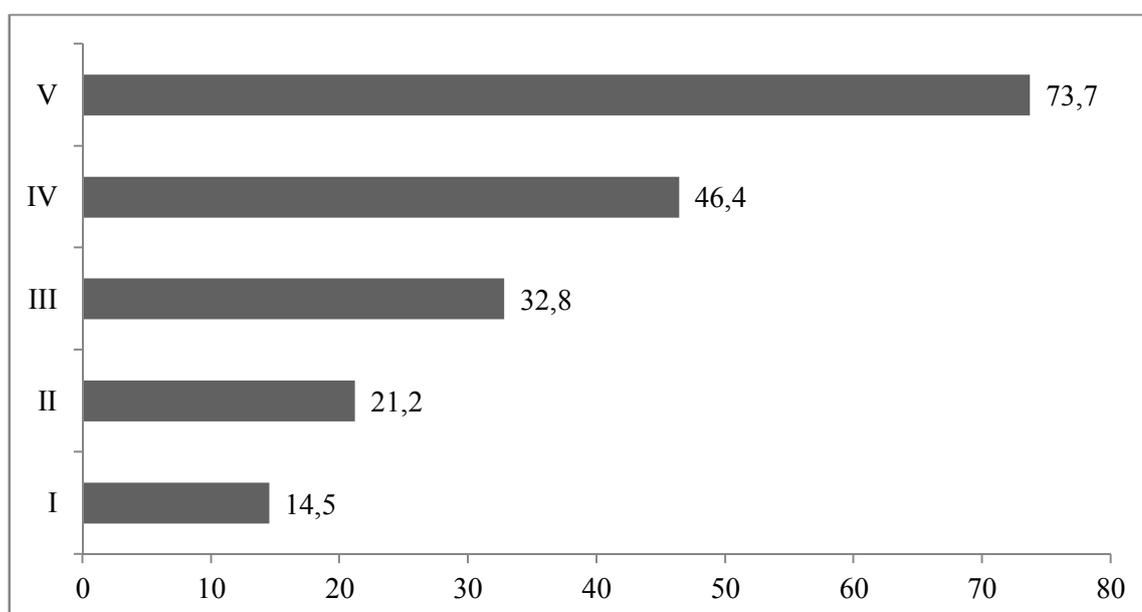
years. Its results place Chilean students' scores statistically significantly below the OECD average on the overall reading scale, mathematics and science (OECD 2010; OECD 2013). According to the PISA 2009 study (OECD 2011b), 64% of 15 years old students in Chile performed poorly in reading, which is a worrying situation when considering their future and potential access to formal and well paid employment.

On the other hand, the poor quality of education is not randomly distributed. Inequality in educational attainment is evidenced by the results of a national system that measures the education quality of schools, called SIMCE. SIMCE takes the form of a test applied to students, with the results being made public to allow the population to compare the quality of education between similar schools. SIMCE results show that students' performance is conditioned by socioeconomic factors; the higher the income level, the higher students score in the different tests (Mizala and Romaguera 2000; Agencia Calidad de la Educación 2012). This inequality may be related to the fact that the richest 15% of the population spend around three or four times more on education than the expenditure destined to the public sector (López and Miller 2008). Additionally, this system suffers from a segregated character. In fact, students from different socioeconomic backgrounds are kept apart and attend different schools, not only because they are not able to afford private school fees, but also because of the territorial distribution and the residential segregation (Sunkel 2003; OECD 2011b). The differences in school attainment, differentiated levels of expenditure, and segregation, have led to a situation where municipal schools, which are 100% free and receive children from the lowest socioeconomic level, have lower attainment levels and become stigmatised as 'problematic schools'. There is evidence that teachers in these schools usually work without expectation of achievement by their students, generating

a lack of learning process and low self-esteem in their students (García-Huidobro 2007).

Inequality is also present in tertiary education, in other words, the possibilities that Chileans have of becoming professionals and increasing their years of education are also dependent on their socioeconomic background. The scores on the Universal Selection Test, PSU, an examination that students have to take once they finish their secondary education if they want to access higher education, present a socioeconomic gradient. The lower the socioeconomic background of the student, the lower his or her PSU's scores usually are and, therefore, the harder it is for the student to be accepted by a university (Muñoz and Redondo 2013). This is reflected in the economic gradient regarding higher education participation. Figure 4 shows that the lower the students' economic level – income quintiles, where I is the lowest and V is the highest - the lower their participation in higher education.

Figure 4: Higher Education coverage according to income quintile 2003 (%)



Source: Marcel and Tokman 2005

It is important to mention that even when students from lower socioeconomic levels could achieve the necessary scores; it would be highly unlikely that they would be able to join a university due to the high costs of tuition fees. In fact, according to the OECD (2009), Chile's tuition fees are the second highest to those of private universities in the USA. Thus, the possibility of receiving good quality secondary education and of accessing tertiary education in order to improve future job prospects is limited by people's purchasing power and access to government loans, which target vulnerable students who have outstanding scores and attainments (Law 20,027).

Different social movements have demanded a transformation of the education system. The first of them, promoted by secondary school students, took place in 2006. Thousands of students protested against the segregating effects of the education system and the limitations of the neoliberal education model, and was successful in influencing the government's agenda (Donoso 2013). The second education movement, which began in 2011, protested against the high tuition fees and loans that students and families are forced to pay and received significant support from the Chilean population (Vera Gajardo 2011). Both movements are related to the education reform that has been under review during the last two years and which has already approved modifications to the system such as the end of the shared funding of private subsidies schools (for more details, see <http://reformaeducacional.mineduc.cl/>). However, there are still several structural elements of this system that impede the opportunities for people from lower or middle socioeconomic backgrounds to raise their living standards by investing in their formal education and accessing good jobs.

4.4.3 Residential Segregation

A third factor that interacts with labour market and education inequalities and has an important impact on health is residential or spatial segregation. Residential segregation is a ‘geographic agglomeration of families with similar social conditions (ethnic, age or class)’, with the socioeconomic level being the predominant factor in Chile and other Latin American cities (Sabatini, Cáceres, and Cerda 2001, 27). This phenomenon is also related to social reforms that took place during the military dictatorship.

In 1979, under the neoliberal dictatorship, the urban land markets were privatised and deregulated (Supreme Decree 420 and Law 3,516/80). This meant that, among other measures, previous legal restrictions on urban limits were eliminated, a series of taxes and regulations on the urban land markets were removed, the state-owned land holdings were sold, and the illegal residents that had settled in the high-income areas of Santiago before 1973 were forced to leave (Sabatini 2003). As with the ideological approach to the education system, it was believed that the urban land market should work as any other market and that the state should avoid implementing regulations that would disrupt the market’s natural equilibrium. This resulted in a steady increase in the price of land which pushed low income families and public housing units further away from the city centre to less expensive areas. (Sabatini, Cáceres, and Cerda 2001; Sabatini 2003; Sabatini and Salcedo 2007). Due to the fact that the state has no instruments to regulate or intervene in the land market, it faces the same high prices that citizens do when they want to buy a piece of land. This explains why currently social housing in Santiago and other big Chilean cities are located between 30 to 40 kilometres away from the urban border (Sabatini, Cáceres, and Cerda 2001). This

concentration of poor neighbourhoods far away from the city centre leads to several social problems.

In the first place, residential segregation reinforces education inequalities. The isolation of poor communities denies residents access to high quality services, among them schools (Sabatini and Brain 2008). As described above, the education system follows a geographical segregation pattern; the best schools are located in the middle- and upper-income neighbourhoods, whereas those with lowest quality and results are found in lower-income communities (Sunkel 2003, OECD 2011d). Spatial segregation therefore worsens the differences between private, subsidised private and municipal schools. In fact, the educational results from the SIMCE test are lower in the segregated areas than they are in mixed zones for each type of school (Flores 2008).

Residential segregation also interacts with labour market inequalities. Not only do people who live in isolated communities have longer to commute, but they are also marginalised from information about good job offers due to their socially homogeneous environment (Sabatini, Cáceres, and Cerda 2001) or their bonding social capital. A study from the Chilean Catholic University shows that around 54% of women who live in popular highly segregated neighbourhoods would rather not work because the income received would not adequately compensate them for the time and money spent commuting. The study also shows that these women also feel unrest leaving their houses and children all day long, fearing that they may become involved in drug consumption or trafficking (Sabatini and Brain 2008). Therefore, some of the people participating in the study would rather live in an informal settlement, such as a *campamento*, that can be situated in a more central location, than in a public housing complex that is geographically distant from economic opportunities. In fact, studies

have shown that men living in *campamentos* have better labour outcomes than men who used to live in *campamentos* but now reside in peripheral public housing complexes (Brain, Prieto, and Sabatini 2010; Celhay and Sanhueza 2011).

The geographic isolation of opportunities creates a number of other social problems that reinforce the differentiation of life opportunities and reinforces the inequalities of Chilean society, for example, students being left behind at school, school-drop-out, higher rates of unemployed youth and teenage pregnancy (Sabatini, Cáceres, and Cerda 2001; Sabatini and Salcedo 2007; Sanhueza and Larrañaga 2007). The segregation of poor neighbourhoods is also associated with an increase in drug consumption, as well as higher rates of crime and violence, leading to stigmatization (Sabatini, Cáceres, and Cerda 2001; Sabatini and Brain 2008). These isolated neighbourhoods, with precarious living conditions, high rates of unemployment and a strong presence of crime and drugs, become ‘increasingly perceived by both outsiders and insiders as social purgatories’ (Wacquant 2008, 237), further increasing their marginalisation. Once again, studies show how residents of *campamentos* would rather stay in their precarious housing conditions than be transferred to public housing which they see as being governed by violence and drugs. Similarly, the people who live in these public housing complexes dream about moving to safer and more quiet neighbourhoods, or even to the countryside, as a way to protect their children from bad influences and danger (Brain, Prieto, and Sabatini 2010). All of this together reinforces a situation of social disintegration and a subculture of despair (Sabatini, Cáceres, and Cerda 2001).

As a way to conclude this section, it is possible to state that even though Chile has been recognised internationally for its economic and social achievements, its

inhabitants have not benefited equally from these successes, and they are increasingly aware of this situation. Not only is economic growth distributed unequally, but so is the nature of their employment, their education and their social relationships, all of them health-relevant dimensions as seen in Chapter 2. These factors not only operate separately but, as the analysis has shown, interact with each other, intensifying their impact on inequality. In other words, this group of dimensions of inequality not only impacts people's health but also leaves individuals in a socioeconomic position which is hard to improve because of the mechanisms upheld by neoliberalism: choice, competition and merits.

4.5 Health inequality in Chile: healthcare and health outcomes

The structural inequalities observed in income distribution, the labour market and employment, education, and residential segregation, are replicated in the healthcare system. Even though between 1990 and 2008 there was a constant increase in social expenditure for healthcare and health expenditure per capita (ECLAC 2010) together with improvement in health indicators, several studies show the persistence of differences in access and quality of health, gaps in health indicators, and disparities in expenses and health information (Arteaga et al. 2002; Frenz 2005; Frenz and González 2010; Sánchez R, Albala B, and Lera M 2005; OPS, OMS, and FONASA 2009; ECLAC 2006).

As described above, until 1979, Chile had a centralised public healthcare system – *Servicio Único de Salud* – financed by the state, implemented through a state-owned network of medical and healthcare services (Titelman 2000). The Military Government implemented reforms at the beginning of the 80's that replaced this

unified public organ with a decentralised system – Law DFL 1-3.063 in 1981 (Aedo 2000) – following its strongly neoliberal economic agenda. The healthcare system was divided into 26 regional health services with the responsibility for primary care falling to each of the 341 municipalities, regardless of their funds or capacity. One of the results of this decentralisation was that rural and poorer municipalities had more difficulties, while the richest municipalities enjoyed more resources per capita dedicated to health, although over time this gap is becoming smaller (Jiménez de la Jara 2005; Aedo 2000; Annick 2002; Bossert et al. 2000).

In 1979, the reformed law transformed the public system into a dual system: a private and a public one – Law 3.626 (Aedo 2000). This process of privatisation meant the creation of private health insurance companies (known as Instituciones de Salud Previsional - ISAPRE's), operating in parallel with the national publicly funded system (known as Fondo Nacional de Salud - FONASA). Under this law, formal salaried workers and retired people are obliged to pay 7% of their incomes to either system. People who have any no or low income (below 210,000 Chilean pesos, approximately 198 pounds) are categorised as A and B beneficiaries respectively. Group C is composed by those individuals who have monthly income between 210,000 Chilean pesos and 306,000 Chilean pesos (288 pounds) and Group D by those whose monthly income is more than 306,000 Chilean pesos. However, if someone wants to be a beneficiary of an ISAPRE, the health coverage plan will vary dependent upon the premium paid and the health risks associated with that person. These are determined mainly according to their age, gender and family situation. It is important to mention that during the dictatorship, the privatisation of the health system was accompanied by a significant reduction in public expenditure on health which caused a decline in the

quality of public infrastructure and care that is still present today. (Jiménez de la Jara 2005; Aedo 2000).

Under this system, people are expected to choose whether they want to receive their healthcare through the private or the public system. In reality, people from lower socioeconomic levels can only access insecure healthcare, while people with more socioeconomic resources can choose to receive private health care, which is usually safer, more efficient and more modern. According to data gathered by the national survey CASEN (2009), only 13% are able to afford private health (ISAPREs), mainly from the upper or upper-middle class (table 7), while the remaining 78.8% of the population belong to the public system (FONASA).

Income is not the only discriminatory variable in this system; the beneficiary's gender and age are also important. Unlike the fixed 7% charged by the public system FONASA, private insurers (ISAPREs) charge their premiums according to health risk assessment. This health risk assessment introduced a 'cream skimming' phenomenon in the private system, i.e. people who have higher risk of becoming ill or incurring health expenditure have to pay higher premiums because they are potentially 'more expensive' to treat (Titelman 2000). This leads to a situation where women of child-bearing age and the elderly are discriminated against by private health insurance companies. Women who may become pregnant face more expensive health insurance since 'their reproductive capacity implies a larger number of 'accidents' and therefore higher costs for the system which must be borne by them'. This is one of the reasons why the proportion of women within the private system is lower than men's, as table 7 shows (Matamala, Gálvez, and Gómez 2007, 45). Table 7 also illustrates the fact that, as people become older and retire from work, they tend to migrate from the private

to the public system as a response to the increase in their premiums and decrease in health coverage (Hernández et al. 2005).

Table 7: Affiliation to health system according to economic and demographic variables

	Public system	Private system	Other system	Uninsured	Do not know
Independent					
Income Quintile*					
I	93,2	1,5	1,2	2,8	1,4
II	90,3	3,5	1,7	2,8	1,7
III	85,1	6,7	3,1	3,1	2
IV	72,3	16,6	4,6	4,1	2,4
V	44,6	44,3	4,2	5,2	1,6
Gender					
Men	76,6	13,9	2,9	4,3	2,2
Women	80,8	12,3	2,7	2,8	1,4
Age					
0-19 years	81,2	12,2	2,5	2,6	1,4
20-44 years	74,9	15,3	2,5	4,9	2,4
45-69 years	78,6	13,3	3,3	3,4	1,5
70 or more years	87,8	4,9	4,6	1,3	1,5
Total	78,8	13,1	2,8	3,5	1,8

* The poorest income quintile is I and the richest V
Source: Prepared by the author using data from CASEN 2009

The differences in coverage and expenditure between the public and private systems are striking. According to Cid (2011), in 2008 6.9% of GDP was dedicated to private and public health, of which 2.4% of GDP went to private affiliates and 4.5% of GDP to public beneficiaries, despite the fact that the proportion of the population in the latter group is four times the proportion in the former (as discussed above). This means that the per capita expenditure on health is completely unequal. As Cid (2011) points out, the GDP per capita in the case of ISAPREs is comparable to Spain or the UK, whereas the GDP per capita for FONASA is lower than Latin America averages, which supports the contrasting realities analysed previously. When the characteristics of the population belonging to each system are taken into account (table 7), the picture

becomes worse: the public sector has the lowest GDP per capita to spend on people's health, yet this is where individuals with lower incomes and higher medical costs are concentrated (Titelman 2000).

From 1990 onwards, i.e. when democracy was reintroduced, various measures were taken to reduce inequity in the Chilean health system, 'reaffirming equity as a declared concern of sanitary policies' (Frenz 2005), while maintaining the decentralised and privatised structure, and thus its segregating character. Among these initiatives, the health reform initiated in 2002 is one of the most important. This reform resulted from the need to adjust to changes in the population's expectations of better access to healthcare when considering the new epidemiological profile and demographic changes (Arriagada et al. 2005). It included, among several aspects, a preventive dimension that included sanitary education, promotion of healthy lifestyles centred on individuals, and early detection of diseases (OPS/OMS/FONASA, 2009).

Part of this strategy aimed at responding to the epidemiological transition and the change in consumption patterns experienced by Chilean society from 1990 onwards. The epidemiological profile of Chile changed in a similar way to other developed countries. Chronic and non-communicable health conditions became responsible for the majority of deaths (Luque, Cisternas, and Araya 2006; Frenk et al. 1991), leading to a need for intervention in a more preventive rather than curative way. This transition is characterised by the development of conditions such as high blood pressure, cardiac risks, and diabetes in a significant proportion of the Chilean population (Ministerio de Salud et al. 2010). According to the WHO (2008), in Chile, 71% of years of life lost are due to non-communicable health conditions, while the regional average in Latin America is 59%. In a more detailed analysis (table 8), data shows that in 2008 obesity

rates – the proportion of population whose Body Mass Index (BMI) is greater than or equal to 30 – and rates of tobacco use in Chile were among the highest in Latin America (WHO 2011b), meaning that the epidemiological transition in Chile has been faster.

Table 8: Risk factors in Upper-middle income countries in Latin America (%)

	Obesity	Current daily tobacco smoking	Non-communicable conditions proportion of all deaths
Argentina	29.7	23.6	80
Brazil	18.8	14.1	74
Chile	29.4	35.5	83
Costa Rica	23.7	6.0	81
Mexico	32.1	13.4	78
Uruguay	24.8	30.2	87

Source: WHO 2011

Considering the previous discussion about the inequalities that Chileans experience in different health-relevant dimensions, it is not a surprise that chronic and non-communicable health conditions are not evenly distributed throughout the population. Different studies in Chile have shown how mortality rates and chronic health conditions, such as diabetes, are negatively associated with people's years of education and socioeconomic level, and the socioeconomic level of the municipalities they live in (Gattini et al. 2002; Vega et al. 2001; Albala et al. 2002; Departamento de Epidemiología - MINSAL 2006; Espejo 2005; Larrañaga 2005; MINSAL 2003; Hertel-Fernández et al. 2007), all of them social determinants of health dimensions related to the neoliberal policy regime. As table 9 shows, inequalities in these

indicators not only characterize the relationship between the highest income groups and the rest of the society. Middle income socioeconomic groups also have significant differences with the higher socioeconomic groups and with the lowest socioeconomic group.

Table 9: Socioeconomic differences in health conditions (probability coefficients)

	Lower socioecon. level	Middle socioecon. level	Higher socioecon. level
High blood pressure	1,7	1,4	1
Obesity	1,6	1,2	1
Diabetes Mellitus	3	2	1
Lack of physical activity	2,8	1,3	1

Source: Larrañaga 2005

One significant example of how social policies have been framed under a neoliberal logic, is a government program developed in 2011 by Chile’s First Lady, promoting healthy practices throughout the population. Under a behavioural perspective (see chapter 2), this program pursued the objective of decreasing ‘risk factors and behaviours’ related to non-communicable health conditions with the emphasis on individuals’ actions. This program, named ‘Choose to Live Healthy’ [*Elige vivir sano*’], aims to encourage a healthy individual diet, promote personal physical activity, disseminate the benefits associated with carrying out family activities, and inspire contact with nature, respect for the environment and outdoor life (www.eligevivirsano.cl). Its modus operandi is mainly distribution of information through brochures and advertisements, as well as the organization of events such as

family marathons. This type of program, oriented towards changing people's practices, recognises individual responsibility for health outcomes while ignoring the social determinants that create inequality within Chilean society (income, labour, education, residential) and the effect on their practices. In other words, the neoliberal logic reflected in this program reduces health-related practices to agency, and neglects the constraining/enabling role of structure and its interplay with agency.

Attempts to include contextual factors when tackling health inequalities have been obstructed by the power that Chilean business groups leverage through their close relationship with politicians (discussed earlier in this chapter). An emblematic case of this obstruction is clearly seen in the delay of the implementation of the Law of Food Labelling and Advertising [*Ley sobre composición nutricional de los alimentos y su publicidad*] (Law 20,606) approved in 2012, commonly known as 'Súper 8', the name of a popular Chilean chocolate. This law has three main components. First, it forbids the advertising of foods to children under the age of 14 which are considered to have an 'excess of sugar, salt, or saturated fat'. Secondly, it forbids selling these 'unhealthy' foods in educational institutions. And finally, it states that all food should have front labelling similar to a stop sign that warns 'excess of sugar, salt, or saturated fat'. . . However, even though this law was approved three years ago, it still has not come into force since it refers to a Food Regulation [*Reglamento Sanitario de Alimentos*] that specifies the limits of sugar, salt and saturated fat for food to be considered healthy. This regulation has been modified three times, each of them increasing the limits previously established, causing the implementation of the law to be postponed (Facultad de Odontología 2015). According to experts working on this regulation, 'food companies and some politicians have publicly argued that this law violates

freedom of expression, disregards the principle of self-responsibility and does not grasp the complexity of food advertising; lobbyists and public mass media have also spread this idea among the community' (Corvalán et al. 2013, 84). This situation reveals the structural power between business and politics, enabling initiatives to intervene in the social determinants of health to be hindered in favour of their own interests. In other words, it illustrates how a matter of public health becomes an issue of economic interests.

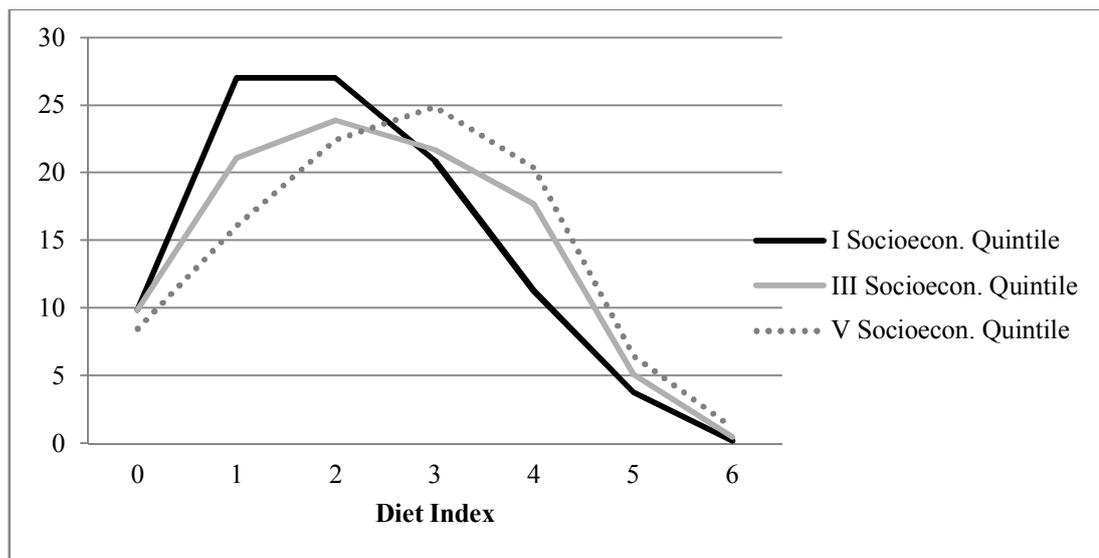
4.5.1 Patterns of health-related practices

Challenging the belief in individual responsibility, the extensive analysis of Chileans' health-related practices that I performed revealed the presence of demi-regularities in which these practices are related to two main social variables: socioeconomic level and gender. The results of this analysis, discussed below, confirm the importance of exploring the mechanisms through which the structure underpinned by the neoliberal policy regime limits the space that people from different social groups have for choosing their practices.

The statistical analysis of the survey ENCV (see Chapter 3 for description) shows that people's socioeconomic condition is negatively related to health-related practices considered to be risky or unhealthy by government and international standards (MINSAL and INTA 2004; WHO 2004). This may be seen, firstly, in relation to diet. Figure 5 shows a gradient throughout the socioeconomic quintiles regarding a diet index (0 to 6 index; as the number increases, the diet becomes healthier – see Chapter 3) meaning that people have a poorer diet than those who are situated immediately above them in socioeconomic terms. As the socioeconomic level increases, the curve moves to the right, illustrating that the diet index increases. This difference ($p < .001$)

is mainly due to a tendency of those within in quintile I to consume less vegetables, fruit, milk, and legumes compared to quintile V. Indeed, data from a linear regression model (table 10) show that this socioeconomic indicator has the largest effect on diet when keeping gender, age and place of residence constant.

Figure 5: Diet Index according to socioeconomic quintiles



Source: Prepared by the author using data from Departamento de Epidemiología - MINSAL 2006

This tendency is also present when analysing how physical activity (doing physical exercise for 30 minutes, 3 or more times a week – description in Chapter 3) is distributed across the population. Data shows a big difference according to socioeconomic level, favouring the most privileged. Fewer than 4% of people in the first socioeconomic quintile – the poorest one – carry out physical activity for 30 minutes, 3 or more times a week, while 9.5% of those who are in the middle socioeconomic quintile (III) and 14% in the highest quintile (V) are physically active ($p < .001$). A binary regression analysis shows that, once again, the socioeconomic level

is the structural variable that explains the largest variance in the physical activity indicator. This effect remains constant and significant, regardless of the amount and range of structural variables for which it is being controlled. Table 10 shows that the odds of doing enough physical activity are 238% and 126% higher for those in quintile V and quintile III, respectively, than for those in quintile I, after allowing for the other structural variables.

Additionally, the analysis shows that 14.7% of the Chilean population display a drinking problem (see definition of indicator in Chapter 3), most of them being men from the lower socioeconomic group. People in higher socioeconomic conditions (quintiles V and IV) are less likely to drink heavily than those from the middle (quintile III) and lower socioeconomic groups (quintiles I and II). In fact, belonging to the richest socioeconomic quintile reduces the odds of an alcohol-related problem by 62.4% in comparison to individuals from the 1st quintile (table 10).

Table 10: Regression models according to health-related practices

	Diet index	Physical activity	Tobacco consumption	Alcohol consumption
Woman	0.31***	0.63***	0.60***	0.18***
Age	0.02***	0.98***	0.97***	0.99***
Urban area	- 0.11	1,23	1.27***	1.48***
Socioeconomic quintile II	0.27***	2.03***	0.90	0.74***
Socioeconomic quintile III	0.36***	2.26***	0.99	0.63***
Socioeconomic quintile IV	0.49***	2.99***	1.00	0.48***
Socioeconomic quintile V	0.65***	3.38***	0.97	0.38***

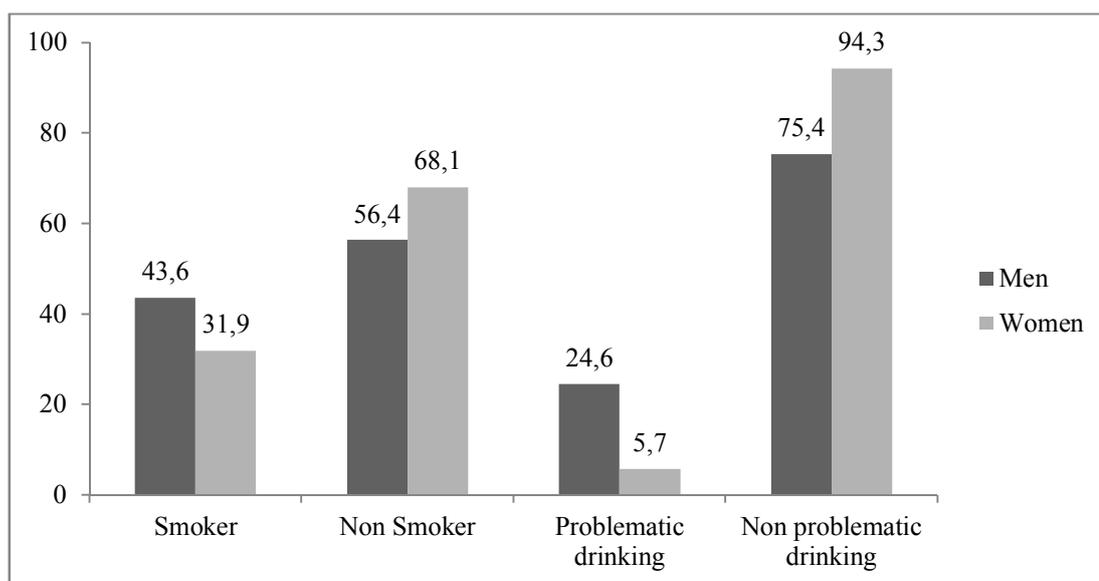
Source: Prepared by the author using data from Departamento de Epidemiología - MINSAL 2006

The second social variable identified as statistically related to health-related practices is gender. Even when data shows that the majority of men and women eat reasonably well according to government guidelines, do not smoke and do not drink what is deemed excessively, men seem to be more likely to engage in fewer so-called healthy behaviours than women. This is reflected in the fact that men are more likely to have unhealthier diets, and represent a higher proportion of smokers and problem drinkers, as table 10 shows. These results are explained below.

Firstly, the extensive analysis shows that food intake for women tends to be more in alignment with recommended healthy standards (WHO 2004) than men. Women are more likely to have a diet with higher consumption of vegetables, fruit, and milk, as well as lower consumption of fried food compared to men ($p < .001$). Regression analysis shows that, statistically, gender has the second largest effect on the type of diet consumed, after income, with females having a diet index around 0.3 points higher

than men. Secondly, binary logistic regression of the ENCV data shows that women are 40% less likely to smoke and 82% less likely to drink heavily than men. This confirms that smokers and those with problematic consumption of alcohol are more likely to be men than women, as seen in figure 6

Figure 6: Smoking and alcohol problematic consumption according to gender



Source: Prepared by the author using data from Departamento de Epidemiología - MINSAL 2006

Physical activity is the only area where men tend to have better habits than woman, although according to government guidelines, the majority of both genders do insufficient exercise. Only 11% of men claim to be physically active, and an even lower 7% of women may be described this way. In fact, the odds of a woman being physically active are 37% lower than for men (table 10).

Thus, the extensive analysis shows demi-regularities between social factors and the carrying out of health-related practices that suggest the importance that structure has for these practices. It shows that individuals' socioeconomic condition is negatively associated with health-related practices considered unhealthy by government and international standards, and also that gender constitutes a factor that constrains/enables these practices. These findings confirm the relevance of researching the mechanisms through which the space for agency that people have over their health-related practices change, according to their socioeconomic level and gender, within a context of strong health-relevant inequalities consolidated by a neoliberal policy regime.

4.6 Conclusion

This chapter has analysed how the Chilean neoliberal policy regime creates inequalities in health-relevant dimensions that affect people's daily lives, and to which extent these are translated into a health gradient that affects not only the poorest but also those in the middle socioeconomic groups. The contextual analysis I performed shows that neoliberal principles of choice, competition and privatisation present in social policies have benefited the upper social classes, while leaving behind the rest of the population. By following a critical realist perspective, the analysis has showed that the implementation of a neoliberal policy regime and its perpetuation through a strong coalition between the domestic business elite and political powers has consolidated a country into one of opposite and contrasting faces. While on the one hand, it presents a successful society with economic growth rates and social indicators comparable to those of developed nations, on the other hand, this policy regime creates strong social determinants that bolster a highly unequal country.

The neoliberal policy regime has created a structure in which income is highly concentrated among the richest 10% of the population. In a commodified society in which access to social dimensions, such as education and health, are dependent on people's purchasing power, income inequality helps to explain why only the richest sectors of society have benefited from neoliberalism. Income inequalities derive to an extent from the heterogeneous economic structure and low value of labour in Chile. Labour regulations inherited from the military dictatorship maintain the balance in favour of employers and businesses by allowing hidden informality, the maintenance of low salaries – especially for women –and insufficient and ineffective spaces for negotiation. The inequalities Chileans experience in the labour market are aggravated by education inequalities. The neoliberal structure of the educational system produces not only differences in school attainment and levels of expenditure according to socioeconomic factors, but it also increases the difficulty of accessing tertiary education as students' socioeconomic level decreases. It does so by affecting young people's scores on tests to enter university, and by tolerating high tuition fees. The lack of a professional degree translates into difficulties finding employment with better salaries and conditions. In turn inequalities in both the labour market and education are compounded by residential segregation, yet another legacy from Pinochet's government. Firstly, one of the most important constraints for getting a better job is the lack of information about good job offers caused by the low social diversified environments in which they live and work. People with similar socioeconomic conditions and education levels are usually exposed to similar job information, meaning that the social similarities between neighbours and social contacts decreases the probability of those isolated from the rest of the community from finding better jobs. Secondly, because public schools are now administered by local municipalities,

education inequalities interact with and are strengthened by residential segregation. The lower the resources of municipalities, the lower the quality of education children living in those neighbourhoods receive.

The chain of inequalities that the neoliberal policy regime has consolidated implies that health-related practices are enacted in different economic, work-related, educational and residential realities according to people's gender and socioeconomic level. This unequal context is reflected in the demi-regularities observed in relation to Chileans' health-related practices. These tendencies suggest the importance that social variables (socioeconomic level and gender) have in people's daily actions, and raises the question about the specific mechanisms within these dimensions and their effects, which will be analysed in the next chapters.

In theoretical terms, if the psychosocial approach is to be followed (discussion in chapter 2) Chile's recent high-income status would mean that material factors would no longer be relevant in order to explain health inequalities. According to this approach (Wilkinson 1996), health inequality should be explained through the negative psychological effects that income inequality produces on the disadvantaged part of the population. However, the contextual analysis developed here not only suggests that Chileans still experience significant material limitations that may influence their health outcomes and practices, but also affirms the importance of the analysis of social causes of inequality and consideration of other health-relevant dimensions, as stated by neo-materialist research (Coburn 2006; Lynch et al. 2004; Navarro and Shi 2001).

The next chapters analyse how people define and experience their own health given this context. They research to what extent people within the middle and lower socioeconomic group think they have control over health determinants and how their

life experiences reveal the different mechanisms through which social structure limits their agency over health-related practices. By combining qualitative and quantitative methods, these chapters not only analyse the meanings that men and women from different socioeconomic groups give to health, but also the ways in which their economic capital, together with their social and cultural capital, shape their way of life.

CHAPTER 5 - LAY KNOWLEDGE OF HEALTH: HOW MUCH CONTROL DO PEOPLE BELIEVE THEY HAVE OVER HEALTH OUTCOMES AND PRACTICES?

5.1 Introduction

The previous chapter provided evidence concerning the chain of inequalities created by the neoliberal policy regime that Chileans experience in their daily lives. It showed that health-related practices are enacted in different economic, educational, and social realities according to people's socioeconomic level and gender. In order to explore the mechanisms through which the structure influences the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal country such as Chile, this chapter analyses the aspects of Chilean society that affect how people understand and experience health and how these are related to people's sense of responsibility for health outcomes and health-related practices.

On the one hand, the fact of being exposed to different contexts might mean that individuals from different social groups define and experience health in different ways. Crawford states that health 'is a concept grounded in the experiences and concerns of everyday life (...) [and] is a category of experience that reveals tacit assumptions about individual and social reality' (1984, 60). While some individuals may emphasise its relationship to illnesses, others may centre their attention on aspects such as its benefits. The definitions that people give to health reveal the importance that different aspects of society have in relation to their health outcomes and health-related practices.

On the other hand, the way in which people from different social groups talk about health suggests how much control they believe they have over their health outcomes. The way people experience health contributes to the debate about the extent to which health-related practices are a matter of individual responsibility, i.e. undetermined agency, and how much of them are a result of being exposed to the material world, i.e. restricted agency. The positions taken within this debate are not random or accidental, but are related to individuals' social realities and experiences (Pill and Stott 1985; Blaxter 1990; Blaxter 2010). As it will be seen throughout the chapter, even when a critical realist approach would argue that individuals are not necessarily aware of the forces and mechanisms that shape their lives (discussion in Chapter 3), the data presented herein contradicts this idea by showing that people are able to see these forces to some extent.

Therefore, this chapter analyses firstly the meanings that men and women from lower and middle socioeconomic groups give to the notion of 'health' and how these definitions are influenced by aspects of Chilean society. By accessing the meanings that individuals give to health, it will be possible to analyse which aspects of their differing realities according to their socioeconomic position, gender and age, affect their understanding and experience of health. Secondly, the chapter explores the factors that respondents believe affect people's health experiences and outcomes, which reveal how responsible people feel about their health outcomes and their relationship to what are seen as 'health-related practices'.

5.2 What does ‘health’ mean?

A number of studies have shown how individuals from different social groups and societies give different meanings to ‘health’, which can co-exist in one discourse (Blaxter 1990; Blaxter 1997). While some associate it with the absence of illnesses – a negative view of health – others relate it to being physically fit and feeling good, i.e. a positive view. According to Crawford (1984, 60), these different concepts reveal ‘culture’s notion of wellbeing’, thus showing what is valued within certain societies and between social groups. This section will be centred on the definitions that men and women from different socioeconomic groups give to health.

There was a wide consensus among the respondents that health is one of the most important things in life. Nevertheless, different groups tended to emphasise specific aspects or meanings of health. Amongst them, five definitions or sets of discourses emerged: health as a function to an end, as not being ill, as vitality, as the combination of mind and body, and as a financial danger. Even though they are presented and described separately here, they were intertwined and co-existed in the participants’ discourses.

The first of the definitions identified was a ‘functional’ understanding of health, also found in previous studies (Blaxter 1990; Blaxter 2010). Health is perceived as useful or basic for doing something else, such as work or a sport, it is a means, not a goal. Being healthy allows people to carry out their responsibilities and valued activities and, therefore, it is amongst the most important things in life. This concept of health was found amongst participants who belong to middle and lower socioeconomic groups studied, men and women.

I think that health is the essential part of a person, without health we cannot do anything. We can't work, we can't do any kind of sport, keeping ourselves active is good for our brain, for memory, for everything. So I think that without health we can't do anything (Felipe, man, middle socioeconomic group, 37 years old)

Physical health is obviously the most important thing that human beings need to be able to function, I mean, we need to have good health to be able to remain active, to be able to work, to live (Jessica, woman, middle socioeconomic group, 41 years old)

For me health is something important, very important (...) because if you get sick, you stay still with your arms folded [*queda con los brazos cruzados*], I think (Juan, Man, lower socioeconomic group, 38 years old)

Some respondents related this functionality to people's identity and existence, revealing the importance that being able to work has within the Chilean society. A sick person cannot work and without work you cannot live, therefore he or she becomes 'no-one' [*no eres nadie*]. Interestingly, with this point of view, absence of health restricts your life not in the sense that you might die directly from a health condition, but due to the fact that it keeps you from working and earning money, and as a consequence you would have nothing to live on.

I think that health is essential for a person because without health, what are we? We are nothing (...) when you are sick you are not able to work and without work I wouldn't have anything to live on, so for me health is essential (Oscar, man, middle socioeconomic group, 65 years old)

This dependency on work to be able to live may be related to the commodification of the social services in Chile. As was seen in the previous chapter, people's market performance is responsible for determining 'what you live on' and which type of access people have to basic social services such as health and education. In the specific example of the previous quotation, an older man who was already retired stated this point of view. However, regardless of the fact that he had worked his entire life, he still worked self-employed as a taxi driver. He stated that the pension he received was not enough to cover his needs and he needed to augment his income. This concept of health suggests the importance of individual responsibility to secure wellbeing notwithstanding the lack of social security, an aspect that will be seen throughout this and the next chapter.

At the same time, it is possible to see significant gender differentiation within this category of health. The activities or responsibilities named by the respondents to which having health is central changes according to their gender. Women stated that without health they cannot raise their family or do any housework, implying that housework is a female responsibility. The traditional gender role of a housewife in relation to health observed twenty years ago by Doyal (1995) is still prominent in Chile (UNDP 2010). In turn, men were exclusively centred on the fact that lack of health would constrain them from working and earning money. Previous research has also suggested the centrality that work has in men's 'cultural construction of being male' and its close relationship with health (Dolan 2011, 591). Thus, the functionality of health according to gender reflects a traditional division of labour with which both female and male respondents identified with:

... you have to take care of yourself because you are the house pillar... if something happens to me, who will go out to get them food? (Rodrigo, Man, lower socioeconomic group, 46 years old)

... if you don't have health you cannot raise your family well, if you don't have health you cannot do the housework (Soledad, woman, middle socioeconomic group, 53 years old)

The only woman that mentioned that having good health was necessary to be able to work was a single mother, daughter of a single mother, who had received no financial contribution from the father of her children or from the State. Her example represents a situation in which women have to be 'fathers and mothers at the same time'.

Physical health is obviously the most important thing that human beings need to be able to function, I mean, we need to have good health to be able to remain active, to be able to work, to live (Jessica, woman, middle socioeconomic group, 41 years old)

This definition was absent from young people's discourses; it was exclusively adults who saw health as a means to an end. The same tendency was found by Blaxter (1990), who argues that it is very likely that young people take the capacity to carry out the tasks of life for granted (Blaxter 2010, 55). Additionally, since young people usually had fewer responsibilities for others than adults, it is possible that they did not feel the pressure of failing their duties and the construction of their identities did not depend on it.

The second approach to health was in line with biomedical definitions by being centred on a negative concept of health, that is, the absence of illness. Understanding health as

the absence of ill-health was very common amongst adults, mainly women from the lower socioeconomic group, whereas men and women from the middle socioeconomic group tended to focus more on the functional side of health. In this lower socioeconomic group, health was related to words such as diseases, pain, medicine and drugs, difficulties and problems. This concept of health may be a reflection of the fact that these women experience health problems more frequently than the rest of the population according to data gathered by UTPCH (2011).

Health may be... when doctors make a diagnosis and they find that your health is bad, it is a disease that the whole country has, one way or another, that requires medicine, where you take medicine, herbs, everything... (Joana, woman, lower socioeconomic group, 41 years old)

I think that health is something important because there comes a moment when you start getting sick, you start feeling pain in your body (Ana, woman, lower socioeconomic group, 36 years old)

A third concept of health was related with vitality, feeling well. This positive meaning of health was expressed almost exclusively by young people in the research, which is a tendency also found in previous research (Blaxter 1990). Young men and women from both socioeconomic groups associated health with something positive, with feeling well, vital and energetic.

Health is... health is to be well in many areas I think (...) psychologically, physically, your body, be well, find yourself well, in a good spirit [*con ánimo*] (Camila, woman, lower socioeconomic group, 17 years old)

For me health means a word that already brings something good, having health

means being well within your body, it makes reference basically to the body, that it works well, to the body and the mind (Andres, man, middle socioeconomic group, 18 years old)

It is interesting to see how this positive approach did not emerge as different between socioeconomic groups. Teenagers who lived under very different material conditions, surrounded by dissimilar environments and experiencing contrasting daily problems or issues, still associated health with similar things. This result may imply, on the one hand, that this tendency has more to do with the period of life the people are in, and on the other, that differences between perspectives and experiences according to the social group to which they belong emerge later in their lifetime.

A fourth meaning of health was an holistic concept, as 'psychosocial wellbeing' with a strong emphasis on mental health (Blaxter 1990). Whether health is associated negatively with the absence of illness or positively with vitality, there is a consensus that health has not only to do with physical health but also with mental health. Even when there was a tendency to understand health as vitality, this concept focussed in an unbiased way on the complementary aspect between the mind and the body.

For someone to be healthy, it goes beyond the physical part. A person that doesn't get sick, that doesn't have a stomach ache, that doesn't have cramps or that doesn't need an operation is not necessarily a healthy person, I mean, if in his head he has, I don't know, depression, stress, but his body is healthy, he is not a healthy person. For me health is something complementary. Your body is fine, works as it should and so does you head (...) So, for me it is that, a combination of both things, you gain nothing [*no sacas nada*] by having a good body if your mind is doing bad or the other way around, if your mind is doing good and your body is bad (Nicolas, man, middle socioeconomic group, 32 years old)

Participants did not only recognize the importance of the two dimensions i.e. mind and body, but also how they affect each other, supporting some control of mind over body arguing that your mental state may determine your physical health. According to their experiences, having many problems or suffering stress or depression can cause physical health problems, such as kidney infections, pain, headaches, and even death. There are two examples particularly worth mentioning regarding this association. The first of them comes from a woman in the middle socioeconomic group (45 years old) whose extended family had suffered many cancers as well as various forms of depression. When we were talking about their health problems, she firmly stated that cancer is caused by the daily stress of their lives and that depression can kill, as it had done her mother.

Interviewer: So you mean that it [stress] can be transformed into cancer afterwards?

Respondent: It triggers it, yes, and everything... you only have to take a look around. There are people that have endogenous depression, endogenous, for all their lives! I don't know... I experienced it personally with my mother. My mother didn't want to live any more, she saw that my sister was dying and she said "I will not bury my daughter" and she said it from the very beginning, so she stopped talking, she stopped eating, she stopped drinking water, for one week and her mind ruled over her body, she caused it all in just one week (Paula, woman, middle socioeconomic group, 45 years old)

The second example was from a woman who recently moved from a *campamento* to a public housing complex located in a troubled neighbourhood. Her teenage son got into a fight with some teenagers from across the street, who afterwards came looking for him and his father, with guns and knives, threatening to kill them. She suffered a facial paralysis, which, together with other health complications, was diagnosed by a doctor, as being a consequence of the stress that she had experienced.

When that problem happened, it affected me, my face fell asleep (...) I went to the doctor (...) and they told me that it was the beginning of a paralysis and afterwards I went to a neurologist and he told me that it was because of the crisis (Paola, woman, lower socioeconomic group, 38 years old)

These two examples reflect how individuals from both socioeconomic groups, who experienced stressful situations of a diverse nature, express the connection between mental and physical health. The experience of health as psychosocial wellbeing was identified universally across socioeconomic groups, ages and gender.

A final association identified in the discourses was the connection between health and financial danger. It was very common for respondents from the middle socioeconomic group when asked about health to start talking about money and how expensive 'health' is in Chile. They expressed a belief that in order to have health or to avoid getting ill, you need to have money and good health insurance. To them, talking about health was talking about money.

(When I think of health, I think of) misery, I think that ill-health leaves you broken, it is the most expensive thing here in Chile (...) I always tell my siblings, they work as self-employed [*independientes*] and do not have insurance, I tell them "one day you get ill and an illness, this size, small, and all you own is gone!", because you need to get better somehow, because if you don't get better you also lose everything (Paula, woman, middle socioeconomic group, 45 years old)

Health does not have any importance for me until it fails, which can be a drama, it can change your whole panorama. As long as we don't talk about health everything is clear, but when it fails... it is like a car automatic gearbox (...) So I have an insurance that seems to cover many UFs [unit of account related to Chilean pesos]. That is the problem, it is always there" (Jorge, man, middle socioeconomic group, 52 years old)

As can be seen in these quotations, health was seen as related to a threat that may become a reality at any moment, and leave people bankrupt. This fear may be considered, once again, as being related to the commodification of health and healthcare in Chile. In fact, Chile has an out-of-pocket expenditure on health corresponding to 38 – 40%, one of the highest within OECD countries. This places the

country way above the average for this group, which is lower than 10% (OECD 2011; Cid 2011).

It is worth emphasising that this type of association was only present in the discourses of individuals from middle socioeconomic groups. This might be because they have a higher chance of using the private or asking for loans or other forms of economic capital that can be spent on health needs, when compared to people who live in *campamentos*. Since spending large amounts of money on healthcare is not a reality for individuals from the lower socioeconomic group, it is not something that seems to be present in their thinking when talking about health.

To summarise, although respondents articulated different definitions of health, all saw it as both having a central importance in their lives (for different reasons) and encompassing many aspects of wellbeing. These complex meanings attached to health reveal aspects that impact how people understand and experience it. The first of them is the centrality of work in a highly product-based society. In addition to being gender-related (Dolan 2011), respondents stated that they needed health in order to work and earn the necessary resources to live. This preoccupation can lead individuals to have two full time jobs to earn the amount of money they feel they need, despite this potential of damage to their health, as will be seen in subsequent chapters. Secondly, it revealed the presence of traditional and patriarchal gender roles that expect women to raise their families while men go out to work to feed their families. This gendered division of labour and the concepts of ‘femininity’ and ‘masculinity’ also had an impact on the health-related practices with which men and women engaged, as will be seen in chapter 7. Thirdly, the stage of the person’s lifecycle also shaped their views on health. While adults concentrated on how to fulfil their duties, young people more

often embraced the positive side of health and vitality as an end in itself. Fourthly, people's health experience and condition influenced the meanings they gave to health. Those who had worse outcomes and suffered from pain and discomfort – women from the lower socioeconomic group – tended to associate health with illnesses and loss of functionality, while individuals who had better outcomes, e.g. young women and men, tended to focus on its positive side. Finally, the commodification of health, characteristic of the Chilean society, is reflected in the way in which middle class people tended to talk about money and fear of bankruptcy when talking about health.

5.3 What affects health? Lay knowledge of the effect of structure and agency

What affects health? What triggers physical illnesses or emotional stress? Are health problems produced by external conditions or are they a result of people's own agency and actions? A variety of factors were identified by respondents: these included the quality of water, working conditions, hygiene, insecurity, noise, pollution, diet, alcohol, violence, depression, smells, and 'lifestyles', among many others. Despite the wide variety of answers, by drawing on ideas in Dahlgren's and colleagues' rainbow model presented in Chapter 2 (Figure 1), it was possible to group them into three sets of perceived influences. The first set unifies level one and two from the model, thus representing 'general socioeconomic, environmental and working conditions'; the second relates to the 'social and community influences', that is, social relationships; and the third makes reference to 'individual lifestyle factors', i.e. internal or agency factors.

5.3.1 General socioeconomic, environmental and working conditions

Within the structural dimensions stated by respondents as having an effect on their health, it was possible to identify a number of structural variables, such as economic resources, nature of their work, and transport system.

The first structural level identified by both female and male respondents from both socioeconomic groups was people's economic situation. They stated that this dimension affected physical and mental health through different pathways. In the first place, not having enough economic resources to live has a causal influence on people's health and health-related practices. Respondents said that living under a tight budget limited not only the types of practices they could carry out since they were not able to afford them, but also the quality of life they were exposed to.

It is obvious that if I have money and I can afford good trainers and good sport pants and go out jogging in the weekend and not being worried about the bill, about this, about that, I will obviously have a much better level of health (...)
I think the biggest affect is not having the necessary resources to live (Jessica, woman, middle socioeconomic group, 41 years old)

... a person that has access to drinkable water will obviously have far fewer possibilities of getting ill than a person that doesn't have it. A person that has resources to have a good diet as well (Andres, man, middle socioeconomic level, 18 years old)

It is interesting to note that the relation between money and health conditions was mentioned mostly by respondents from middle socioeconomic groups. Participants who lived in *campamentos* barely mentioned this factor in relation to health, mainly because they stated that they always found a way to get the money for their basic needs, such as food. However, they did recognise the relationship between the precarious housing conditions in which they lived and their health, which they saw, ultimately, as a consequence of their lack of money.

My daughter had hepatitis, but I think that it was because the water we were drinking was not good, a lot of polluted water (Joana, woman, lower socioeconomic level, 41 years old)

In some cases (what affects health) are bad smells, people that live nearby landfills... or that sometimes the municipality doesn't take the garbage away (Patricia, woman, lower socioeconomic level, 45 years old).

A study made by the NGO Un Techo Para Chile shows that 20.5% of the *campamentos* houses did not have access to drinking water and only 34.8% had access to the public sewage system (UTPCH 2011). These unsanitary conditions may lead to health problems, such as one mentioned by a number of respondents, hepatitis.

Participants stated that not having sufficient money to live a healthy life also affected them psychologically. Stress, and its link between material conditions and health

outcomes, has been found in previous studies on lay theories (Popay et al 2003). Even though the economic and employment situation of middle class people was better than that of lower class people, the relationship between lack of money and emotional stress was mainly present in the accounts of middle class participants. According to them, the difficulties of their situation often produced high levels of stress and anxiety. Not only did it make them feel scared about their economic insecurity in case of ill-health, or an economic or other type of crisis, but also in their daily lives when they couldn't give their children what they wanted to.

And to think on a Saturday or Sunday, when everyone is going out, going to restaurants, you look at your kids and say 'what do I cook for them?'. You know, isn't your health going to change if you have some resources compared to when you don't have anything? Obviously your health changes, your mood changes, your thoughts change, everything changes (Jessica, woman, middle socioeconomic group, 41 years old)

Finally, the third dimension by which participants mentioned money affecting their health was in determining the health system they could belong to. They argued that those who have enough money can access better health care and prompt attention; those who do not, may have to wait longer periods of time, for lower quality care.

Interviewer: And what things do you think affect health?

Respondent: Today the difference is in whether you are in FONASA or in an ISAPRE [see Chapter 4, section 5 for explanation] and having the money. For example, I say, 'I am poor with ISAPRE' because I have 90% of hospitalization coverage (...) It is expensive but it is a benefit that gives you a certain calm that you wouldn't have if you needed to go to a public hospital (...) where it can take them 20 hours to see you for a peritonitis and you can die on the way (Soledad, woman, middle socioeconomic group, 53 years old)

Respondents' experience of the health system and its commodified character will be explored in more detail in the next chapter.

The relationship between money and health was in fact mainly discussed by women. As was seen in the definitions that people gave to health, men follow a 'breadwinner' model role, i.e. they stated that they needed to be healthy in order to work and provide the necessary resources for their families. As Dolan observed in relation to men's evaluation of their financial situation, 'good' husbands/fathers were identified as those who provided reasonable standards of living for their families' (Dolan 2007, 717). Thus, the absence of references to this factor not only confirms a functional view of health but might also reflect a negative moral judgement towards men recognising or acknowledging that the economic resources they bring home are insufficient.

The second macro-level factor mentioned by the participants was the nature of their paid work. While this dimension was mentioned by men and women from the middle class alike, only men from the working class stated the impact that their paid work had on their health. As will be seen in the next chapter, women from the lower socioeconomic group are mostly dedicated to household work. Respondents argued

that characteristics of paid work, can affect both physical and mental health. Respondents from different socioeconomic groups saw this relationship with different emphasis, which corresponded to their working realities.

From the beginning, participants stated that their employment and labour histories have had an impact on their physical health. In the case of men from the working class, respondents stated that the intense physical labour they have been subjected to had damaged their health. The types of jobs that they had were usually manual, with a high physical demand, contributing to an image of masculine toughness, observed in previous research (Dolan 2011). This was frequently accompanied by an early entry in the labour market, thus generating a physical weariness that they perceived as difficult, if not impossible to reverse.

I worked for 10 years in welding and by working in welding I acquired an occupational disease that is very complicated for me until today (...) because of the inhalation of the smoke from welding and because of the steel particles, which are the most complex ones, steel particles, not iron (Pablo, man, lower socioeconomic group, 48 years old)

I had the bad luck that I had to load lettuce (...) the ice-cold in the mornings, in winter mainly, you have to be inside the mud, and over the years that produces arthritis. I say this is my experience because my mom [*mi vieja*] was in the farm every year and she is not able to walk anymore because of her legs, her legs hurt (...) and I worked a lot when I was young (...) when I was about 8 years old I went with my mom [*mi vieja*] to clean, inside the mud (Pedro, man, lower socioeconomic group, 42 years old)

Respondents from the middle class also mentioned the physical effects that their work has had on their health, but from another angle. Here the situation was described as something circumstantial that would change if they changed jobs, and not as a physical hazard or accumulation. This difference was mainly due to the fact that they usually had non-manual employment, which according to them led to sedentary lives and gaining weight.

My health has always been in response to the work I have (...)I stopped working per shift and (...)obviously I gained weight, before I was not this chubby, afterwards I started gaining weight because the 8 hours that I used to work standing, now I work sitting down (Nicolas, man, middle socioeconomic group, 32 years old)

Therefore, the different nature of their employment as well as a later entry into the labour market led people in the middle socioeconomic group to experience the relationship between physical health and employment in a different way, where work was perceived as less harmful. The most important effect that men and women from middle class perceived was mental stress. They stated that the mental effect of work was related to anxiety about being paid, the type of responsibilities that they bear,

contractual issues, and not being able to do work that they like. Here participants stated that being in an unstable or unfulfilling job may lead to depression and self-esteem problems, giving evidence of the impact that labour and employment inequalities have on health outcomes, described in Chapter 4.

The period in my life in which I have been most sick... I think it was when I was unstable in relation to work [*inestable laboralmente*]. Yes, I had depression, you value yourself very little, you have less chances to get many things and when you have children, that produces a lot of anxiety, you see everything as bad (Jessica, woman, middle socioeconomic level, 41 years old)

... what made me go (to a psychologist) was the frustration related to work (...) from 2001 to 2005 approximately... I even worked in a call centre! I had only been in bad quality [*penca*] jobs! I told you that I started selling alarms and all those kind of things, so it reached a point in which I got frustrated, I was never able to find something in what I had studied (Claudia, woman, middle socioeconomic level, 34 years old)

... they don't pay me when they should, I mean, they pay me a bit, then another bit and another bit, and like that. And because of that I am stressed (...) this uncertainty is very overwhelming (Nicolas, man, middle socioeconomic level, 32 years old)

In turn, men from the lower socioeconomic group related their stress within work mainly due to emotional distress (e.g. working in a cemetery), not having enough time to rest and be with their families (e.g. working 6 days a week or having 2 full-time jobs), and for the lack of clients when self-employed.

... when I started this work, after around a year I started to feel my body heavier, stressed... you only want to go out to have fun, to get it off your chest, play football (...) you see many people crying (at the funerals) but you can't cry, you cannot get it off your chest. You have to be straight up, looking and every day, every day, every day (Juan, man, lower socioeconomic group, 38 years old)

As may be seen, the characteristics of the working conditions that these individuals stated as causing them stress varied according to their socioeconomic level. The effect described by workers who belong to the middle socioeconomic group is different to that perceived by those from the lower socioeconomic group. Whereas the former related their stress to being frustrated because of a lack of better opportunities resulting in feeling that they are overqualified or that they should have a better quality job, the latter related it to being overly tired and the unstable nature of self-employed work. The impact suffered by women from middle socioeconomic group of having paid work and being responsible for household work will be analysed in the next chapter.

Thirdly, according to the respondents, the place in which they live also affected their health. In this sense, Santiago was not portrayed as a friendly or health-promoting city, quite the opposite. Participants from both socioeconomic groups, adults and teenagers, recognized how different aspects of their surroundings affect their mental and physical health. One of the strongest features mentioned was insecurity and fear of crime, aspects related to high income inequality, according to Wilkinson and Pickett (2009). Respondents stated that they lived in a reality where they were constantly scared of being victims of assault, robbery, attacks, or being hit by a car, where they feared that drugs and alcohol were everywhere. Respondents also feared strangers, particularly

women when walking by themselves in the street. Only 45% of Chileans state that they feel safe walking alone at night in the city or area where they live (OECD 2014, 141). Some of them had already been mugged or their houses had been robbed, exacerbating their feelings of anxiety and emotional stress.

(I have) fear. For instance, being by myself in the street and suddenly I feel that there is someone close by or that someone is coming with a strange expression, I don't know, being on the bus and seeing that someone came in and I feel that he will get off at the same stop as me, that makes me hysterical, all shaking, a nervousness that I cannot control (Juana, woman, middle socioeconomic group, 35 years old)

The environment (in Santiago), the environment that you go out, you see a car in the street and you have to be careful that it doesn't hit you or another car that is near you... it's like you are more stressed in the street, like with crimes that in any moment you can get mugged [*cogotear*], all those things stress you when you are in the street here in Santiago (Pedro, man, lower socioeconomic group, 42 years old)

Even though this need to be alert at all times was seen across socioeconomic groups, it was also observed that people who live in *campamentos* felt themselves to be exposed to a reality that was much more violent. *Campamentos*' residents expressed how fights in their environment are very violent, including shootings and deaths, drug trafficking and consumption, and house robberies, amongst others. This type of situation restricted their daily lives, not only by limiting the times of the day they could be outside or the places they could go, but also the quality of their sleep.

... it's a stress if you need something at 10 at night and you cannot go out to buy it. You run out of something, the soft drinks for the kids, and you cannot go out to buy it. I don't know, countless things that you might need at that time and you are not able to go out because there are unknown people, or known as well, that for two quid, one quid [*luquita*], can stab you (...) So I have to take care of myself and not go out at night nor early in the morning, at 6.30 you also can't go out (Rodrigo, man, lower socioeconomic group, 46 years old)

... it's because the drugs have arrived and all of that. But when you go out to buy, for example, I don't feel safe (...) in the morning, afternoon or when I go to school sometimes, I don't walk through that square, because there is a square in the middle and they hang out there, and I don't go through there (Yasna, woman, lower socioeconomic group, 16 years old)

It's bad, it's terrible, here you sleep with one eye shut and the other eye open... you don't have a place to live and live here in this shit... mainly us that we live close to the corner, people have broken in many times, on all sides (Sara, woman, lower socioeconomic group, 34 years old)

Respondents stated that living in Santiago was also detrimental to their health because of the pace and type of life you are obliged to live there. They described how Santiago's life is too fast, with too many people everywhere, too much noise and pollution. They said that this led people to live under constant stress, which was often contrasted with living in the countryside. Many of the participants argued that people who live in rural areas are healthier because they are calmer, a consequence of living in a more relaxed and health promoting environment.

... there are many factors here in Santiago, I think that the stress we live daily affects our health, without any doubt, we are too many people in a small place, the work pressure is big, the noises, the smog, there are many factors... mainly here in Santiago. Now, probably in regions it is different. As a matter of fact, when we travel somewhere, be it towards the north or south, you see that people are more relaxed than the ones that work here in Santiago, I think that maybe they live many more years than we who live here in Santiago (Felipe, man, middle socioeconomic group, 37 years old)

... with the stress you have here in Santiago you are more tense, you are not as relaxed as in the countryside, partly because you know that in the countryside the air is different, you are more relaxed, you don't have so many things... (Pedro, man, lower socioeconomic group, 42 years old)

Therefore, life in Santiago implied an emotional distress shared by individuals from both socioeconomic groups, mainly women, associated with higher levels of anxiety from the fear of crime and its fast-paced environment. This could be understood as a shared element from people's 'habitus' within different realities.

The last macro-level element that respondents mentioned as affecting their health was the transport system. In the year 2007, a new public transport system was implemented in Santiago with the objective of making it more efficient. This new system has received much criticism regarding its efficiency; modification of typical and high demand bus routes, increase in the journey time, overcrowded transport due to fewer buses, increase in the combination between different lines from previously simple routes, resulting in people's extreme dissatisfaction (Briones 2009; Yáñez, Mansilla, and Ortúzar 2010). Respondents stated that many aspects of the current transport

system affected their mood and mental health. They pointed to aspects such as being able to spend less time at home, being constantly annoyed, experiencing people's anger, and being late for work.

You see in the subway and in the buses how people hit each other in order to go through faster than the others and it is an enormous stress level! Because at work people don't believe that you have transport problems, they don't believe you that the subway is full, they don't believe you that the buses are not enough, they don't believe you that the Transantiago is very slow [*se viene a la vuelta de la rueda*], bosses don't believe you! So you reach a stress level so high that people are... in every sense becoming rude, because in order to get to work early they don't care to run over people [*pasar a llevar*], they hit each other. The state of nervousness is terrible, I've seen people crying! Imagine that! What can you ask them? Tell me, are those people going to be healthy? (Jessica, woman, middle socioeconomic group, 41 years old)

Thus, the transport system was a factor that not only caused stress because of the considerable time people spent commuting, but also because it led to deterioration in their social relationships at work as well as within the community. This seemed to be a problem that mainly affects middle class people, since their houses are far away from their places of work as a consequence of the residential segregation. As was seen in Chapter 4, sometimes *campamentos* are located nearer to the city centre or their residents have employment closer to the place they live.

In summary, respondents are aware of the influence that social structure had on their health. Throughout their discourses, it was possible to observe the importance that economic resources have in relation to both their physical and mental health. At the

same time, it became clearer how the same factors affect health in diverse ways according to people's socioeconomic level and gender. We now turn to the social and community influences recognised by the respondents.

5.3.2 Social and Community Influences

Social relationships and the characteristics of these relationships were factors that respondents mentioned as affecting their health, mainly their mental health. The types of problems mentioned were different according to participants' socioeconomic level and gender.

The social relationships described as problematic by participants who lived in *campamentos* can be divided into those that take place inside their houses and those that occur outside them. As was observed in their discourses, these individuals were exposed to high levels of violence and abuse. Several respondents, mainly but not exclusively women, stated that they had suffered domestic violence perpetrated by their partners. Numerous episodes, with different levels of violence, were narrated.

My husband was an alcoholic. Of all the time that we were married, he beat me every day (...) Like 15 years, but every day, every day he would beat me (...) he beat me like this, he threw anything towards me, he left me unconscious (Carmen, woman, lower socioeconomic level, 62 years old)

These situations did not only have a harmful effect on their bodies, but also their mental health through feelings of depression and lack of self-esteem. They all stated how at one point they gathered the necessary strength and support to split up or get a divorce from their partners. This was one of the reasons why most of the respondents from this group are in their second or third marriages.

However, living in *campamentos* not only implied higher levels of domestic violence, but also problems of coexistence with their neighbours. Some respondents mentioned having good relations with their neighbours and belonging to a tight-knit community, but most of them, women and men alike, reported difficulties with their neighbours, that their spaces were not respected and that it was ‘better not to get involved’ [*mejor no meterse*] with their neighbours. At the same time, those people who came to live in *campamentos* later in their lives tended to complain about the aggressiveness of people, their inadequate vocabulary in front of children and their practices in general and in relation to health.

Just because of the fact of living here, I live stressed (...) you are here, you see your neighbour passing by with a trash can and he cleans it right here (in front of the house) and he leaves his side clean so that he can tell others that we throw garbage away. So, it’s a thing that you already avoid looking outside. They come to test stolen cars right here! (...) The kids cannot go out to play because sometimes the drunken neighbour is sitting outside swearing. If their dad doesn’t drink, why should they see that in the neighbour? They watch movies confined to their bedroom... These things stress you out; believe me, it is exasperating! (Maria, woman, lower socioeconomic group, 39 years old)

The social relations outside *campamentos* were also mentioned as a factor that affected respondents’ mental health. As seen in Chapter 4, Santiago’s residential segregation leads to a territorial stigmatisation which is experienced mainly by participants from the lower socioeconomic groups. They stated how they felt discriminated against because they lived in a *campamento*, and also reported difficulty in getting loans or access to a credit card because their address denotes their socioeconomic condition.

... many of us are discriminated for that ‘ah, these are from *campamento*! They are all dirty, thieves, criminals’ and it hurts when it is people from around you (...) those people that live around you, the only thing they are worried about is to discriminate against us (Joana, woman, lower socioeconomic level, 41 years old)

When I started high school I was ashamed (...) many people sometimes think that because you live in a *campamento* you are rude, you swear, that this and the other, and I was not like that. So those things made me... for instance, I couldn’t say ‘ok, we can do the work at my place’, things like that... and when they asked me ‘where do you live?’ I said ‘that way, that way’, things like that (Camila, woman, lower socioeconomic group, 17 years old)

These types of relationships made them feel ashamed and inferior, even when they argued that these stereotypes did not apply to them. The territorial stigmatisation that residents from poor neighbourhoods experience (Wacquant 2008) may also have a negative effect on their health outcomes (Kelaher et al. 2010; Atkinson and Jacobs 2008). Therefore, not only were they exposed to higher levels of violence and coexistence problems inside their *campamentos*, but they also suffered symbolic violence and discrimination when they interacted with people from other socioeconomic levels, increasing their social exclusion further. This phenomenon is also experienced by other low socioeconomic groups who do not live in *campamentos* (Cornejo 2012).

The situation described by middle socioeconomic group respondents presented a picture of less violence, both inside and outside their houses. The main problems associated with social relationships that they mentioned were family issues and lack

of communication. Participants narrated how losing members of their family, or the death of close friends, had triggered deep depressions in them. This is an aspect that, as they stated, affects people from everywhere in the world and from all social classes; it was, in their words, 'things that are inside the ranking of most tragic things'. Men and women also named issues such as having a bad relationship with their partner or children and having problems in general.

One aspect mentioned that seemed very interesting was the lack of communication with neighbours and with the community in general, suggesting low levels of social capital. A respondent expressed how the growing individualism of present times leads people to stop communicating, greeting and caring about each other, thereby contributing to different illnesses. It is interesting to see how this contrasts with the daily experiences of *campamentos*' residents and their need to hide away from their surrounding community in order to avoid getting stressed and having problems.

I think that people get sick with loneliness (...) I remember that my mum used to go out to sweep the door and everyone would say hi, everyone asked you about your kids... now nobody does. And now with these things, these gigantic constructions they make of flats, nobody sees each other! I mean, I think that if they are lucky [*con cueva*] they say hi to the guards, only if... the other day I went to a flat around here (...) and I found it weird that in the elevator there was a sign ‘to greet is good for health’, just like that, I mean, you realise they are telling you that you have to say hi, something that you learn when you are born and now they have to tell you in a sign that you have to say hi! (Paula, woman, middle socioeconomic group, 45 years old)

The absence of reports about domestic violence within this group could be related to fewer occurrences or that they did not feel comfortable revealing them. A survey of 1,109 Chilean women carried out by DESUC revealed that women from the middle socioeconomic group were also victims of psychological and physical violence (table 11). However, the frequency was lower when compared to those women from the lower class, which could also be subject to under-reporting.

Table 11: Percentage of women who perceived domestic violence from their current partners in the last year according to socioeconomic level

	Psychological Violence	Physical Violence
Low and middle-low socioeconomic group	23.4	7.4
Middle socioeconomic group	16.0	6.1
Middle-high, high, and very high socioeconomic group	16.6	6.5

Source: Prepared by the author using data from DESUC 2008

Therefore, a contrast in the realities of their lives emerges since the quality of their social relationships seemed to be highly influenced by the place in which they lived and their gender. Firstly, those individuals who lived in *campamentos* were exposed to a more violent and aggressive environment, whether inside their houses, within the *campamentos*, or outside them through stigmatisation. This means that they were attacked both explicitly by their relatives or neighbours, and implicitly by the world outside their place of residence. Even when the middle class is not frequently subject to stigmatisation, they may also be victims of domestic violence and seem to long for better social relationships. Secondly, it is important to note that participants who referred to social relationships as a factor affecting their health were almost exclusively women, an aspect which echoes findings of previous research (Blaxter 1990). This indicates that violence is a phenomenon experienced differently by men and women. It is likely that most females feel more vulnerable than men in their social relationships, a feeling that could reinforce the patriarchal idea that women are more fragile than men. Finally, it is also relevant to note that some individuals do have an awareness of the impact that their social relationships have on their health, an aspect that challenges critical realists arguments and emphasises the importance of researching lay knowledge (Popay et al. 1998).

5.3.3 Individual or Agency Factors

Besides the external factors related to the socioeconomic, environmental and working conditions of people, or the social relationships they had with others, participants stated that their own actions were one of the main dimensions that affect health. Looking after your health is one of the most important factors according to the female and male respondents from both socioeconomic groups, both adults and young people.

By stating the effect that people's actions have on their own health, participants made reference to health-related practices such as hygiene, having a balanced diet, and being physically active. The way these actions were stated and named implied a belief in the fact that the causes of health are internal to each person, revealing a normative concept of health seen in previous research (Cornwell 1984; Blaxter 1997; Popay et al. 2003). These were some of the answers of participants to the question 'what do you think that affects health?':

Self-care. For instance, food, only an example, if you eat healthy, you will live healthy. But you see so many people eating junk food and they are always ill... (Oscar, man, middle socioeconomic group, 65 years old)

Obviously everything depends on how you take care of yourself. It is obvious that if you smoke, if you are an alcoholic, a drug addict, you will destroy your body, you will get sick (Ana, woman, lower socioeconomic group, 36 years old)

Health implies many things, but for me health is care. Firstly, the personal care that each of us should have towards oneself, that is, not doing things or consuming things that can affect your personal physical integrity. The health system begins in me (Pablo, man, lower socioeconomic level, 48 years old)

Seeking medical help was a common practice cited by the respondents, mainly by women and by those who belonged to the middle socioeconomic group. Previous research has stated that 85% of women have the main responsibility for taking their children to the doctor whereas only 15% of men are expected to carry out this duty (UNDP 2010, 73). Even when male participants from the working class recognised the

importance of this practice, they showed a higher tendency to avoid seeking medical attention.

... not having a check-up like to know that you might have something. There are exams, for instance the EMPA [*Medical Preventive Exam for Adults*] that is a simple exam that can evidence a disease like diabetes, but one is not cautious, one doesn't do it, having the opportunity to do it because it is always available at the GPs [*consultorio*] (Paola, woman, lower socioeconomic group, 38 years old)

You have to take care of yourself before you get ill, that, I don't know. Because if I start to feel pain and I don't get treated, it is obvious that it will affect me in other ways afterwards. I think that... it may be that, because I never treat myself. As I told you, I never go to the doctor (Juan, man, lower socioeconomic group, 38 years old)

This reluctance to seek medical care revealed a diverse experience of the health system and relationship with doctors between the groups. Even though respondents from both socioeconomic groups complained about waiting times in the public sector and the cost of private healthcare, the image they had of doctors and the health system differed. While participants from the middle socioeconomic group saw doctors as a legitimate and respectful authority that would be able to help them, participants from the lower socioeconomic group showed a tendency to mistrust medicine. Some of them expressed mistrust in doctors and that they preferred to 'heal themselves' by other means such as consuming herbs and following 'other secrets of nature'.

... doctors nowadays, I don't think that... they go to university and I don't know what for! They are 14, 15 years learning a profession and it turns out that

it is yourself who has to say the disease that you have and then act on it, that can't be (...) If I have a stomach ache, I go to my yard and get mint leaves, common rue, wormseed, and I get better. If I have fever, I put my feet in cold water first and then I take a cold shower to lower the fever. And if I have pains, I take a very cold shower and then go to bed (Rodrigo, man, lower socioeconomic group, 46 years old)

An aspect that could be related to this attitude was the lack of dialogue that respondents said occurred between doctors and low socioeconomic level patients, which will also be seen in the next chapter. Men and women from this group expressed their frustration that, on many occasions, they were not able to understand what they were being told, and that sometimes they were even mistreated by the medical staff. Previous research has argued that issues such as perceptions of discrimination and lack of respect by health service staff impacts help-seeking behaviour in a negative way (Cawston, Mercer, and Barbour 2007; Kelaher et al. 2010). Therefore, it is not surprising that men and women from the lower socioeconomic group did not recognise the legitimacy of doctors' knowledge, since it no longer makes sense to them, and thus do not seek medical help when they need it. In fact, two respondents who suffered from different cancers were not under medical treatment since they did not believe doctors could heal them and because they did not understand the severity of their condition. Additionally, there were parents who opposed the government's campaign to vaccinate children against meningitis, following an outbreak in Santiago in 2012. In their opinion, the origin of this health condition was not the one being presented by the media, but, in fact, the sun. Therefore, they developed their own treatment, which consisted of putting aluminium foil on their heads, by which they hoped to avoid getting meningitis.

At the same time, participants from this socioeconomic group who actually looked for medical help, affirming it as an appropriate way to look after your health, experienced limited access to the public system, as seen in Chapter 4. Usually they were not able to get appointments for months or even years, and sometimes they had no access to appropriate medicines since they were not given an appointment to get the necessary prescriptions. Nevertheless, they emphasised in their accounts that attending the doctor comes under the actions that are under people's own control and, therefore, is a matter of personal responsibility. This type of affirmation began to reveal a strong internal contradiction between acknowledging the difficulties they faced, that is, the social determinants, and a high sense of individuals' responsibility, that is, agency.

A person's attitude was another individual dimension that female and male respondents from both socioeconomic groups and age ranges recognised as central to staying healthy. A healthy person was seen as someone who was happy and who had a good attitude, someone who did not depend on anyone else and who was able to live his or her life with dignity, regardless of their employment circumstances, housing conditions, shortage of money and personal frustration. That is, a strong internal locus of emotional control.

Be happy! When you are low it's worse, you get more diseases, but when you are happy... don't be embittered, embittered people are always ill! (Juan, man, lower socioeconomic group, 38 years old)

(A healthy person) is a person that feels good about herself, that is happy, even when... the thing is that for me health is mental, as I told you, even when you have problems it is wanting to move forward and be happy. I have the case of a friend that she is like very happy, in spite of everything that happens to her.

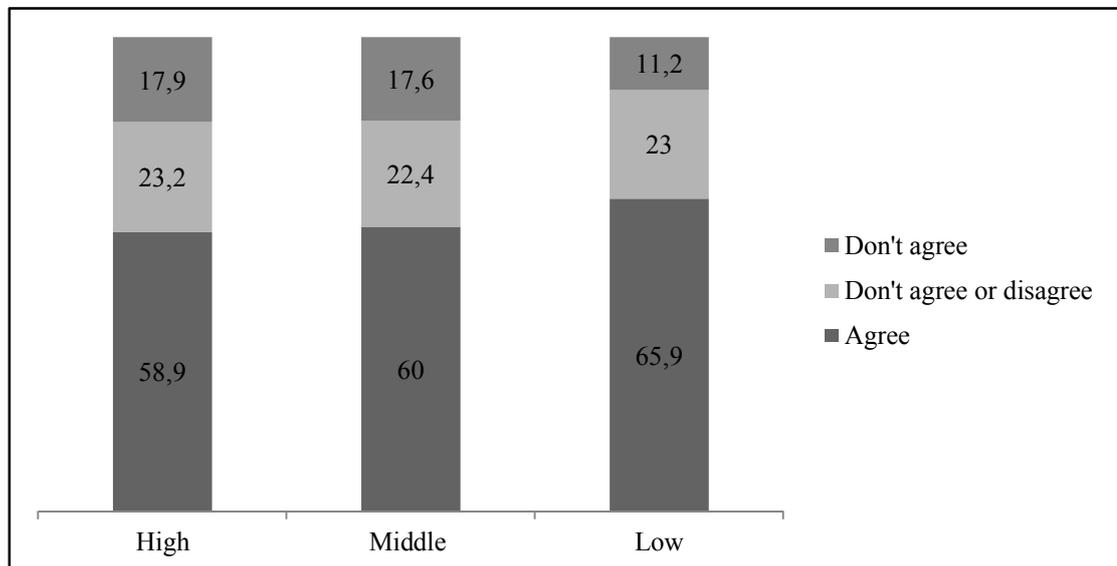
I see in her what a healthy person is (Catalina, woman, middle socioeconomic group, 17 years old)

It is interesting to see how sometimes this mandate of keeping a positive attitude was stated as a 'fight against the system'. Respondents argued that those who were able to cope with the system were the ones who remained positive and happy, thus, healthy. These statements reflect the importance that respondents gave to mental health and how it may impact physical health; they were both seen as intrinsically related and, therefore, affecting one another.

A healthy person is a positive person that tries to find the best in life, that tries to convince herself that life is this way or that tries to accept that this is what we have and take it in the best way and try to say 'thank you', 'good morning', 'good evening', 'I'm sorry', 'take my seat', I mean, for me this reflects a person... I don't know if healthy but positive, that tries, that tries to fight against this system that is so cold, has so much nervousness, so much stress, so many mental illnesses that Chileans have (Jessica, woman, middle socioeconomic group, 41 years old)

Thus, the presence of a strong belief in individual responsibility for health-related practices and attitudes emerges from participants' narratives. Quantitative data from a National Survey confirmed how this concept was strongly present throughout the different socioeconomic groups. Figure 7 shows that more than half of the Chilean population agreed with the statement that people have serious health problems because of their behaviour.

Figure 7: Agreement and disagreement with the statement that people suffer serious health problems because they behave in ways that harm their health, according to socioeconomic level (%)



Source: Prepared by the author using data from CEP 2011

As may be observed, the practices named by the respondents coincided with national and international health campaigns, described in Chapter 4, that aim to educate people regarding their health-related practices. All participants were aware of the importance of having an adequate diet, carrying out physical exercise, avoiding alcohol and tobacco as well as other drugs, and seeking medical help when it was needed. However, it is potentially surprising that individuals who have very different material

resources and are exposed to highly diverse social relationships and environments nonetheless agreed to such an extent on the importance of people's own actions regarding health.

The fact that this concept was observed across gender, age groups and socioeconomic levels implied the presence of a normative idea of health: 'the presence of health reflects correct behaviour, self-discipline, willpower and virtue, and its absence is a sign of weakness' (Blaxter 2010, 70). When participants stated that health depends on practices and actions that are under people's control, they implied that people may be judged and may judge others for not carrying out health-promoting activities, for an 'incorrect living' [*el mal vivir*]. The internal locus of control creates the idea that health outcomes depend on the type of life people 'decide' to live (Blaxter 2010) and contradicts the importance and relevance of all the external factors that had been named by the participants themselves.

5.4 Conclusion

This chapter has analysed the aspects of Chilean society that affect how people understand and experience health and how these relate to people's sense of responsibility for health outcomes and health-related practices, shedding light on the mechanisms that influence the space for agency that men and women from different social groups have over health determinants. It showed how the social and economic inequalities consolidated by the neoliberal policy regime – presented in Chapter 4 – are translated into different definitions and experiences of health according to people's socioeconomic group and gender. While middle class participants emphasised the centrality of health in order to be able to work, women living in *campamentos* were focused on their poor health outcomes. However, a common structure was seen across their health concepts: a highly commodified society where economic resources are essential to fulfilling basic needs, to the ability to carry out health-promoting practices and to access good quality healthcare were hindered because of unequal distribution. Chile's commodified character is argued to be one of the reasons why people associated health with insecurity as well as with employment.

Respondents' definitions of health also give evidence of a patriarchal society with traditional gendered divisions of labour. While women mainly stated that health is necessary to take care of their families, men argued that they needed health to be able to work. These concepts reveal the construction of gender identities in which women are in charge of housework and well-being of their families – including looking for medical help – whereas men are responsible for bringing money home. Additionally, the fact that women experienced domestic violence more frequently than men and felt more insecure, especially those from the lower socioeconomic group, contributes to

the traditional image of females as more vulnerable and fragile than men, a central aspect that will be analysed in relation to health-related practices in Chapter 7.

The way in which respondents talked about health also revealed how much control they perceive having over their health outcomes and their health-related practices. Their narratives presented a tension between ‘fatalist’ and ‘lifestylists’ approaches (Pill and Stott 1982; Pill and Stott 1985) to the causation of health outcomes. The relevance of this finding is twofold. Firstly, it means that individuals are aware to some extent of the impact that external factors – structure – have on their health status and practices. Even when critical realists would argue that people are unaware of the mechanisms shaping their health-related practices, respondents’ narratives proved otherwise. Therefore, lay knowledge may be considered an important source of information that provides ‘invaluable insights into the dynamic relationships between human agency and wider social structures that underpin inequalities in health’ (Popay et al. 1998). Secondly, it showed how respondents defended the importance of their own actions and attitudes in relation to their health – agency. This way of emphasising the importance of ‘will and effort’ seems very similar to what Robert Crawford called the ‘ideology of individual responsibility’ (Crawford 1977, 677). Participants’ discourses implied a belief in rational individuals who know the consequences that their health-related practices may have for health outcomes and who, simultaneously, live in a society that does not influence their decisions so that they can fully control their actions and choices. Even when participants recognised the constraints found within their environments, i.e. socioeconomic, environmental and working conditions and social relationships, their discourses argued that ‘it is still the individual who is called upon to resist them’ (Crawford 1977, 677).

It is possible to see how this tendency to emphasise individual responsibility echoes the neoliberal values and the governing capitalist economic principles that defend individual liberty and personal responsibility. As discussed in Chapter 2, this type of regime argues that people should be held responsible for their practices and the resulting outcomes because they have chosen them freely. Figure 7 showed that more than half of the population agreed with this message, which was reflected in the responsibility and agency-centred discourse from the participants. This situation does not only transform the mind and body in a space where the socioeconomic order and neoliberal values are reflected (Crawford 1984), but also reinforces the moral judgement made towards people who carry out what are perceived as health-damaging practices.

Due to the importance of commodification found in people's discourses, as well as social relationships and gender roles, the next chapters will be focused on analysing the mechanisms through which people's unequal economic, social and cultural capital – a consequence of the Chilean neoliberal policy regime – influence and limit their mental attitudes and their capacity to choose the practices they want to engage with. By contrasting respondents' discourses with their context through a critical realist approach, the next two chapters will give evidence on the mechanisms through which structure influences the space for agency that men and women from different social groups have over their health.

CHAPTER 6 - HEALTH-RELATED PRACTICES AND ECONOMIC CAPITAL

6.1 Introduction

By following a critical realist perspective, the previous chapters have provided different elements to analyse the research question, that is, through which mechanisms the structure influences the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal country such as Chile. Through a contextual analysis, Chapter 4 described the chain of inequalities that the Chilean neoliberal policy regime has consolidated, and how the context from which people speak varies according to their gender and socioeconomic level. It also showed how this unequal context is related to the tendencies observed in relation to Chileans' health-related practices and how it constitutes a gradient that affects both middle and lower socioeconomic groups. In turn, Chapter 5 provided an intensive analysis to show how this chain of inequalities is translated into different lay definitions and experiences of health. It gave evidence of the importance that economic resources have in people's health concepts due to its commodification, as well as the importance of social relationships and traditional gender roles. However, it also showed how respondents' narratives reveal a tension between perceiving the impact that these structural dimensions have on their health, and their strong sense of individual responsibility.

This chapter combines intensive and extensive analyses, taking into account the previously developed contextual analysis, to answer through which mechanisms do the unequal economic capital that men and women from middle and lower

socioeconomic groups have affect their agency power over health-related practices, and how are these mechanisms related to the Chilean neoliberal policy regime. Firstly, it explores how the inequality of people's economic capital affects factors such as their diet and the extent to which they engage with physical activity, smoking and drinking alcohol, particularly to excess. It explores how the lack of economic capital that people have who belong to middle and lower socioeconomic groups impacts their health-related practices and how it restricts their space for agency over these practices. The chapter goes on to analyse the impact that respondents' employment conditions have on their practices which might affect their health. The way in which aspects such as having a contract or not, the age of entry to the labour market, number of hours worked, and the need to combine household work with paid employment impact people's lives and limits their agency power over health.

6.2 The effect of unequal income

As already seen in the previous chapter, according to the respondents' accounts money is one of the central factors that seem to influence health outcomes. This section will show how people's economic capital in the form of disposable income affects the possibilities they have to engage with what they regarded as health-promoting practices.

6.2.1 Commodification of health: ‘if you want good things, you have to pay for them’

One of the main practices named by the participants that affect health is seeking medical help when needed. In the previous chapter it was seen how people from all social groups consider this to be a health-related practice under their control.

You have to know to go to a doctor when you feel that something is not working well (...) you get nowhere with a person that ‘ouch, it hurts here, my finger hurts, my finger hurts’ but you never go to the doctor, you will fall.... I mean, it doesn’t matter if you say twenty times that your finger hurts if you don’t go to the doctor to check yourself (Soledad, woman, middle socioeconomic group, 53 years old)

However, when respondents talked about their previous experiences in relation to healthcare and when their economic reality was analysed, problems were highlighted with their tendency to assume personal responsibility for seeking medical help, and for paying and following through all treatment. The commodified character of health in Chile seen in Chapter 4 alongside the existence of a public sector with insufficient resources to deliver a good quality service to most of the population that rely on it, makes money critical and hinders people from seeking medical help.

The first aspect that appeared in individuals’ discourses, from both socioeconomic groups and genders, was the length of time needed to get a doctor’s appointment in the public system. All of those respondents who were a part of FONASA, mainly but not exclusively those that belong to groups A and B (groups explained in Chapter 4), stated that it was very hard to get a doctor’s appointment.

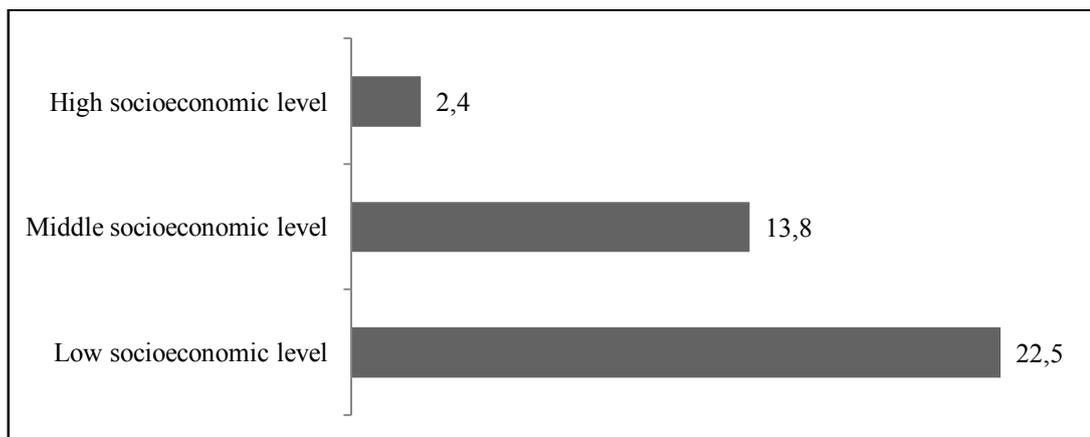
I have a problem in my back and a neurosurgeon is seeing me at the Salvador [public hospital], but everything is done through the public system, and I had to wait one year to get that appointment (Claudia, woman, middle socioeconomic group, 34 years old)

I have to go and get my medicine for hypertension, but I can't because there are no appointments! (...) It's already taken 6 months to get an appointment to see a doctor! (Carmen, woman, lower socioeconomic group, 62 years old)

... I am not the only one because when you relate to more people, you talk to people and when you get to the topic of health in a conversation, let's say, with the neighbours, everything is the same, that you have to wait, there are long waiting lists... As a matter of fact, I've asked for a neurology appointment for my son... years! It's going to be 3 years that we have been waiting (Paola, woman, lower socioeconomic group, 38 years old)

This situation, which affected people of all ages, meant that people did not receive the medical attention or treatment they needed, even though they looked for it. Figure 8 shows that the lack of treatment because of the waiting time was a problem that affected almost 25% of Chileans who belong to the lower socioeconomic group and 14% of the middle class, giving evidence of the social gradient. This not only created high levels of frustration amongst people, but also led to a worsening in their health outcomes and the impossibility of carrying out health-promoting practices, such as exercising. Participants who had untreated conditions, for instance back pain or high blood pressure, had more difficulty carrying out physical exercise three times a week. They understood that this situation limited their possibilities to stay healthy.

Figure 8: Chileans who, in the previous 12 months, did not receive a treatment they needed because the waiting list was too long, according to their socioeconomic level



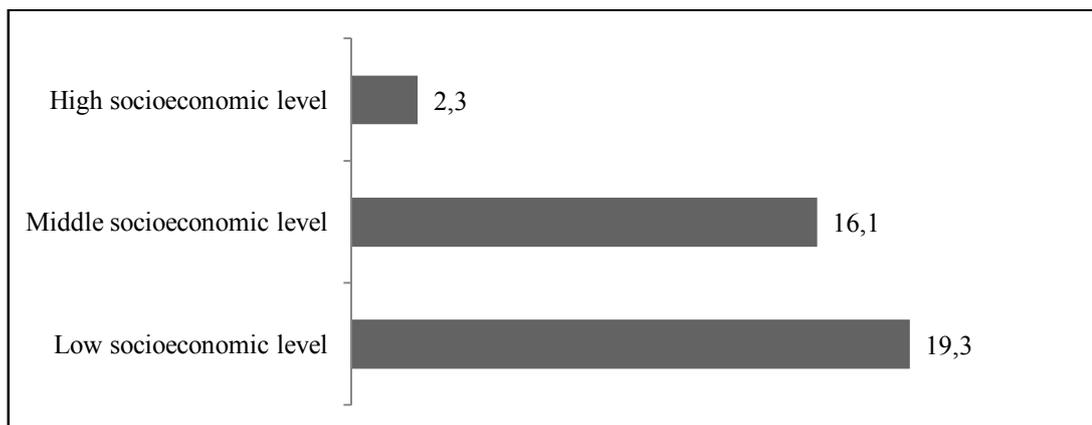
Source: Prepared by the author using data from CEP 2011

One way that people dealt with this problem was by consulting a private doctor. Respondents stated that if they needed or wanted prompt and proper medical attention, they had no other choice but to pay for it. Even though Chile has a national health plan called AUGE that guarantees that healthcare must be provided within specific time limits, within determined costs and for a minimum of healthcare quality for the treatment of 80 illnesses of high social impact in accordance with Law 19,966 (Ministerio de Salud 2004), participants argued that it was very difficult, if not impossible, for them to cover the expenses that were not included in this plan. This problem is one of the reasons why the out-of-pocket expenses for health accounts for 4.6% of the share of final consumption in Chile, while the OECD average is 2.9% (OECD 2013) and once again reflects the commodified character of the Chilean health system.

On many occasions the AUGE does not cover diseases that one does not have the resources to get treatment for, diseases that are more complicated. That's what makes one angry! Emergency rooms are always crowded, when the kids are sick you always have to wait one way or another to be seen by a doctor, and many times you are not even given the medicine! And sometimes the diseases find you with empty pockets [*la pillan más mal del bolsillo*] (...) Many times you are prescribed expensive medicine, they [doctors] just write it like that and not even tell you, I don't know, 'let's look for a cheaper alternative' (...) So that's when you sometimes say 'men, they know one is from a low-income background (...) and that you don't have resources to buy expensive stuff... (Ana, woman, lower socioeconomic group, 36 years old)

The situation described by this woman was not exclusive to people from the lower socioeconomic group, but also affected some respondents from the middle class. Some of them stated that, even when they were in pain, they would rather spend the money to feed their children, which reveals both their tight budget and the high costs of medicine. Others had the necessary resources to ask for a loan or to pay with credit cards, which they said provided only a temporary relief since they would have to find a way to repay their debts later on, such as selling their houses when the illness was very serious and the debt too high. Figure 9 shows that around 16% of people from the middle socioeconomic group did not receive required treatment because they could not afford it.

Figure 9: Chileans who, in the previous 12 months, did not receive a treatment they needed because they said they could not afford it, according to their socioeconomic level



Source: Prepared by the author using data from CEP 2011

The frustration from not being able to see a doctor or to follow a treatment because of not having the necessary economic resources to go private was worsened by the fact that medical staff from the public system did not appear always to treat patients well or with respect, as described in Chapter 5. A number of participants told of their experiences on several occasions when doctors had not listened to them properly, did not explain their diagnosis and sometimes did not take into consideration their physical discomfort and had sent them back home. Respondents said that they felt treated disrespectfully, leading them once again to avoid going to doctors.

...my experience in the public system [*consultorio*] with my daughter was not very good because there they treat you badly, not in terms of the tools they have to treat you but the people, the way they treat you. People don't treat you well, I have never understood why, it's like it was not their job, I think they don't like it (...) When I delivered my son (in the private sector) I was able to compare and you cannot believe the difference! It's too big! In terms of

cleaning, of the way people treat you, of everything! (Juana, woman, middle socioeconomic group, 35 years old)

I had an examination and my levels were above the reference level [condition not specified in the interview], it should have been 37 and I had 67, for instance, it had something to do with the calories of the body. So I asked ‘Doctor, why?’, and she told me ‘Come on, that’s something that only we doctors understand’ (Margarita, woman, lower socioeconomic group, 45 years old)

Of course, in the clinics (private) it’s good because they do everything they have to do because you take your money and they have to treat you well. But I don’t want to have anything to do with public doctors [*de consultorio*] ... (Carmen, woman, lower socioeconomic group, 62 years old)

It is significant to see the comparisons they made between personal treatment received in the public system versus the private one. According to respondents, having the economic resources to attend the private sector would not only assure them prompt attention, but would also give them access to a better and more respectful relationship with doctors and medical staff. Even when this problem was stated as something that would not affect the medical treatment itself, it had consequences, not least in people’s future subsequent help-seeking behaviour (Kelaheer et al. 2010) as well as the risk of their misunderstanding the diagnosis and treatment due to the lack of dialogue between patients and doctors.

The experience of looking for medical attention was very different for the few who could afford the private system. These respondents, all of them from the middle class, stated that their experience with doctors and medical staff was very good. Not only did they get appointments very quickly, but the quality of both the medical and personal

treatment was perceived as being very good. It is worth mentioning that participants noted that, in their view, the doctors' availability for and willingness to undertake dialogue and polite relationships in the private sector was due to the fact that they were paying for the service.

If I am in pain, I go, I pay and I make a doctor see me, very simple. It doesn't take me more time than asking for the appointment by phone or internet, I go, it's a simple procedure (Nicolas, man, middle socioeconomic group, 32 years old)

The two times that I have had relations with doctors, no problem. Maybe because of where my surgery took place, the Professors' Clinic, so the social treatment was very good (...) No problem, everything good, in a proper time. I think that in this, health changes a lot, between private and public, it changes a lot (Felipe, man, middle socioeconomic group, 37 years old)

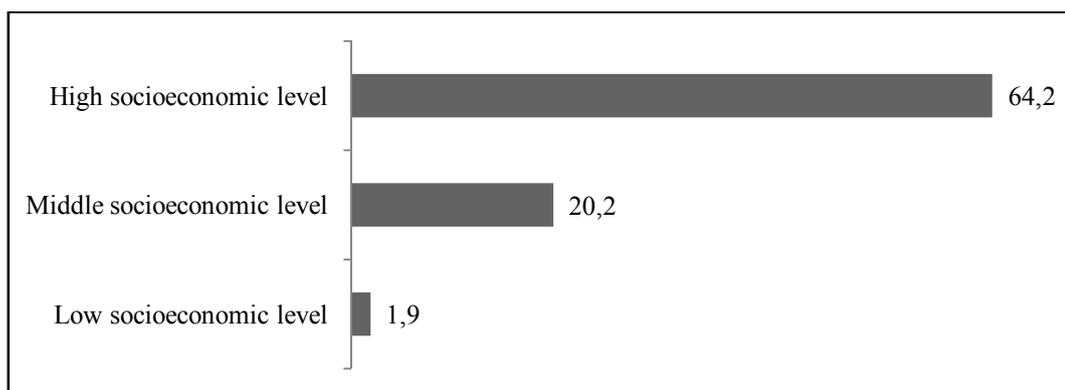
However, very few people could actually choose where they want to receive medical attention. Even when the principle of having the liberty to choose whether to be treated in the public or private sector is one of the main reasons for having a dual health system and for maintaining it since 1979, it may be seen that this freedom was something that most participants did not actually experience. According to the respondents' accounts, those who could afford to have private health care were members of an ISAPRE, whereas those that belonged to the public system had no choice but to stay within it. This was due to the fact that they did not have an employment contract that enabled them to pay health contributions, or they did not have enough money to pay the premiums. This was especially true in the case of women of reproductive age, as seen

in Chapter 4, as well as old people and people who had on-going known health conditions, such as high blood pressure or diabetes.

(I have) FONASA because unfortunately ISAPRES for us (women)... we are not very profitable for the ISAPRES (...) I left the ISAPRE due to the fact that we are two women, we get extra charges. We were both within our fertile age period and we were too expensive for me [to continue paying] (...) so I left and now we are in FONASA (Paula, woman, middle socioeconomic group, 45 years old)

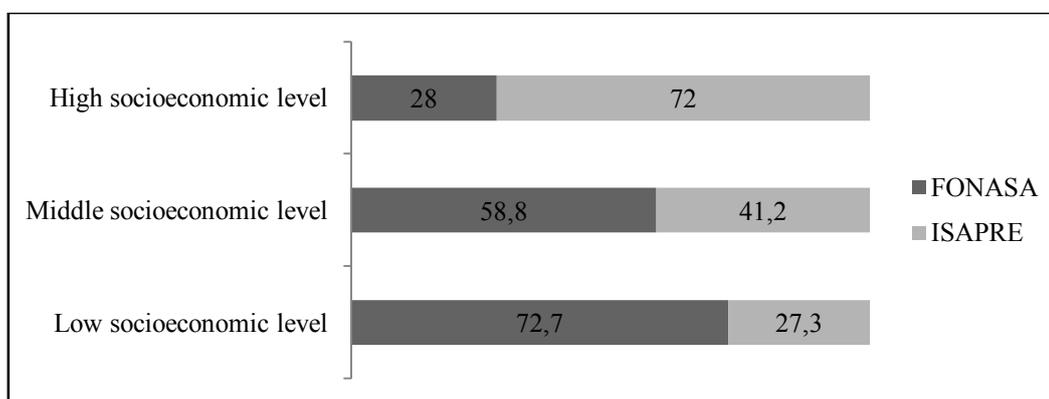
Most of respondents stated that they would change to the private system if they could afford it because of the negative experiences they had had in the public system. This is also seen in a national survey that asked people which system they would prefer, FONASA or ISAPRE, if both cost the same. Considering Figure 10 and Figure 11 together, it is observed at least 20% of Chileans from the middle socioeconomic group and around a 25% of those from the working class who belonged to FONASA would have liked to change to an ISAPRE if they did not have to pay more. Therefore, the principle of being at liberty to choose, which is an important justification of the dual health system in Chile, is something that is not valid for many Chileans, largely because of the highly unequal income distribution.

Figure 10: People who belong to an ISAPRE according to socioeconomic level



Source: Prepared by the author using data from CEP 2011

Figure 11: Preference for FONASA or ISAPRES, assuming that they would cost the same



Source: Prepared by the author using data from CEP 2011

Overall, women were more likely to comment on their negative experiences and opinions about the health system than men. This situation reflects the fact that they are more likely to seek medical help – for themselves and others – than men, that they themselves need more medical help, e.g. during pregnancy and childbirth, and the patriarchal division of labour, where women are the ones in charge of the whole family's health. As stated in the previous chapter, it is mainly women that are responsible for taking children to the doctor in Chilean households (UNDP 2010).

Nevertheless, regardless of the variety of disincentives that people had for seeking medical help, or the impossibilities they found in actually receiving the attention and treatment when it was needed, respondents tended to emphasise the importance of personal responsibility in carrying out such activity. Even when they were aware of all the trouble they would have to go through to be seen by a doctor, it was very common for respondents to refer to people ‘choosing’ or ‘deciding’ not to go to the doctor, as if it were a deliberate decision. This point of view reveals a tension in the participants’ discourses between the economic impossibility of receiving prompt and good quality attention caused by low incomes and health commodification – structure – and the importance of having the will to get treated, that is, agency. This contributes to the resigned disposition evidenced by people who said: ‘if you want good things, you have to pay, it is as simple as that’.

6.2.2 The cost of health-related practices

A second way through which people’s economic resources influenced health outcomes was by limiting their possibilities to engage with what they regarded as ‘healthy’ practices. Respondents stated that in present-day Chile it is expensive to live a healthy life. Not everyone had the possibility to have a ‘healthy’ diet or to be physically active. As this section will show, the scarcity of money experienced by middle and working class men and women impacts the space for agency they have over their health-related practices.

To start with, people who lived in *campamentos* did not always have sufficient money to buy food, of any type. Some of the respondents explained that they had gone through times where their income was not enough to feed them and their families leading

teenagers to abandon school on some occasions in order to work and bring more money into the house.

Last year it was critical, critical, critical, I could barely make money for the buying of bread for the morning and bread for the evening (Rodrigo, man, lower socioeconomic group, 46 years old)

Sometimes we do not have enough [money] to eat, we run out of bread or food, things like that. And you feel bad for that, I feel bad for that because I cannot help, whereas if I start working, obviously I can give some coins to my mum for her to buy things for the house (Benjamin, man, lower socioeconomic group, 15 years old)

Unfortunately, this situation is shared by more than a quarter of the Chilean population. Data from the OECD states that nearly 28% of Chileans did not have enough money to buy food that they or their family needed in the previous 12 months, compared to a 13% OECD average (OECD 2014, 28). Thus, low income constitutes a mechanism that restricts the ability of the poorest sectors of the society to purchase sufficient food.

When talking specifically about what they considered ‘healthy’ food (fruit, vegetables, legumes), respondents from both socioeconomic groups raised the relationship between the scarcity of money and high prices. It is relevant here to mention the global food crisis in 2007-2008 and its continuing effect on the increased prices of this type of food (UN-DESA 2011). In fact, Chile’s food inflation was 7.6% in 2012, when fieldwork was done, and 7% in 2014 (http://stats.oecd.org/Index.aspx?DatasetCode=MEI_PRICES) while the OECD average was 2.8% and 2.1% respectively. This is why respondents named income as one of the main reasons why they did not have healthier diets. Even when participants

from both socioeconomic groups, gender and age groups were aware of what the government advocated about a healthy diet and which foods promote or harm health, they could not always afford to follow these standards or recommendations. As Chapter 4 showed, there was a gradient throughout the socioeconomic quintiles with regard to a diet index (Figure 5 in Chapter 4).

Products such as fruit and vegetables, which constitute the basis for a healthy diet according to the World Health Organization and the Chilean Ministry of Health standards (WHO 2004; MINSAL and INTA 2004) and are constantly being promoted through the '5 a day' campaign, were too expensive for a middle and working class's income to afford on a daily basis.

It may be possible to do it occasionally, but you cannot go out of your budget for healthier things that are there. At this moment, fruit and vegetables are so expensive! My son tells me "mum, let's eat salad!" and the lettuce is 800 [approximately £1] pesos in the market! Can people live a healthy life? (Jessica, woman, middle socioeconomic group, 41 years old)

... you cannot cook the food that you did two years ago because everything is so expensive! Imagine the legumes, before you could cook them and now you can't (...) the price of vegetables are going through the roof [*está por las nubes*] (...) your income is not enough and you cannot afford those things (Ana, woman, lower socioeconomic group, 36 years old)

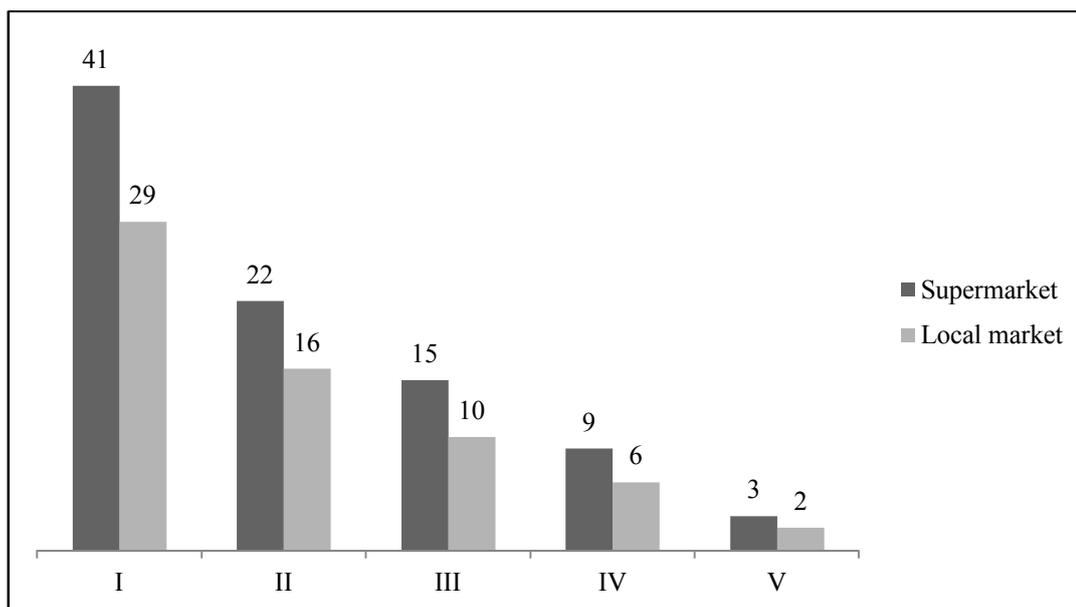
The fact that in this country we are all fat and that there are many more morbid obese than before is because the cheapest food is the worst. I mean, for instance, if I am in the street and I need to have lunch with 1 *luca* [1,000 Chilean pesos, equivalent to approximately £1.10], which is what most people have to

buy lunch, with 1 *luca* I can eat 2 hot dogs and have a soft drink (...) that is why in Chile there is so much obesity, diabetes, hypertension. Health in Chile, as a concept, is also undervalued, people don't worry about their health...

(Nicolas, man, middle socioeconomic group, 32 years old)

From a critical realist perspective, it is possible to illustrate this situation through the relationship between the price of the recommended 5 portions of fruit and vegetables a day, and people's actual income. Figure 12 shows how people from the poorest quintile (I) would have to spend on average between 30% and 40% of their income per capita in order to eat an apple, an orange, a banana, lettuce (200gr) and tomato daily. Those who belong to the middle quintile (III) would have to use between 10% and 15% of their income per capita, which is 5 times higher than what those belonging to the richest quintile (V) spend from their income. This shows the social gradient of the economic limitations that individuals from different social groups face in order to eat the recommended '5 portions of fruit and vegetables a day'.

Figure 12: Percentage of monthly income per capita needed to buy the recommended ‘5 portions a day’, according to socioeconomic quintile



Source: Prepared by the author using data from ODEPA 2013 and INE 2013

Respondents from both social classes had developed different strategies to cope with this situation. The first of them was to find cheaper places to buy food, such as a neighbourhood or local market, rather than supermarkets. Participants said that in these places they had more access to healthier food, such as fruits and vegetables, for a lower price as figure 12 shows. In some cases, especially for those people who lived in *campamentos* that were situated in more rural areas, respondents told that they relied on what they could grow in their yard as well as the fruit and vegetables of the season. This way they could afford free or less expensive food.

... we sowed everything: chard, cilantro, corn, beans, and we ate that, potatoes, so we were not out of food. Now everything is growing, pumpkins are growing, there is onion this year, there is garlic, and this year we added eggs! (Rodrigo, man, lower socioeconomic group, 46 years old)

The second way that respondents ‘made money work’ was by decreasing the quality of food, or at least not buying the best. Middle class respondents particularly stated that the boundaries set by their low incomes hindered their selectiveness regarding quality when buying food such as sugar, flour and meat. They said that if they could afford it, they would buy food of better quality that would be better for their health and that of their families. Participants from the working class ended up having monotonous diets with little variety with a strong preponderance of carbohydrates, such as pasta, rice, potatoes and bread.

... maybe if I had the money I would have access to a better quality salt, a better quality sugar, maybe to a more refined meat, or of better... Because, of course, if I am going to buy meat, I’m not going to buy the leanest one, the lean ground meat, which costs 6.000 pesos per kilo, you know, but the other one that costs 3.000 pesos (Claudia, woman, middle socioeconomic group, 34 years old)

... because of our economic state we have increased pasta, specifically, spaghetti, rice, we eat a lot of potato, lots of chicken meat, then pork and after that red meat (Pablo, man, lower socioeconomic group, 48 years old)

However, once again, even when people were aware of the constraints that money implied in terms of diet, they also talked about the importance of personal choice and individual responsibility. While they recognised that it was expensive to eat in what they considered a healthy way, self-control and personal care in relation to diet were identified on several occasions as one of the main determinants of health, through expressions such as, ‘if you want to take care of yourself, then you take care, if not, you eat everything’ (Juan, man, lower socioeconomic group, 38 years old). Again, there was a tension within their discourses. While on the one hand they were aware of

the constraints that people, including themselves, faced when enacting their health-related practices, on the other hand they still felt a high degree of individual responsibility for their practices.

The same tendency was seen regarding physical exercise. Even when respondents stated that carrying out physical activity was a matter of individual responsibility, by arguing that they were inactive because they were lazy and lacked self-discipline, most of the participants, mainly those from the middle class, demonstrated their conflicted position by stating that they would like to start doing regular physical exercise, but they could not because it was too expensive or time-consuming. They recognised that this health-related practice was in fact not available to everyone, except for those who could afford it, that is, the higher classes.

There is a big sports culture in Chile. But it is more for the high social classes...
yes, it is true (Claudia, woman, middle socioeconomic group, 34 years old)

Some people have the chance to go to a gym but others don't, some go in their lunch time and all, but for our social level it is more complicated (Jessica, woman, middle socioeconomic group, 41 years old)

(Sports) are from 'Plaza Italia' upwards [upper class neighbourhood], sports are for the top part (Jorge, man, middle socioeconomic group, 52 years old)

It is relevant that some of them already exercised through their domestic or paid work, but that they still wanted to do something that they 'chose' to do, not something that they were 'obliged' to do. This means that the scarce economic resources from middle and working class respondents did not give them the opportunity to choose to exercise. At the same time, they also raised the point that they could also do exercises that cost

nothing, such as running or riding a bike. Nevertheless, these were sometimes activities that they did not enjoy, or had insufficient time to do or a safe place to practice them, as will be seen in the next chapter. The activities that they did enjoy, such as swimming or playing football, had to be paid for and they typically did not have the money for that.

I don't do it because I don't have the money to, but I think that one of the things that I like the most is water, swimming (Soledad, woman, middle socioeconomic group, 53 years old)

Sunday's program is to go to the (soccer) fields. But I don't know, there are factors... Sometimes also, there is a lack of money before you get to the end of the month and I cannot go (Jose, man, middle socioeconomic group, 31 years old)

Whereas middle class people often stated that if they had the money they would join a gym or something similar, the unfulfilled basic needs of those living in *campamentos* led to a different disposition towards physical exercise. In this context, individuals had daily concerns that seemed more urgent than taking exercise, such as having enough money to buy food or the constant need to find permanent and secure housing. The following quotation, from a man who came from a middle class background who ended up living in a *campamento* for financial reasons, illustrates this point:

Here people are more involved in their needs, not their personal care. They are more involved in the need of being providers, with the problems that the *campamento* will be eradicated, it will be expropriated, you need to have money to get the subsidy and you cannot stop eating to raise that money. So I think that the situation in which they are involved makes it senseless to do things which help take care of themselves. If you will forgive the expression, but they tell you 'hey, you think I have time for that shit?' (Pablo, man, lower socioeconomic group, 48 years old)

Therefore, due to their precarious situation, physical exercise and becoming fit was deemed senseless. However, they carried out lots of physical activity due to the nature of their employment, which were manual jobs that required the use of their bodies and strength. Also some of them cycled all year round instead of taking public transport as a way to save money.

To summarise, the critical realist analysis developed so far shows that the scarcity of people's economic resources constitutes a mechanism through which the structure influences the economic access they have to healthcare, health-promoting diet and exercise. This mechanism affects individuals from middle and lower socioeconomic groups, confirming how the social gradient of health impacts not only those who belong to the poorest groups, but also those located at the centre of the social ladder. As Chapter 4 described, Chilean's scarce economic resources or low income are caused by Chile's neoliberal policy regime through poor income redistribution and low salaries. This is a situation that affected both middle and working classes, leading to a reality in which carrying out what are promoted and seen as health-promoting practices could be considered a privilege reserved for those who are well-off. However,

alongside being aware of the constraints they faced in order to have prompt medical attention or to have the ‘5 portions a day’, participants felt a strong sense of personal responsibility for what they did and how they lived their daily lives. This suggests that the theoretical tension between choices and chances that underlies the research problem is internalised in people’s everyday practices and perceptions.

6.3 Employment inequality

The nature of work and employment conditions has been recognised as one of the most important social determinants of health (WHO - CSDH 2008; Marmot and Wilkinson 2003; Marmot et al. 1978). As was seen in Chapters 4 and 5, not everyone in Chile has a good quality job, and many face high levels of vulnerability and insecurity. Respondents were aware of the impact that this dimension had on their health, both physical and mental. This section analyses how the nature of work promoted or hindered their expression of everyday practices related to health.

6.3.1 The working conditions of the middle socioeconomic group

Most middle class respondents were employed; all men and most women interviewed had a job at that moment. All of them had completed their secondary education and some had started tertiary education, but had not finished it, mainly due to their need to start to work and earn money. They said that the fact of not having a professional qualification was one of the main reasons why most of them had ended up working in low paid jobs, and in areas which they did not consider interesting or challenging, which caused personal frustration. This was why many of the participants from this social group expressed a strong desire to continue their studies. They believed that if they had better educational credentials, they could at least have higher salaries or more

stimulating jobs. Their stories were clear examples of the chain of inequalities and interplay between employment and education inequalities described in Chapter 4. Teenagers are not mentioned in this section because none of those interviewed worked on a regular basis, only occasionally, to be able to travel during their holidays with their friends.

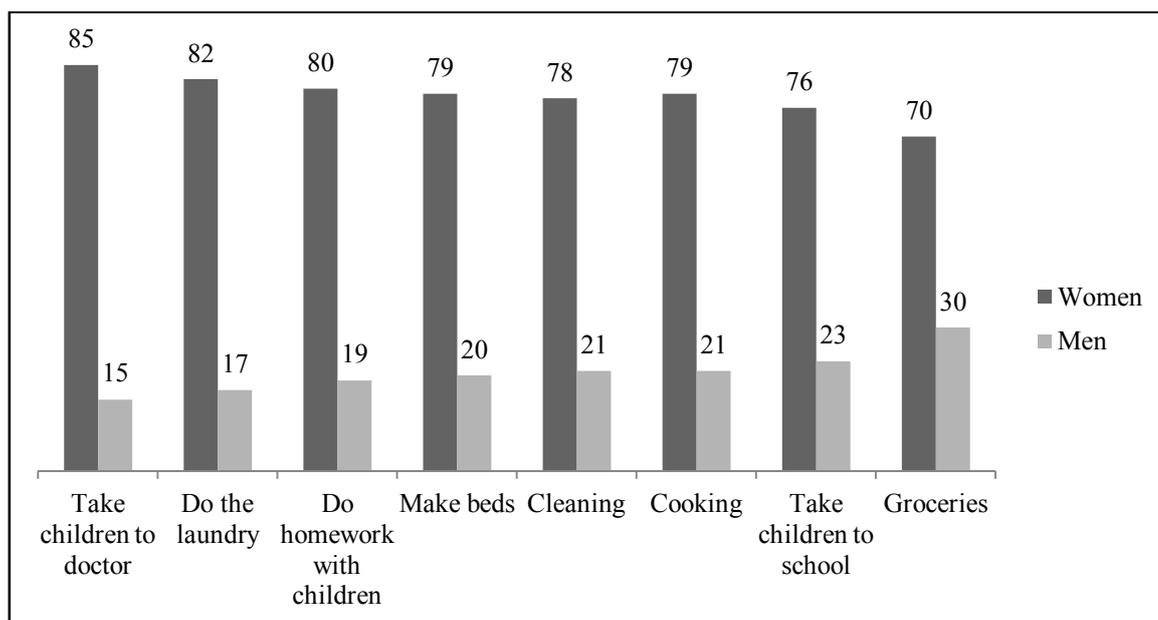
The working reality of the middle class created circumstances that constrained people's capacity to adopt the health-related practices they felt responsible for. Respondents often said that their salaries were low and insufficient for their daily needs (also seen in Chapter 4), which meant that some of the male participants had been forced to take two full-time jobs, and female participants had been forced to complement their jobs with informal manual work, such as sewing and cooking. Additionally, they said that the legal limit on working hours (45 hours per week according to articles 22 and 28 of the Labour Code) was not always respected. They mentioned that they had to work longer hours at their offices which were unpaid. Finally, the long distances of their daily commute due to the residential segregation (Chapter 4 and Chapter 7) with an inefficient public transport system, also decreased their free time. Therefore, even when both men and women interviewed recognised the benefits that jogging for half an hour or having a workout routine would mean to their health, they had no time to do it. Since participants, mainly men, left their houses early in the morning (around 7 am) and arrived home late at night (between 8 and 9 pm), those who had younger children did not have the chance to see them or spend time with them during weekdays. This is why they said that their weekends were mainly dedicated to their families instead of them using that free time for physical activities.

I think (I don't do exercise) for a lack of time and for my job, well, jobs take up your time, you also get tired... So while you get home, you have to choose whether to do exercise or to rest, so... I also think that it is a lack of will because you can do it (...) but yes, I have two jobs, so... (...) I work at a gated community at the weekends at night, so the scarce time I have, I have to do other kind of activities, shopping, being with my kids, going out with them (Felipe, man, middle socioeconomic group, 37 years old)

In Santiago people live very far away from their jobs, so moving from one place to the other and then get home to do exercise, no! Be part of a sandwich in the tube and then get home and put a workout outfit? No! I doubt it (...) In Santiago there is no time, I mean, it takes 2 hours to get from one place to another, a person that lives in Puente Alto and work over there, my son work in Parque Arauco (shopping centre) and lives here, I means, it 4 hours a day! (Soledad, woman, middle socioeconomic group, 53 years old)

It is important to notice a gender difference here. In addition to being responsible for taking children to the doctor, as discussed in previous chapters, women were also responsible for all other housework (Figure 13). This situation left them with almost no time to carry out any physical exercise and placed them in stressful circumstances since there is a higher social expectation for them to be physically fit, as will be discussed in the next chapter. In their opinion, it was easier for women from the highest socioeconomic level to follow an exercise routine since they were able to afford domestic service and, therefore, were not obliged to carry out these household duties.

Figure 13: Gender of the main responsible person to exercise some housework (%)



Source: UNDP 2010, 73

This lack of free time also made it more difficult for middle class people, particularly women, to cook healthier meals. Even when some respondents remarked that people ate junk food ‘because of comfort’, the reality of people’s lives suggested that lack of time is not an irrelevant issue. Those women who had full-time jobs and arrived home late at night, said that they did not have enough time to cook traditional meals, such as beans or stews, but that instead they tended to prepare something that was fast and easy. Therefore, lack of time is a mechanism through which structure not only affects the possibilities that middle class individuals have to be physically active, but also the quality of their family’s diet.

For instance, when I arrive at 12 or my daughter that arrives at 9 (...) we cannot afford to cook beans at that time! Or lentils or stews [*cazuela*], which are more elaborate meals and for me they are very healthy! But you don't have time, so you cook pasta, rice, (boxed) mashed potatoes, very basic and fast things (Jessica, woman, middle socioeconomic group, 41 years old)

The second consequence of low-quality employment is related to the absence of a formal contract. As was seen in Chapter 4, a large proportion of the working population had informal, unprotected and unstable jobs. Within legal age range of Chile's working population, 23% are not part of the social security system, secured by formal contracts (Fundación Sol 2013). This means that they lack access to health, pension and unemployment insurance. As the following quotation illustrates, not having a good quality job not only produced personal frustration but also decreased the probability of having access to good quality healthcare.

I was never able to have a fixed contract, therefore I was always treated by public health, ok? And since I was a single mother and all of that, I was always considered (by FONASA) to be poor (Claudia, woman, middle socioeconomic group, 34 years old)

The lack of social security was not a daily problem since most people did not need to visit the doctor or receive medical treatments very often. However, in the event of health problems or special health conditions, such as pregnancy, the lack of an employment contract became critical for them.

... when my wife was about to give birth (...) I broke my foot on the Sunday playing football and then it was a mess because there was no insurance, no nothing. My wife was going to give birth during the week (...) and I have a very bad, very bad time. I had some savings, luckily, but since (my leg) was in a cast, I couldn't earn money and there was no working licence, there was nothing (Patricio, man, middle socioeconomic group, 52 years old)

Thus, those middle class Chileans who had informal and unprotected employment found themselves in a very vulnerable situation for health provision, which not only increased their anxiety and stress, but also limited their possibilities to obtain medical help when needed.

The last consequence of poor job quality is related to the stress or uncertainty that the previous conditions – low salaries, lack of free time, informality – generated in middle class respondents. This group of participants expressed how being under a heavy work load and stress at work sometimes caused their bodies to feel tight and tense. When this tension was compounded by irregular payment of salaries and the frustration of low job-satisfaction, the result would be anxiety. To deal with this situation, some of the respondents said that they smoked or had a drink every day after work. The effect that these substances had on their bodies made them feel momentarily more relaxed. Other participants stated that they ate more food, especially junk food, to 'kill anxiety', which when combined with the long working hours and lack of opportunity to carry out physical exercise, led to them being overweight and other potential health complications.

... even when it was my own decision to stop teaching [previous job], I carried with me a frustration (...) a frustration for not doing what I like to do. So I have gained weight because I've been feeling anxious, from that moment until now I feel anxiety and I eat, eat, eat, eat, eat. No exercise, I don't play football, I don't go out for a walk, nothing, it is from here to work and from work to here. Besides my job is already a full-time work, (I also) do web pages here at my place, so for me that means arriving home at 9 pm, and sitting down to do web pages until 1, 2, 3, and sometimes until 4 am (Nicolas, Man, middle socioeconomic group, 32 years old)

One of the participants showed clear awareness of the impact that employment conditions and nature of work have on health by remarking that she always observed people at the bus stop smoking or eating chips as a result of their stress. This practice seemed to be common for those respondents who smoked. Many of them narrated how, on their way home from work, after a long day, they had a cigarette or two while they were waiting for the bus or when they were walking towards it. Since they were not allowed to smoke in their places of work or in most of their homes, they used this moment within their commuting time to light up and relax.

... the stress that we have leads you to smoke. I've seen people who smoke only because they are nervous and even when people say 'oh, but the cigarettes...' sure, you know that a cigarette will not heal you, will not do anything, but even if you don't believe it, when you are going through a moment of anxiety, it really calms you, it calms you (...) So people are stressed all day long and you see them in the bus stops, I see them smoking while they wait for the bus (Jessica, woman, middle socioeconomic group, 41 years old)

Even when they showed an awareness of the impact work had on their physical and mental health, almost all of those in the middle classes who smoked said that they could stop smoking, or eating junk food, if they wanted to, that is, both were something that they had ‘under control’. They argued that it was something that they had made a conscious decision to do, emphasising their will power and revealing the morality associated with these practices, which will be analysed in the next chapter. They said that they smoked because they enjoyed it and it’s the relaxing effect, not because they were addicted to it.

I think it is a matter of habits, it is a habit, a habit that you make (...) I wouldn’t call it an addiction (Felipe, man, middle socioeconomic group, 37 years old)

Physical exercise was another strategy that some of the middle class participants used to cope with stress. They remarked that besides helping them to stay fit and physically healthy, it helped their mental health. They perceived it as something that could help them get out of their daily routine, ‘to release tensions, something like that’ (Jose, man, middle socioeconomic Group, 31 years old). This is why they said they would like to do more of this sort of activity. However, as was previously seen, there were also important constraints that they had to overcome to engage in this health-promoting practice.

To summarise, the characteristics of the low-quality employment from the middle socioeconomic group respondents constitute mechanisms that constrained their space for agency over their health-related practices, explaining to some extent the gradient regarding diet and physical exercise presented previously in this chapter. Because of the lack of time and energy and absence of social security, this social group found it difficult to spend time on physical exercise or preparing healthier meals, especially

women in employment who also had their double shift of housework. At the same time, these conditions made it more likely that these individuals would smoke, drink alcohol and eat junk food.

6.3.2 Labour characteristics from the lower socioeconomic group

Most of the respondents who belonged to the lower socioeconomic group worked as self-employed labourers, in manual occupations that used their physical strength. Data from UTPCH shows that 30% of the 361 people surveyed who were working and lived in *campamentos* in Santiago, worked as self-employed (UTPCH 2011). However, the quality, stability and security that these jobs provided for them and their families was very low. Even when self-employed work generated an income, the work did not pay contributions to the health system, pension and unemployment insurance, and was usually unreliable. The uncertainty of this work produced high levels of emotional stress but did not compensate by providing access to good quality social services. The same situation existed for those who worked as dependent-employees with no formal contract, the case for most of the women interviewed from this socioeconomic group.

All of the respondents who were working, or who had worked, started working as children, around the age of 8 and 10. Their families need for this financial support reveals their poor early life conditions. Starting work when young had prevented them from finishing school, so while some had received up to eight or nine years of education, others had only one or two. Their lack of formal education and precarious environment had produced work histories with many interruptions, periods of unemployment and job changes. This provides evidence of how different factors that affect health interact with each other and compound the total effect (see Chapter 4).

Data show that 54% of the working residents of *campamentos* in Santiago had a formal contract, but only 29% had a permanent contract (UTPCH 2011). This means that 71% of working people did not have a permanent contract, leaving them and their families highly vulnerable, as described by this respondent:

Four years ago my dad broke his foot, we were several days without money, without something to eat because he didn't have a contract (...) they [employers] didn't give him anything to support us (Benjamin, man, lower socioeconomic group, 15 years old)

The situation for women from this group was slightly different. Data show that 61% of women living in *campamentos* in Santiago were unemployed, whereas the figure for men was only 31% (UTPCH 2011). While some female participants worked outside their homes, the majority were unemployed or economically inactive. None of those who had a job said they had a contract, meaning that in situations such as pregnancy, they were not able to access benefits such as paid maternal leave. Even when their partners had a formal contract and had access to better health care, they could not add these women to their health plans because usually they were not formally married. Therefore, women from the working class were more vulnerable to lack of appropriate health care and social security than men.

The nature of the jobs held by people from the lower socioeconomic group led to different consequences in their participation in practices regarded as 'healthy', as well as to their health status in general. However, the analysis focuses only on those related to health practices. The analysis of experiences and views of men and women will be presented separately since their working realities were so different.

In the first place, the work done by male respondents living in *campamentos* involved physical activity on a daily basis. The manual nature involved activities such as loading trucks, construction, digging, and walking long distances, which kept them physically active during the working day. Therefore, even without any physical exercise of their choice during their free time, they recognised that their jobs kept them physically active.

At least my work is active, because I have to be all day long with the shovel, unloading (the truck), so that is a lot of movement and then you burn a lot of fat (Pedro, man, lower socioeconomic group, 42 years old)

As they worked long hours and even had two jobs sometimes, they did not have free time to engage in any voluntary physical activity. It is very interesting that when they talked about this lack of time, they also mentioned that it prevented them from studying at night school. This reveals their basic unfulfilled needs and how they had a higher priority than spending time on their bodies and health care.

There are two noteworthy examples of men who regularly did physical exercise outside their work to release their tension. The first one is a man who cycled to work and back home every day. The *campamento* where he lived was located on the city outskirts where most factories were situated, so he had a short distance between work and home. As well as this being a way to save money and to stay fit, he described it as a moment that he used to relax and to disconnect himself from the different problems he faced at work. Even when he argued that this was an ‘involuntary exercise’ since he would use the bus if he had enough money, he recognised the benefits that it brought him.

... it's like you change the switch, you pay attention to other things (on the way). I step off my bike very relaxed, calmed, it's like I get disconnected from the situations I may be experiencing at my work and that has always been very important for me. The working situation is one and the family situation is another, but in my route [between them] it is there when there must be the change, the moment to leave the situation you are at (Pablo, man, lower socioeconomic group, 48 years old)

The second example is that of a man who worked in a cemetery digging graves. Being involved in funerals and surrounded by sorrow and mourners every day produced emotional distress in him and his colleagues. As a way to deal with it, the company that owned the cemetery encouraged them to play football once a week in a club. The respondent recognised this strategy as a real help for them since it dissipated all the tension and sorrow that they felt during funerals but could not show.

... the company has a club for us and every Friday we have to play football, to vent ourselves and yell, that is why we go there (...) and then you are nice when you get home [*uno llega suavcito aquí a la casa*] (Juan, man, lower socioeconomic group, 38 years old)

However, not all of them had an opportunity to release stress in this way. Similar to the middle socioeconomic group, male participants from the working class noted how they turned to a cigarette when they were looking for a moment of relaxation after a long day of work. Many of the participants said that once they came back from work or when they had breaks during the day, they would smoke a cigarette or two to relax, even when they knew that it was harmful to their health. Unlike middle class respondents, they were not often forbidden from smoking while working. However,

since their jobs were manual, they said that they never smoke while working because it distracted them.

... cigarettes kind of relax me and I know that they harm me but they relax me.

Sometimes I have lunch (at work) and I feel like smoking, even when I know it harms me, but it relaxes me (Juan, man, lower socioeconomic group, 38 years old)

Finally, some of them mentioned a practice which they now morally rejected but which they had engaged in previously or knew people from their social circle that still did. This is the practice when men go out to drink with their male friends ‘because I deserve it’. They reported how it was common for other men in the *campamentos*, or they themselves in the past, to work hard all week long, come back home Friday evening, give a portion of their income to their partners and then go out for the whole weekend to drink heavily with the rest of the money. The respondents said that the justification used was ‘I kill myself working, I deserve to enjoy myself [*darme el gusto*]’. Respondents said that they did not engage in this practice since they earned so little money, that it would be a waste and morally wrong to spend it on alcohol. The extensive analysis of ENCV survey (described in Chapter 3) showed that nearly 18% of people who belonged to the poorest quintile (I) presented a drinking problem, comprising 29.5% of men but only 6.3% of women (Departamento de Epidemiología - MINSAL 2006). These statistics reveal the masculine character of this practice, an aspect that will be discussed in Chapter 7.

The scenario for the female working class participants was quite different since most of them were unemployed, and those who were employed were self-employed or had no contract. In the case of those who were employed, it was common for them to work

as nannies and domestic staff for people from a higher socioeconomic level. This meant having double shifts of household work: at their jobs and at their homes. Almost none of them said that they received help from their partners to cook or do the laundry. If they did get help, it was usually another woman, e.g. a daughter, sister, or mother, confirming once again the traditional division of labour. Additionally, having paid employment outside their houses required finding inexpensive or free day-care – usually relatives – to look after their children too young to go to school, as seen in Chapter 4. When they could not find this help, they had to stay at home. Some of them were able to work from home, e.g. doing crafts, selling vegetables and fruit. These women expressed that they had to combine carrying out their household work with paid activities throughout the day. Even when this type of work solved the problem of adequate day-care, respondents said that it increased the intensity of their double shift since they were performing two roles at the same time.

Those who did not have a paid job were usually in their houses all day, cleaning, cooking, doing the laundry and taking care of their children. Since most of them said they did not enjoy good social relations with their neighbours, or did not feel physically secure, their possibilities for physical activity were limited to what they could do inside their houses. These women said that sometimes they felt that they had ‘too much’ free time. This gave them the space to think and reflect about their lives, which could lead to anxiety and sorrow because of their tough situation. According to a survey done in *campamentos* in 2006, almost 44% of the 300 women living in *campamentos* surveyed had depressive symptoms, whereas only 27% of men had these symptoms (Bedregal et al. 2006). The propensity to depression that ‘full-time housewives’ have has been previously examined (Doyal 1995), and seems to be worse for those who belong to lower socioeconomic groups. Some of the participants said that it was in those

moments of hopelessness, anxiety and sadness that they looked for the ‘company’ of cigarettes, an aspect which echoes findings of previous research (Graham 1993).

... the habit of smoking, it’s not that you need to smoke, it’s the stupid time when you don’t know what to do with your hands. So at some point in the future you can avoid it by working, doing something at your house and cigarettes will decrease (Maria, woman, lower socioeconomic group, 39 years old)

... (cigarettes) are like your company in everything that you do (Ana, Woman, lower socioeconomic group, 36 years old)

Unlike middle class teenagers, almost all the young men and women living in *campamentos* who were interviewed, were in work currently or had been in work. For most of them work did not cause a lack of free time, stress or affect their possibilities for engaging in health-related practices. They usually worked a few hours a day and used this money to augment their families’ income. The only case reported where employment affected their health-related practices was in the case of a teenager who worked in a fast-food restaurant as part of her school program. In her case, eating free junk-food almost every day led her to have a higher intake of fat and sugar.

To sum up, the way in which employment influenced the health-related practices of individuals from the lower socioeconomic group depended on their gender, revealing how these two dimensions interact. Even when practices may be seen as the same, such as smoking, it is important to understand that the meaning and motivation for it may be different: while men usually smoke to relax after a hard day at work, women sometimes have a cigarette as a way to cope with their stress and lack of company.

6.4 Conclusion

This chapter has shown through a critical realist approach that combined intensive and extensive analysis, how Chileans' space for agency to engage with health-related practices is restricted by structure through their economic capital in the form of low-income and low-quality paid work. In the first place, people's income determined whether or not they could access the private healthcare system, that is, a system with enough resources to deliver good quality care when needed. Secondly, it limited the type and quality of food they ate; as income decreased, so did the consumption of fruit and vegetables, the quality of food and its variety. Finally, people's tight budgets also hindered them from engaging in physical activity since exercise that they tended to enjoy, such as swimming, had to be paid for, or they could not afford to pay for a safe place to carry out free exercise, such as running, or they had to dedicate their time to more basic needs. Even when low income restricted the space for agency most severely for those respondents in the lower socioeconomic group, it also proved to be relevant for those who were part of the middle class.

The analysis also showed that employment conditions, that is, low salaries, lack of free time, informality, consolidated by the neoliberal policy regime (Chapter 4) are additional mechanisms through which structure limits the space for agency men and

women from the lower and middle socioeconomic groups have over their health. Even though respondents from both socioeconomic groups shared similar health consequences, such as feeling stressed or anxious about their work situation, their engagement in heavy drinking of alcohol and the justification given for it was different. While participants from the middle socioeconomic group stated that it was a way to relax in the same way as smoking a cigarette or eating junk food, respondents from the lower socioeconomic group would seek refuge, pleasure and, sometimes, reward from it. At the same time, the physical activity done by men was different due to the manual and non-manual nature of their work, even when they both faced similar constraints to engage in voluntary or chosen physical exercise. Although women from the lower socioeconomic group had more time to take physical exercise than those from the middle class, because most of them were unemployed or economically inactive, their lack of money and security prevented them from spending time in this way. Thus, the nature of people's work affected their health practices in different ways, depending on their socioeconomic situation.

In both cases it was possible to see the presence of a social gradient of health. Individuals from both socioeconomic groups have their health-related practices constrained by their low-income and low-quality paid work. Thus, these mechanisms have an impact that goes beyond the poorest groups of the Chilean society. Additionally, the tension in people's discourses described in Chapter 5 from a new perspective was also seen across both socioeconomic groups. While on the one hand respondents were aware of the effects that income and the characteristics of their work had in influencing their health-related practices, on the other hand they tended to express a personal responsibility for their actions. Respondents seemed to have internalised the government messages about individual responsibility over health-

related practices and outcomes within a context of high inequality in diverse health-related influences.

The idea that health-related practices depend on the information people have on them, this analysis suggests, may not be accurate. Even when they knew which foods are healthy and which are not, the positive effects that physical exercise would have on their physical and mental health, and the damaging power of cigarettes and excessive alcohol consumption, insufficient incomes and precarious or unstable employment conditions produced a reality in which people could not choose what they knew would be healthier for them. Their choices were constrained by the chances of their material conditions.

However, the mechanisms that derive from the inequality of economic capital consolidated by the neoliberal policy regime are not the only ones through which structure restricts the space for agency that individuals have over their health. The next chapter will analyse the mechanisms through which people's social and cultural capital relations constrain their agency power over their health-related practices. This will identify additional ways through which structure influences health. By combining extensive and intensive analyses, it will explore how inequalities that derive from Chile's neoliberal policy regime revealed in Chapter 4, such as residential segregation and strong social segmentation, create moral and social boundaries that limit the space that people have for choosing their health-related practices.

CHAPTER 7 - HEALTH-RELATED PRACTICES, SOCIAL AND CULTURAL CAPITAL

7.1 Introduction

The previous chapter analysed the mechanisms through which the unequal economic capital that men and women from different social groups possess affected their agency over health-related practices, and how these mechanisms were related to the Chilean neoliberal policy regime. The critical realist analysis showed how people's low income, low salaries, lack of free time, and informal labour code, constitute mechanisms that, to varying degrees, limit the space for agency working and middle class Chileans have over health. Additionally, the analysis identified a tension in the respondents' discourses between the importance of health 'chances', that is, an awareness of the impact that social determinants of health have on their practices, and the centrality of health 'choices', meaning individual responsibility for health outcomes.

In order to answer the research question thoroughly, it is still necessary to explore critically the mechanisms through which the social and cultural capital possessed by men and women from different social groups influence their health-related practices, and how these mechanisms are related to the neoliberal policy regime. As discussed in Chapter 2, Bourdieu states that the distribution of different types of capital determines people's location within the social structure. While the previous chapter analysed the mechanisms related to economic capital, this chapter is focused on the social and cultural capital in its embodied state, that is, the actual or potential material and non-material resources that people have from belonging to a network of social relationships

and the ‘dispositions of the mind and body’ (Bourdieu, 1986, 243) respectively. Earlier research has examined the effects that neighbourhoods and social relationships have on health outcomes, showing that as the socioeconomic level of neighbourhoods, housing quality, and social support and inclusion decrease, mortality, morbidity and the adoption of health-damaging practices increase (Blaxter 1990; Wilkinson 1996; Kawachi et al. 1997; Lynch et al. 2000; Stafford, McCarthy, and Wilkinson 2006; Cockerham 2007). By combining extensive and intensive analysis, this chapter explores how social networks and their heterogeneity, that is, people’s social capital, together with the social norms within them, that is, their embodied cultural capital, create forces that set social and moral boundaries for the engagement in health-related practices. Firstly, through a critical realist analysis, this chapter explores the way in which Santiago’s residential segregation and the subsequent low heterogeneity of social networks impact how people enact the health-related practices in different ways according to their socioeconomic background and gender . Secondly, the chapter analyses how social norms and expectations about health-related practices differ between men and women from different socioeconomic levels, and how this is related to the amount of agency they have over health.

It is important to state that the division between cultural norms and material boundaries is an analytical one, since in real life these dimensions are intertwined, as implied in the concept of ‘habitus’. According to Bourdieu, the habitus engenders the dispositions that give meaning to people’s social location and practices, as discussed in Chapter 2. This ‘structuring structure’ would produce those health-related practices that make sense to people according to their economic, social and cultural capital. However, in order to understand the mechanisms through which these norms limit individuals’

agency in more detail, they were analysed separately from the material conditions in which people live.

7.2 Social Capital: neighbourhoods, social relations and health-related practices

7.2.1 Residential segregation

Chileans from different socioeconomic groups live in different neighbourhoods and perform their daily lives in different social environments. As discussed in Chapter 4, Santiago is a city characterised by having a strong residential segregation according to the socioeconomic level of families and individuals. This leads people to move in separate and internally similar social circles. The reality presented and experienced by the respondents showed that this segregation not only creates isolation from the rest of the society and access to poorer quality services, but as the neighbourhoods' socioeconomic level decreases it also exposes them to conditions in which potentially detrimental health-related practices to health become more common.

In the first place, the fear of crime described in Chapter 5, both by the middle and lower classes, constrains individuals from engaging in physical activities, particularly those that do not involve spending money. As already seen, respondents mentioned that even when their budgets did not allow them to join a gym or use a swimming pool, they could still go out jogging or use the free municipal facilities to exercise. According to them, the main reason for not doing it was their 'laziness'. Nevertheless, participants' discourses showed that fear of crime is a mechanism that constrains their physical activity which in turn influences their health. This echoes the results from

previous research which showed the importance of reduced physical activity and restrictions in outdoor activities as a mediating link between fear of crime and health (Stafford et al. 2007; Jackson and Stafford 2009). These studies confirm the statistical association between fear of crime and reduced physical activity, suggesting a feedback model in which fear harms health and ill health increases fear of crime.

Experiencing fear of crime was present in both socioeconomic groups' narratives, especially women's. As seen in previous research, women are more likely to be afraid of crime than men partly because they feel more vulnerable physically, and because they feel at greater risk of crime than men (Jackson 2009). The social environment in which respondents lived made them feel scared of going out for a run or cycling by themselves. Many participants said that they had done it, or would do it, if someone came along to make them feel safer. They could only do it very early in the morning or late in the evening, which made it harder because the lack of daylight and fewer people on the street increased their sense of vulnerability.

Interviewer: What stops you from doing more exercise?

Respondent: Because here there is no place to!

Interviewer: Would you like to go to a square or something like that?

Respondent: Of course!

Interviewer: And there is no place around here?

Respondent: Yes, there is one, but you don't go there, because of what I told you earlier...

Interviewer: Because of the slums [*poblaciones*] and that?

Respondent: Yes, it scares me! (Carmen, woman, lower socioeconomic group, 62 years old)

I felt scared about going out at night for a run. I have a bike and I have used it only a few times (...) It scares me, yes, we have tried with my daughter to go to cycle in the afternoons but at the end I feel scared, it scares me. And early in the morning it also scares me, so no, apparently the only choice is the gym and I cannot afford it, I mean, it's unreachable (Paula, woman, middle socioeconomic group, 45 years old)

Secondly, the amount of free time they have to be physically active or to cook healthier meals is reduced due to the length of time people spend travelling, a consequence of the long distances that people have to travel and the inefficient public transport system. As was seen in the previous chapter, Chileans from the middle and lower socioeconomic group had long working hours, preventing them from being physically active. This was made worse by the number of hours spent travelling to and from their place of work. People usually returned to their houses very late at night, with little or no energy to engage in any type of physical activity or to cook elaborate and healthier

meals, as seen in Chapter 6. Thus, the combination of lack of free time and fear of crime constrained participants' possibilities to be physically active. This was made worse by the stress and anxiety produced by the inefficient and overcrowded nature of the public transport.

Hence, there are two main mechanisms by which Santiago's residential segregation impacts people's real possibilities of engaging with health-related practices that could benefit their health. Fear of crime and lack of free time limit the space for agency that men and women from the lower and middle socioeconomic groups have over their health. Thus, the access to health-related practices is not only influenced by the unequal distribution of income and the poor quality of employment, but also by the neighbourhood in which people live.

7.2.2 Habitus and 'normality'

The heterogeneity of the social networks (see discussion in Chapter 2 for definition) to which participants belong also has an impact on their health-related practices. The results from this section will be analysed with due regard to the differences of socioeconomic background between the working class and middle class.

Men and women from middle class: 'I do what everybody does'

Respondents from the middle socioeconomic group generally felt that their neighbours and friends had similar practices and way of life as they had. When they were asked to compare their reality to their acquaintances in terms of socioeconomic condition or diets, they said that it was 'normal', that it was very similar and that there were no important differences between them. Participants stated that when they visited their neighbours' or friends' houses, they could observe that they lived in quite similar

ways, revealing how they shared a social position and, therefore, habitus (Bourdieu 1990). According to Bourdieu, those who share the same habitus have similar dispositions, thoughts and perceptions, all of which are experienced as something ‘natural’ or ‘normal’ (Bourdieu 1984, 173).

The ‘normality’ of practices was questioned by respondents only when they compared their realities to those who belonged to a different socioeconomic environment or status, be it higher or lower, that is, those who had different social locations and dispositions. These types of comparisons are very useful to comprehend what in their opinion was ‘normal’ and what was not, that is, what made sense to them according to their habitus and what did not. Two examples will be presented to illustrate this point.

The first example is that of Nicolas. This middle class man had a low socioeconomic background, and grew up in a marginalised and vulnerable neighbourhood in Santiago that had high rates of crime and drug addiction. He described how during his childhood and teenage years it was very common for him to see alcoholics, criminals and drug addicts. In fact, he reported that since childhood he was offered drugs several times, but that he never accepted them because he said his mother showed him how drug addicts deteriorate. He found a job elsewhere and moved out of that neighbourhood. Along this road, he met his current partner, who has a middle socioeconomic background. At the time of the interview, he lived with her in a traditionally middle class neighbourhood in Santiago with their two daughters and most of his social networks were also from a middle socioeconomic level. He recognised being in a very different environment from the one in which he was raised and where his extended family still lives.

When he narrated his story and what he stated as his ‘personal choice to be different

from the others', he compared himself to his younger brother, who still lived in his old neighbourhood. Nicolas said that his brother was not able or did not want to move to a safer and higher socioeconomic level neighbourhood. He established a link between his brother being an alcoholic and the fact that he still lived there, surrounded by a social environment of vulnerability and where health-related practices that may damage health were considered a 'normal' strategy to deal with stress and the harsh conditions of life. In his own words,

... it was a personal choice to be different from the others. My brother as well, you know, but my brother, even when he went to the university and everything, my brother stayed there with my folks [*mis viejos*], it's like he is stuck. So now my brother is still hanging out with the same guys, every week my brother is partying [*se manda sus carretes*], drinking with the same people over there, he does not have a bad salary but he is still stuck in there (...) I think that my brother is also alcoholic, because he is following my father's footsteps, I mean, he drinks on Friday, Saturday and Sunday until midday. There's no weekend that he doesn't do it and he is proud of it [*se jacta de hacerlo*]! (Nicolas, man, middle socioeconomic group, 32 years old)

Firstly, Nicolas's quotation shows an awareness of the impact that social networks have on health-related practices. His words imply a belief that if his brother moved out of that neighbourhood, as he did, he would probably drink less alcohol since he would be in a different social environment. Therefore, according to Nicolas' experience, the characteristics of social networks to which people belong do not always imply a benefit to their health outcomes or health-related practices, an aspect considered by previous research (Portes 1998; Halpern 2005). Belonging to certain social networks may

sometimes be related to following social norms, such as smoking or drinking, which are in other circumstances considered negative to good health. This reveals the importance that shared dispositions and experiences have on the practices that people enact.

Secondly, Nicolas' quotation revealed the centrality he gave to individual responsibility. He felt personally responsible for leaving his parents' house and neighbourhood and, consequently, blamed his brother for not doing so. However, it is possible that other mechanisms, of which Nicolas was not necessarily aware, were underlying his brother's alcoholism and the difficulties he had with regard to moving out. One of them, implied in the quotation, could be the association between high levels of alcohol consumption and the construction of masculinity: 'he is following my father's footsteps'. This relationship reported by previous research (Courtenay 2000) will be discussed in more detail in the second part of this chapter.

The second example is that of Juana, a middle class woman who worked in a high socioeconomic neighbourhood and institution. Most of her colleagues came from a higher socioeconomic level than hers, that is, had a different habitus and shared different dispositions to hers. Juana said that in her daily life, the socioeconomic differences between her and her co-workers had meant that she had been able to try food that was new to her, had a healthier diet since they all ate healthier meals, and joined the weekly Zumba class offered by her employer.

Respondent: I think that one of the things that I have seen here that is different is when I go to the cocktails they do here. Here they eat a lot of vegetables, because they eat celery sticks, carrots, lots of cheeses, things like that. In my social life, like from my house, it is always more common things like fried snacks [*soufflés*], chips... there is the difference, here they have things that are healthier and there they don't.

Interviewer: (...) And if you for instance had celery and carrot sticks in a social meeting with your friends, do you think they would eat it?

Respondent: I think that my friends would say 'aw, that's tasty!' but they would eat more of the other stuff, I think they would. As a matter of fact, when I go to these meetings here I eat more chips than carrots; I think it is cool but not very tasty (Juana, woman, middle socioeconomic group, 35 years old)

This example shows that social networks' heterogeneity can imply different health-related practices, in this case, types of diets. Juana's bridging social capital, that is, her social networks whose members were different to each other and had a different socioeconomic background (see Chapter 2) exposed her to new tastes and flavours implying a positive effect that social networks and bridging social capital can have on health, as seen in previous research (Petrou and Kupek 2008; Kawachi et al. 1997). It is interesting to note that even when she and her friends from a similar socioeconomic situation – her bonding social capital – thought that these new foods were interesting, they still preferred to eat what they usually ate, in this case, chips. This preference could be explained through what Bourdieu calls 'taste', i.e. the propensity to appropriate objects or enact practices associated with a social position (1984, 173). The example of Juana and her bonding social capital reveals how taste functions as a social guide that leads individuals to choose those practices, e.g. eating practices, that

they consider appropriate to their place within the social structure (Bourdieu 1984, 466). However, even when she did not change her eating patterns, she became aware through her bridging capital that other real eating options existed.

In the respondents' opinions, they were engaged in many of their health-related practices because those within their bonding social capital also did them. Several participants stated that meetings with their families or friends were usually centred on food; they met for dinner or lunch during the weekends as a way to spend time together. They told how this implied eating too much and sometimes eating food they considered unhealthy, such as pizza or fried food.

I can tell you that every weekend [we do a barbeque]. On Saturdays we meet our neighbours, I told you we meet them, and [we do] that (Jose, man, middle socioeconomic group, 31 years old)

... with the guys we were hanging out it was every Saturday, Friday evening, barbeque, pizza, this, that, and you ended up stuffed! (Claudia, woman, middle socioeconomic group, 34 years old)

It was also common to find references about going to the shopping mall during weekends, either with family or friends, as a way of changing their daily routine and doing something special. In these situations, people commonly ate fast food or junk food due to the special offers available in these places.

During the week [our diet] is very normal, we eat pasta, mashed potatoes, but in the weekends we go out, we eat at the mall or we bake a pizza or we buy pies [*empanadas*], things like that. During the weekend it's like we can enjoy [ourselves] because the family is all together, but not during the week (Trinidad, woman, middle socioeconomic group, 15 years old)

In most cases these situations were seen as problematic by middle class respondents. They recognised that these social meetings implied practices that they did not consider healthy, such as eating too late, too much and 'non-healthy' food. Some of the participants had in fact opted to participate less frequently in the social meetings, in this way reducing their social life. However, when these meetings were with relatives and not friends, it became harder to decline.

A similar situation was expressed with regard to smoking and drinking alcohol. These practices were immediately associated with social life in respondents' narratives. They said that it was in situations like being at a party, going to a casino or when they were talking with their friends, that they smoked and drank the most. Most of the smokers said that they had started to smoke because everyone else did and they wanted to stay in tune or just show off, which confirms how their own practices were influenced by those within their bonding social capital.

[I associate alcohol] with meeting my friends, dancing for a while, talking, mainly to socialise. (Jessica woman, middle socioeconomic group, 41 years old)

On Sundays I like to open a good bottle, I like good wine, on Sundays with the starters. My daughter arrives with her husband, my wife is there, and we open a bottle. Talked out, that's how I like it. (Jorge, man, middle socioeconomic group, 52 years old)

In the case of teenagers, some of them started avoiding certain social groups when they did not want to drink heavily or smoke anymore. Their strategy to stop engaging with these practices was to reduce their social life or change their circle of friends; in other words, look for areas where people had different dispositions and carried out other practices. For some respondents, it was not in fact their choice to keep a distance, but their friends who more or less pushed them out; those who did not drink or smoke were excluded by the rest, revealing the possible social cost of going against the group.

[My classmates] always organise meetings and they all meet except for me and my five friends because we are the ones that do not smoke and do not drink. So we are not like them [*no estamos en su onda*]. They don't invite us to the parties or anything (Trinidad, woman, middle socioeconomic group, 15 years old)

Unlike the attitude towards smoking or smokers, alcohol consumption was interpreted in two ways. On the one hand, some respondents associated it with death and disease, which is why they said that it was something that they tended to reject. This negative connotation seemed to coincide with personal experience of repeated incidents of drunken relatives or friends. On the other hand, those participants who had not experienced any traumatic nor negative incidents with alcohol were not negative towards it.

Interviewer: What is the first thing that comes to your mind when you think about an alcoholic drink [*un trago*]?

Respondent: Well, the vice of alcohol is terrible. I have a brother that unfortunately is addicted to alcohol and you see how he has had family issues because of that, he has split up twice and many times there have been problems in the family because of him, so alcohol is harmful, it is harmful... (Oscar, man, middle socioeconomic group, 65 years old)

Ah... serious problem (...) For me, I feel that I lived through ugly stages with my nephew... I associate alcohol with fights, with disaster, like ahhhh... I am scared of people that drink (Paula, woman, middle socioeconomic group, 45 years old)

Finally, there was also a connection between the physical exercise done by respondents and their social relationships. Those respondents who had friends or close relatives who carried out physical exercise regularly, tended to do it themselves as well, whereas those whose social relations did not engage with this practice did not have the same incentive. This reality became clear when men and women from the middle socioeconomic group were compared. In women's accounts it was hard to find references to friends or social relations with regard to physical exercise. According to their narratives, their bonding social capital, i.e. those social networks composed by individuals with a similar socioeconomic condition (Szreter and Woolcock 2004), was not especially sympathetic to physical exercise, if they had any kind of engagement at all. This echoes the quantitative data presented in Chapter 4, which showed that women were less likely to carry out physical exercise than men.

The reality for middle class men seemed to be different in this aspect. Even when they said that they did not exercise regularly, there were several times when meeting their

male friends for a football match was mentioned. Men usually considered playing football with their friends as a social situation where they could ‘hang out’ together for a while. They usually stayed after the match for the ‘third half’ [*tercer tiempo*] where they had some beers and sometimes a barbeque. In the case of women from this socioeconomic group, sport was not a practice associated with socialising. In this sense, physical exercise was social practice for men, but not for women.

Men and women living in campamentos: coping with precarity

Those respondents who lived in *campamentos* reported living in a different situation to those from the middle class. Even when participants stated that their realities were similar to their neighbours’, they acknowledged the presence of health-related practices in their neighbourhood which they did not approve of and did not engage with that could be detrimental to health. Their criticism of their neighbours’ or friends’ practices shows their intention to be distanced from them, revealing the moral character that these practices have, as will be seen later in this chapter.

Some of the participants said that their *campamentos* were very quiet and that they had no knowledge about these types of practices. However, they were a minority. Most of them stated how, on a daily basis, they witnessed drug trafficking and consumption only a few steps away from their own houses, and on some occasions how they themselves or their relatives had been involved in it. This revealed the association between these practices and living in poor conditions and precarious housing. In fact, a survey by UTPCH found that 47.6% of *campamentos*’ residents in Santiago stated that it was common to see drug trafficking in their *campamentos* and 74.9% to see people drinking alcohol on the street (UTPCH 2011).

Ana, a *campamento* resident, told me how in the past it was very common for her to

get drunk and smoke a lot. She said that her numerous problems and anxieties had led her to seek refuge in alcohol, something she stated she was not proud of. She said she only stopped after people from the NGO that worked with *campamentos*' residents talked to her and explained the damage she was causing herself and her body. Even though she was able to quit, she said that many of her neighbours were not able to recover from alcoholism. This was a reality that could be seen on a daily basis in her *campamentos*, an example being, her next door neighbours, who she said were always drunk.

Interviewer: Do you see a lot of people drinking in your environment?

Respondent: Yes, there's a lot of people who are already alcoholics because here, in this '*campamento*', there's a group of gentlemen that are alcoholics, we call them '*chicha*' [*a popular Chilean alcoholic drink*], so it is very sad to see those people... It is like they are hanging on only to that and are not able to see life differently (Ana, woman, lower socioeconomic group, 36 years old)

Ana's linking social capital, that is, her social networks that were with an individual who related to her in a relationship of 'authority gradients in society' (Szreter and Woolcock 2004, 655), e.g. NGO, helped her to recover from her addiction. Having their support, as well as the chance to actually understand what the substances were doing to her body, was a central resource in her opinion, which not all Chileans who live in poverty have. The positive impact that the presence and relationship with the NGO had meant in this case, could be related to Siegrist's self-regulation hypothesis, which argues that in order to be able to exercise self-regulation, socially excluded people need self-efficacy, self-esteem, and self-integration (Siegrist 2000). The relationship that Ana had with the NGO volunteers provided her with these necessary

functions: by making her feel that she had the capacity to quit smoking and drinking, by her being treated well and with respect by people from a higher socioeconomic background, and by belonging to the networks that this NGO represents. This suggests that the presence and role of the NGO in *campamentos* could increase people's space for agency by giving them the functions needed to quit or decrease health-related practices that could harm their health, such as addictive drug consumption and binge drinking, and by offering other coping strategies or diminishing, somehow, the precariousness in which they live. Unfortunately, due to access and security reasons, the sample of this research did not include examples of people who had no contact with NGOs, therefore no comparisons could be made.

Most of participants who lived in *campamentos* stated that it was unusual for them to have people over for lunch or dinner, denoting a low frequency of social contact. They usually ate by themselves and rarely met with friends or relatives for occasions like a barbeque, since they did not have enough resources to buy special food. However, when they did have guests they usually tried to have something special and different from their daily fare. By this they usually meant meat or some traditional Chilean dish, things which they did not have money to buy or time to cook in their everyday lives, as seen in Chapter 6.

... we do it only (change our diets) in occasion, like birthdays, sometimes, seldom [*muy a lo lejos*], we do a barbeque, sometimes we don't, it all depends on how the [economic] situation is (Pedro, man, lower socioeconomic group, 42 years old)

This situation revealed a lonely life, an aspect that increased their daily difficulties. Their solitary character was also reflected in the meaning that this social group gave to smoking. Contrary to what was expressed by middle class respondents, this social group did not state that it was friends who engaged with this practice that led them to smoke. The need or wish to smoke was triggered by moments of crisis or when they were troubled, confirming once again the relationship that these practices have with the harsh conditions endured by this socioeconomic group. Previous research has shown how single mothers and mothers who live in poor material conditions, that is, groups considered to be under high levels of stress, find relief and a calming influence in cigarettes, when other forms of social support are not present (Graham 1987; Graham 1993; Sperlich and Maina 2014). Respondents described how, in moments like these, they smoked a cigarette to feel more relaxed and to try and forget their problems or try to find a solution for them. In this sense, smoking was frequently associated with a moment of reflection and introspection.

Respondent: ... when I'm with other people I don't like to smoke.

Interviewer: In which occasions do you smoke?

Respondent: When I'm by myself, when I'm with my partner, we talk about our days, our kids, the problems... (Pablo, man, lower socioeconomic group, 48 years old)

[I smoke] occasionally, when I'm nervous, when I have problems that cannot be solved (...) When I'm nervous, for example, I have problems, I have debts that I cannot pay, my head starts filling up with idea and I need to push them away and it's like the cigarette relaxes me, it's like I start to get calmer (Benjamin, man, lower socioeconomic group, 15 years old)

However, this solitary way of smoking was not the only way. There were a few examples in which respondents stated that they smoked in social meetings or when they wanted to spend some time with their friends or neighbours. This approach was prevalent amongst teenagers at parties and recreational social activities. It was also more common in women's accounts, which makes sense as they spend more time on their own in their houses, because of their housework and higher fear of crime, described previously. These women narrated how they would look for a neighbour with whom to talk and smoke a cigarette, suggesting their need to cope with the stress generated by their caring responsibilities and the precarious circumstances in which they lived (Graham 1993). This type of situation revealed the interplay between gender and socioeconomic situation.

I used to go out looking for a neighbour, we talked a lot and then I stopped smoking and I didn't go out anymore. It was actually that I went out to smoke a cigarette and I looked someone to be with in order to smoke (Paola, woman, lower socioeconomic group, 38 years old)

The perception was somehow different in relation to the consumption of alcohol. Even when there were examples of people who stated that they used to drink as a coping strategy, the emphasis was on sharing a moment with friends and family more than drinking by themselves. This difference could be a reflection of the negative moral

connotation that alcoholism receives in the context of poverty, as will be seen later in this section. Men and teenagers stated that they usually had a drink or two with their friends in order to have a good time and also after football matches, meaning that alcohol was usually present in their social gatherings.

[I drink] when I go to the [football] fields, on Fridays (...) after the match we do a barbeque and we share amongst each other (Juan, man, lower socioeconomic group, 38 years old)

The interplay between gender and socioeconomic condition becomes relevant once again with working class women's experience of alcohol consumption. Most of them gave it a negative connotation and associated it with addiction, violence and abuse. The emphasis given to the behavioural change that it produces was related to their histories and past social relationships. Almost all of the female respondents who lived in *campamentos* had a relative or partner who was an alcoholic, and who had suffered high levels of violence inside their houses as a consequence, an aspect related to the rates of domestic violence seen in Chapter 5. These women strongly rejected alcohol consumption, said that they did not drink on any occasion and that they got very nervous when people around them drank. Thus, in this case, the engagement of their social environment with problematic alcoholic drinking discouraged their engagement in it.

Respondents who lived in *campamentos* said that they had changed their social networks as a way to avoid, or sometimes promote, consuming too much alcohol, cigarettes and sometimes drugs, which confirms that belonging to social networks is not necessarily beneficial for health (Portes 1998). They argued that since they started

meeting people who did not engage in these practices, they themselves stopped enacting them. The example revealed by Pedro is very illustrative of this situation.

Pedro is a 42 years old man who had lived his entire life in the same working class neighbourhood. He first lived in his parents' house and then moved to a *campamento* close by when he got married. His constant presence in this area meant that he had a group of childhood friends with whom he used to hang out. He described how every time he met them, which used to be every weekend, they would drink a lot and he would arrive drunk at his house. This situation went on for a long time, he got into car accidents and other kinds of problems, until he said it became unbearable for his wife, children and himself. The only way he found to stop doing this was to stop meeting his friends. He narrated how he became more a 'family man' and that he spent his free time with his family in his house, away from the 'street world' as he called it.

... I used to get completely drunk, next day I wouldn't remember what I did and complaints would arrive at my house, people would tell my wife... and I used to tell myself 'you're doing great!' [ironic tone]. And because of that I started sorting my mind out and moving away from the street world environment, until I did it. And here I am, where you see me now, working on my business, I go to the fruit and vegetable market [*la vega*] with her, we only work... (Pedro, man, lower socioeconomic group, 42 years old)

This type of behaviour could be thought of as resilience, that is, ‘the process of overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risks’ (Fergus and Zimmerman 2005, 399). This would mean that individuals like Pedro could achieve better health outcomes despite belonging to social networks, where, for example *campamento*, health-related practices that may damage health are more common. This would imply an emphasis on the individual and agency by focusing on the strengths that people have in the form of assets, such as self-esteem and self-confidence, or resources, like family support, rather than on structure. However, even when some individuals are able to overcome adversity and get a positive outcome out of a negative situation, it would be a mistake to argue for individual responsibility alone. Assets such as self-confidence and self-esteem are related to, for instance, a healthy childhood development and strong parental support, which are highly related to social context (Bartley 2006). ‘Resilience is not a quality of an adolescent that is always present in every situation. Rather, resilience is defined by the context, the population, the risk, the promoter factor, and the outcome’ (Fergus and Zimmerman 2005, 404) and is therefore related to structural forces and resources available to each individual according to their social location.

In conclusion to this section, it is possible to state that respondents had similar dispositions and experiences to those who belonged to their bonding social capital which reveals the impact that habitus has on health through its influence on health-related practices. Respondents’ narratives showed how they tended to adopt those practices that were ‘natural’ or ‘normal’ to ‘people like us’. This is a characteristic intrinsically related to their social location through their habitus, which proved to be different according to respondents’ socioeconomic groups and gender. For instance,

even when the practice of smoking was found in both socioeconomic groups, the disposition for doing it was different. For instance, while women from the middle class did it as a social activity, those who lived in *campamentos* smoked as a way to cope with their daily difficulties. At the same time, the analysis showed the impact that bridging and linking social capital have through the changes they can produce in people's dispositions and perception of 'natural'. These results confirm that social capital may have a positive or negative impact on health-related practices depending on the practices that each network promotes, as well as the social norms involved with each (Cullen and Whiteford 2001). The next section will be centred on the specific impact that the social norms of people's social capital have on their health-related practices. In other words, it will explore the mechanisms through which cultural capital influences the amount of agency that men and women have over health determinants.

7.3 Social norms and health-related practices

Practices are not only influenced by social networks and their characteristics, but also by the cultural capital people possess, expressed by the social norms and values that are shared within them (Bourdieu 1984). The adoption of health-related practices may be used as symbols of social status, as ways to express the distinction between social groups (Bartley 2004; Blaxter 2010) and not only as a consequence of rational choice, as expressed by the health behaviour theories (for discussion of these theories, see chapter 2).

This section will firstly analyse the mechanisms through which cultural capital, in the form of social norms and social expectations, influences the space for agency people from different socioeconomic groups have over their health-related practices, and secondly, how these mechanisms impact men and women differently.

7.3.1 Middle socioeconomic group: Moderation and Refinement

Throughout the interviews conducted with middle class individuals, it was possible to see on repeated occasions a discourse which offered a conflict between moderation, self-control vs. excess, lack of self-control, an aspect observed by Crawford in his research on American society (1984). In this case, the tension made reference to the contrast between what was described by respondents as ‘refined’ vs. ‘cheap’. Within this socioeconomic group, the social norm that appeared central was ‘having control over yourself’, that is, over your mind and body. The way respondents described their health-related practices reflected the importance that these values have within this social class, and how it acted as a mechanism that restricted their space for agency over health-related practices. According to their accounts, those who belonged to their social class are expected to have a good understanding of their body’s limits, and to be responsible by respecting them. They said this was seen through the health-related practices that people ‘chose’ to enact, and the effects these had on people’s bodies.

The first practice to reflect the value of restraint over excess was the way people eat and what they eat. When respondents described their diets, they emphasised how they tried to make it as healthy as possible considering the different constraints they faced, already described in the previous chapter. They said how they ate ‘adequate’ quantities and avoided excess, using expressions such as equilibrium and ‘just a little bit’.

Interviewer: What is a healthy diet for you?

Respondent: When you eat at the correct time and when I see that everything is proportional. I will not eat a giant dish of mashed potatoes with a hamburger and everything. I like if I'm eating to eat, ok, the hamburger with a little bit of mashed potatoes. If I'm going to eat the sweet that my mom bakes, ok, I will eat only one. I like to ration [myself]: well, if I'm going to eat, let's make it little (Trinidad, woman, middle socioeconomic group, 15 years old)

This way of eating moderately seems to be characteristic of this social class when compared to people from a lower socioeconomic level. The example of Nicolas, who as mentioned previously grew up in a working class family but may now be considered a middle class individual, is very helpful in understanding this topic. He told how his diet had changed over time, along with his upward mobility. He stated that:

... in my parents' house the food was always cooked with a lot of oil, a lot of fat, because my dad liked that. So when beans were cooked it was with pork skin, you know, very heavy meals (...) I came to live with my partner and it was all the opposite! It was like a touch of oil, very little salt... so it was much more healthy, but I was not used to that, it was a hard change for me (...) The difference was strong and it was hard for me to get used to the food, but now I see the difference and I reject a little bit my mom's food, but not that much (Nicolas, man, middle socioeconomic group, 32 years old)

Due to the fact that he was raised and socialised in a lower socioeconomic environment, the dispositions he had acquired towards eating were different to those of his new middle socioeconomic circle. His 'taste,' in Bourdieu's terms (Bourdieu

1984), did not coincide with the new type of diet that his new socioeconomic level implied. He described how nowadays, after several years of marriage, he was still able to see differences between his partner's food tastes and his own, showing that dispositions towards diet endure, as well as their relation to socioeconomic level. While he longed for fast food and more abundant dishes, his partner always condemned him for that behaviour.

People who were overweight or those who ate in excess were morally judged within this social class because they were viewed as not taking correct care of themselves and having no self-control. From this perspective, moderate and controlled behaviour is reflected in a healthy body size and image, i.e. being thin, which is socially expected in middle class people and a symbol of social status. The body becomes a sign of self-control and willpower; in other words, 'the thin person is an exemplar of mastery of mind over body and virtuous self-denial' (Crawford 1984), imposing strong pressure and duress within respondents from this socioeconomic group. From their perspective, these attitudes symbolised people's social class and helped them to be distinguished socially from those people that came from a lower socioeconomic background. People who failed to have the self-control needed to stay fit or eat 'adequate' amounts of food and subsequently became obese, were described as cheap and unrefined, confirming how the will of social distinction acted as a mechanism that influenced diet and how different body shapes were valued.

I think that obesity is very ugly... I think it's ugly! (...) I associate it completely with poverty. It is a very personal thing, you know, but it is true, I associate it totally with that. I see it as poverty, as lack of education, I see it as something ugly, very ugly (Claudia, woman, middle socioeconomic group, 34 years old)

Related to this attitude is the fact that for the middle class participants, junk or fast food was considered a 'sin', something against which people sometimes failed to control themselves. However, they also argued that, as long as it was done just once in a while it was fine to eat chips, hot dogs or sweets. Some women said that instead of 'falling' for junk food when they were anxious about something, they chose to smoke since cigarettes had the advantage of not being fattening. Even when both eating junk food or smoking to excess were morally criticised because of the lack of control they demonstrate, they said that at least smoking did not affect their accepted body image.

The importance of body image was also reflected in the way physical activity was considered by respondents. As stated in Chapter 6, there was a desire to exercise on a daily basis in participants' narratives. However, this was mainly due to the association between physical exercise and body size rather than a response to a physical health concern. Participants from this socioeconomic group, particularly women, longed to have more time to go to a gym or ride a bike, not only because they wanted to improve their cardiovascular system or feel healthier, but especially because they wanted to lose weight, get fit and look better.

Middle class respondents' norms oriented towards social distinction were also seen in relation to smoking and drinking alcohol. As with food, they said that it was all right to drink and smoke as long as there was no addiction and it was not done to excess. Additionally, they said that when people drink it was expected that their behaviour did

not change in any way. Thus, they all said that when they drank they did it with moderation and control, not only due to a concern for their health, but mainly as an issue of social image. It is important to state that even if in fact they drank or smoked more than they reported, their narratives revealed the importance and value of balance and self-discipline as elements of social distinction.

Respondent: ... they (friends) control themselves, if there is no more (alcohol), then there's no more. They are not begging for coins [*no se arrastran por una moneda*], nothing like that.

Interviewer: And when you hang out with them, why do you drink just a little bit?

Respondent: Because I think that with a little bit it is enough (...) it is to drink just a little bit and that's it (Ignacio, man, middle socioeconomic group, 16 years old)

I think that there are things that you can't... OK, smoke a cigarette, but don't smoke the whole packet! (Soledad, woman, middle socioeconomic group, 53 years old)

This is why those people who drank or smoked to excess were subject to moral judgement. Smelling of tobacco or alcohol, as well as getting drunk in public, were strongly disapproved of by middle class respondents. Such aspects, related to their personal hygiene and appearance, could lead someone to misjudge them as working class individuals. Therefore, when they smoked they took precautions such as washing their hands or eating a mint, and tried to never do it in closed spaces, including their own houses.

What I don't like about cigarettes is the smell that it leaves. As a matter of fact I sometimes get on the bus and there is a person that recently smoked his cigarette and it's unpleasant. And because of that I don't smoke sometimes because I don't want to sit beside someone and that he thinks I stink of cigarette (Jose, man, middle socioeconomic group, 31 years old)

Likewise, participants stated that excessive drinking was also detrimental socially and not only because of health issues. According to them, people's social image was damaged when they were seen drunk in public. They regarded a drunken person as someone who had lost control both of his/her alcohol consumption and body, as someone who had no limits regarding their alcohol consumption. Thus, adults taught their children from a young age *how* to 'drink correctly', which firstly meant never losing control of one's own body. They said that you have to learn to drink alcohol in such a way that you do not get drunk easily.

... since I was a kid I was taught how to drink so that the 1st time I was at a party and had a drink, I wouldn't fall dead (Soledad, woman, middle socioeconomic group, 53 years old)

Another concern about the social image was *what* people drink. Parents said they taught their children that they shouldn't drink cheap drinks and that they should be selective in what they had. According to respondents, people shouldn't 'drink as much as you can afford', but rather 'drink quality drinks, regardless of their price', showing how social distinction influences how and what middle class people drink. By having selective drinks, they did not only show their self-control but also their refined taste when drinking. Some of them stated that they did not like to drink just any type of wine, but only those which were good and more refined.

When (my daughter) started taking drinks, I used to tell her: “Dani, don’t take any crap, for what? If a nice drink is more expensive, you will enjoy more than 10! (...) If you are having a beer, don’t take an Escudo [popular Chilean beer], take a Heineken, I don’t know, something nicer, that you enjoy more! If you go to a disco, don’t buy the 2 bucks drink, even if you have 10, get more expensive drinks and you will enjoy them more! (Paula, woman, middle socioeconomic group, 45 years old)

Drinking cheap alcohol and to excess was associated by participants with people who belonged to a lower socioeconomic level, which is why it was so important for them to teach children to engage correctly in this practice. Claudia’s example is very illustrative in relation to this issue. She was married to a man from a lower socioeconomic background, whose family usually drank excessively, something she was not used to and did not approve. According to her, their different behaviour towards alcohol was due to them having received a different education to her. Her education from hers and therefore, they behaved differently regarding alcohol consumption. Her account illustrates how respondents related this type of behaviour to a lower social stratum.

(His) cousins are very good to hang out together, (his) brother, (his) family. I don't see them much because for them having fun is going to a relative's house, all the family and eat and drink until they die, you know, and for me that is not having fun and I don't like that my daughters see drunken guys, you know (...) For me that is not having a good time, maybe for (him) that is normal because when (he) was a kid (he) did that and it is something normal in (his) environment because it was always like that, but not for me, I think it's horrible! (Claudia, woman, middle socioeconomic group, 34 years old)

To summarise, in middle class participants it was possible to see a culture of moderation, where everything that was done beyond socially accepted limits or excessively was judged morally. As stated by Crawford, 'individuals are not free to do as they please: each choice is infused with moral significance; one must exercise freedom 'responsibly'' (Crawford 2000, 229). Thus, it is a social class whose space for agency over health-related practices was not only constrained by their lack of resources and time as seen in Chapter 6, but also by very strict moral behavioural boundaries derived from a will for social distinction. This situation emphasised the individuality of actions and responsibility that each person had for his or her own actions promoted by the neoliberal policy regime, which increased the anxiety and pressure that this social group experienced having to live up to these strict social norms. At the same time, this situation revealed the personal character of these practices. Deciding what to eat or to drink or how much to smoke did not depend exclusively on people's wishes or deliberate choices, but also on the social image that they wanted to project.

7.3.2 Lower socioeconomic group: enjoying the moment

The situation expressed by respondents from the lower socioeconomic group was different; here moderation was not a social status symbol, since it could be interpreted as shortage of money. Due to the harsh reality in which residents from *campamentos* lived, where often there was not enough money, attitudes of moderation and self-control observed in the middle class lost their distinctive purpose. Not only were these values senseless to them, but they were also contrary to the social distinction they wanted to express between themselves and those who they considered to be really poor, that is, those who could not afford to eat at all. People from this group wanted to avoid showing poverty or suffering, not their capacity for moderation.

The first practice through which the ‘value of enjoying’ acted as a mechanism of social distinction that influenced the space for agency working class people had was through their diets. As seen in Chapter 6, people from this socioeconomic group suffered stronger economic constraints at when feeding themselves and their families than those who belonged to the middle social class did. As a consequence, when they had money or they could access food easier, participants stated that they had to take advantage of the situation and enjoy it. Limits and control over diet made no sense to them, which is why they did not understand the restrained way in which middle and higher class people eat.

I think that poor people always eat better than people from a better economic situation because I think that people from a better situation are more restricted, more tight to eat (...) But when there is a moment in which we can eat well, we eat well, we don't care about the expenses that we will have, we don't care about anything (...) you only act, you eat, you treat yourself, that's the way we are (Pedro, man, lower socioeconomic group, 42 years old)

Be poor but be well fed, that when worms eat you they say 'these were poor, they ate a lot, they never saved anything, they ate it all!' Eat but die happy as well (Joana, woman, lower socioeconomic group, 41 years old)

This attitude was also reflected in the way they educated their children. Instead of teaching them to value moderation and self-control positively, as middle class respondents did, working class participants treated their children when they had the opportunity. If they could buy or give them the food they were asking for, they said they did it, regardless of whether or not it was healthy. The association behind this attitude was that they never knew when they would be able to do it again. Therefore, if one morning they had cheese to put in the bread and their kids asked for it, they would give it to them because tomorrow they might only have bread. Thus, children acquired the disposition to eat in great quantities and with no moderation when there was enough food.

A similar situation was seen in relation to junk or fast food. Whereas middle class respondents conceived this type of food as a sin that they had to avoid through self-discipline, amongst the participants who lived in *campamentos* this type of food was seen as a small luxury that they could hardly ever access since they could not afford to eat out, and the amount of oil needed to cook this type of food made it very expensive.

Therefore, by having chips or hot dogs, they were showing to their social environment that they had enough money to afford this food and not necessarily acting according to a rational choice of what was healthier for them.

Interviewer: Do you eat junk food?

Respondent: Mmmm, no, even less now, you can't even treat yourself... maybe you can go out to have a hot dog... once in a million! (Ana, woman, lower socioeconomic group, 36 years old)

... we cannot afford the luxury of having a steak with French fries, we cannot do things like that, we cannot afford it (Camila, woman, lower socioeconomic group, 17 years old)

Contrary to the middle class respondents, the importance of body size and being fit did not emerge as a central topic in the interviews. Again, moderation reflected in being slim was not a symbol of social status within this socioeconomic level. With the exception of some teenagers who stated that they were concerned about the arrival of summer and not being in good shape, it was not possible to see a strong social pressure to remain fit, as observed amongst middle class respondents. In fact, on some occasions participants actually stated that a healthy child needed to be a little bit fat as opposed to a malnourished child which they associated with 'real poverty'. Even when they connected obesity with being unhealthy, they associated having some fat in the body with a healthy status and not being poor.

... when I was a kid I was chubby, but not fat, fat. I was probably in my normal weight, I didn't have diseases, I was healthy (...) In my house my mom always had chicken casserole [*cazuela*], she cooked these things with *ulpo* [a traditionally Chilean drink (*mazamorra*) made with toasted flour, hot water and honey or sugar], things that have many calories (Pedro, man, lower socioeconomic group, 42 years old)

As a consequence, within this social group there was no pressure to do physical exercise or to stay fit. Generally, this practice did not have the same meaning for the working class participants as it had for those from the middle class. Among *campamentos*' residents, carrying out physical exercise was related to people's daily activities as a consequence of their manual employment or as a way to keep their minds busy or to relax. However, there was a difference between genders since women were somehow more aware of their body image, and expressed a wish or need to work out more often than men. The next section will analyse these gender differences.

The ability to enjoy a moment as a mechanism of social distinction over self-control also influenced the space for agency they had over smoking cigarettes. Even when respondents recognised the damage that smoking does to their health and body, those that were smokers saw it as a moment of pleasure that they were not willing to give up. This aspect seems to be related to what Graham's work on women living on poverty previously indicated. She states that 'for many of the mothers who were caring on a full-time basis for children, smoking a cigarette emerged as their only luxury' (1987, 55). Given the circumstances in which participants lived, being able to smoke was seen as a way to treat themselves and also showed that they could afford these small luxuries.

This [cigarettes] is the vice that we have (...) it is fair enough that we can have some vice, there's no need to be so dramatic (Maria, woman, lower socioeconomic group, 39 years old)

Therefore, the possibility of enjoying a cigarette and the relaxing effect participants stated that it had led them to downplay the smell that it could leave on them or the negative social image that the middle class observed. Also, the fact that their neighbours or people from their social circle were addicted to alcohol or drugs made cigarettes the lesser evil. In this sense, smoking cigarettes was the least health-damaging practice in which they could seek to relax and cope with stress.

It is interesting that the social norm of 'enjoying the moment' changed regarding alcohol consumption and became closer to that observed in the middle class. Working class respondents did not morally judge people that had alcoholic drinks as long as they did it 'with respect', meaning moderately. People who drank heavily were considered alcoholics and were judged because of the way alcohol changed their behaviour as well as for spending their scarce money on it. Due to the fact that they had experienced problematic alcohol consumption, either because they themselves had done it in the past or because a relative did it, they knew the type of problems that people could get into, such as having accidents or getting into fights.

The disapproving tone with which they spoke about drunken people or those who depend on their vices suggests a desire to keep a distance from them in a symbolic sense. They wanted to make sure that people knew that they were poor but 'clean' in contrast to those who became 'dirty' by engaging in drugs and heavy alcohol consumption. This 'cleanness' suggested an intention to show 'innocence' for their poverty, in the sense that they were not poor because they wasted their money on

alcohol or drugs unlike those residents who they described as ‘dirty’ or ‘guilty’ for their lack of resources. At the same time, their narratives implied a belief in individual responsibility over those social determinants that made this social group more prone to consume alcohol in excess, revealing the moral character that this aspect has.

... why the wretched man drinks when I know that his family does not have what to eat?! That bothers me (...) I’ve always said that the vice is from the extra, that is, if I smoke and one day I don’t have any money for cigarettes, then I don’t smoke. We have been weeks here without smoking because we don’t have money to buy bread, snacks for the children and stuff like that (...) They reverse the priority! I’ve heard ‘I break my back working, I have to treat me’ and that shit is worthless! (Pablo, man, lower socioeconomic group, 48 years old)

In this sense, heavy consumption of alcohol acquired a negative social connotation amongst participants that reinforced the social stigma present in the middle class discourse that associated working class people with high levels of alcohol consumption. Participants’ efforts to make it clear during the interview that they did not engage with this practice suggests how important it was for them to be socially distinguished from poor people who had no control over their situation.

To sum up, this section showed that social distinction is a mechanism that also restricted the space for agency that Chileans who lived in *campamentos* had over their health-related practices. Their shared habitus was translated into social norms that valued the possibilities of enjoying life and treating themselves as a way of social distinction from those working class people that could not afford to eat properly, creating a disposition to eat in great amounts when possible, as well as consuming junk

food and smoking in public places. At the same time, they also showed the need to distinguish themselves from those working class people that consumed drugs or spent their scarce money on alcohol, since they want society to consider them 'clean' and innocent for their situation.

7.3.3 Gender: the construction of masculinity and femininity

Even when social expectations about masculinity and femininity interact with people's socioeconomic condition as described above, they also have an independent impact on health-related practices. Respondents expected men and women to engage differently with different health-related practices, according to their cultural capital. For instance, while respondents considered it 'normal' for men to drink or smoke publicly, it was socially and morally frowned upon for a woman to do the same. This section will analyse how social norms and values, that is, cultural capital, influences the agency that men and women have in relation to the health-related practices they adopt.

In general, there was a social expectation that women would be healthier. Participants from both socioeconomic groups believed that it was women's role to take care of their families' health, whereas it was normal for men to engage in riskier practices, an aspect related to the construction of masculinity and femininity as per Courtenay (2000). Women should have healthier and more moderate diets, carry out more physical exercise, and consume less tobacco and alcohol, since they were perceived, both by men and women, as the weak and vulnerable gender. Foods such as vegetables, salads or products low in calories and fats were considered feminine, as types of food that belonged to women, and therefore rejected by men. The previous extensive analysis provided in Chapter 4 showed that women did have healthier diets than men,

confirming this image of women as healthy eaters and how they create their gender through their health-related practices.

At the same time, respondents said that women worry more about doing physical exercise as a way to cultivate their healthier and feminine social image. However, as seen in the previous chapters, not only did quantitative data show that women carry out less physical activity, but the analysis of their realities also revealed that they did not have enough time or energy to engage in this practice. These difficulties became more acute as their socioeconomic condition decreased. The contrast between expectations and reality could cause the presence of a strong tension for women to be fit and sporty, regardless of their actual possibility to do so.

Women take better care of themselves by trying to eat more salads, they eat healthier (Felipe, man, middle socioeconomic group, 37 years old)

I don't know if it is for aesthetics or something, but most women eat less, or I don't know, my male classmates buy thousands of chips and eat them during the break and my female classmates don't do that, if they buy something it is something very small... (Trinidad, woman, middle socioeconomic group, 15 years old)

Conversely, participants expected men to neglect these aspects and to be less worried about their physical health. As seen in previous research, these practices respond to their construction and enactment of masculinity as the hegemonic and stronger gender (Courtenay 2000; Dolan 2011). Most male and female respondents from both socioeconomic groups spontaneously contrasted the type and amount of food that men and women ate. They stated how it was normal for men to eat more red meat, barbeques, and junk food than women, which suggests how masculinity was created

by demonstrating a lower concern about health status and body image through their diets.

Red meat is mainly for men, all fried food and things like that are more for men than for women (...) junk food, chips, all those things (...) I cook a white pasta with only a touch of oil for me, some egg white or a salad or soup, but healthy (Carmen, woman, lower socioeconomic group, 62 years old)

There is always this idea that women want to be very thin, perfect and that men only want to be normal, they are not looking for a perfect body (Ignacio, man, middle socioeconomic group, 16 years old)

Jessica, a middle class woman who had one daughter and one son said that the way their children ate and their awareness about their bodies and health surprised her. In her opinion, her children were the opposite of what was considered 'normal'. While her son was worried about his body shape and image, and ate salads and diet food, her daughter loved junk food and did not seem particularly worried about staying fit. Her account is an example of how women that ate too much or ate a lot were judged, because they did not fit with the hegemonic construction of femininity in which women should be worried about their body image.

... my daughter loves junk food and her brother doesn't, it's like all upside down, it should be the other way around, but in their case it is different. She longs for *churrascos* [a popular Chilean meat sandwich]... she doesn't eat them because her brother is always telling her "you are going to get fat, you are going to be a shorty fatty", but she loves *churrascos* and all those things. And her brother doesn't, he is healthier. When he is able to, he eats lots of salad, he eats a lot of salad and tuna fish, those things, you know. But... or simply he doesn't eat junk food, he eats the ordinary food that we have at home which is normal food. But she doesn't, if she could she would eat junk food every day, every day she would eat hot dogs, *churrascos*, all of that, pizza... (Jessica, woman, middle socioeconomic group, 41 years old)

Likewise, social norms also implied a gender differentiation in both socioeconomic groups in relation to smoking and drinking. There was a belief amongst the respondents that women should not engage with these practices for two reasons:

Firstly, since they were considered to be masculine practices, participants said that women shouldn't adopt them in public because it could damage their feminine image. They stated that alcohol affects men and women in different ways, producing a change in behaviour that seemed stronger in the latter. In most of their narratives, women that get drunk were described as 'pathetic' and were considered to be trying, wrongly, to be equal to men. The narratives were sprinkled with words such as deception, pathetic, and personal offense, among others, giving free rein to the moral criticism and judgement that underlies them. This position was stated more strongly by female than male respondents; women felt that women who get drunk harm the sense and image of being a woman.

I've seen women in very bad conditions, bad, horrible, that shouldn't be for a woman. And it is not that my way of thinking is *machista*, or maybe I am, I don't know, but there are things, values that a woman cannot lose (Jessica, woman, middle socioeconomic group, 41 years old)

... women are feminine and they should have more respect, take more care of themselves (Joana, woman, lower socioeconomic group, 41 years old)

According to participants, the main problem was being seen by others. The issue was not necessarily the health affects that smoking or drinking could have, but the image projected, revealing the social and relational character of these norms. Respondents, particularly women, stated that it was not the same thing to see a man smoking on the street as it was a woman. They said that it was not that women should not smoke or drink, but that they should not do it on the street or in a place where anyone could see them since that damaged their image.

I had never seen her (daughter) drunk, but I was told that she had been drinking in a house and I hit her, I hit her, I hit her mainly because, I always tell her 'I didn't hit you because you had been drinking, it is because you were drinking in a house that was not yours, I mean, so that everyone could see that you are 16 years old and you were drinking?' (Paula, woman, middle socioeconomic group, 45 years old)

It doesn't look good, it is not feminine (for a woman to smoke). It is OK if she was to smoke secretly or in her house, but to be with a cigarette on the street no, I don't like that (Carmen, woman, lower socioeconomic group, 62 years old)

According to the participants, the second reason why women should not engage with these practices was because women were thought of as delicate and fragile. They were believed to be more fragile and vulnerable than men, and therefore it would be irresponsible for them to drink heavily or smoke too much since it would be damaging not only to their social image, but also to their bodies. Echoing the results from previous research (Courtenay 2000), men were believed to be stronger and to better resist the adverse effects of these damaging health-related practices, which is why it was considered more normal for them to adopt these practices.

... I think alcoholic drinks would harm more a woman, I have that impression, it would harm her more since women are more... I don't want to say weaker but they are less resistant to those things, because drinks are alcohol, so if they drink hard it could be worse because their bodies resist less. So I think it is more harmful for women than for men (Oscar, man, middle socioeconomic group, 65 years old)

When I see a girl smoking, it's not for them, young girls destroying their lungs... and since people say that women's bodies are weaker than men's, that they are like a glass, everyone says that, so I think that women shouldn't smoke (Pedro, man, lower socioeconomic group, 42 years old)

However, participants said that nowadays both men and women smoke and drink alike. It was not uncommon to see women smoking in the streets anymore, which is something that could be related to a decreasing inequality between genders (Waldron 1998). It is interesting that teenagers criticised the fact of assigning a gender differentiation towards smoking or drinking. They said that these gender norms were artificially constructed by society, mainly through advertising, and that they made no

sense. This attitude may be pointing towards a decrease in the differentiation of gender roles related to health practices in future generations, even when the contradiction between rationally accepting it and morally judging it was present in some of the teenagers' discourses.

[I relate smoking] more to men, even though women also do it a lot, there are women that are always with a cigarette in their mouth (...) nowadays it is not rare [to see a woman smoking] because of how times are, everything is like revolutionised, but in the past I think that it was more natural to see a man smoking on the street than a woman, maybe because of what people would think, but now it's not like that, there is not a big difference (...) each of us is owner of their lives and can do whatever you like with it (...) but I think is only fair because then people are not saying "she's like this, she's like that", there has to be an equivalent law [*ley pareja*]. Not because you are a woman you should be discriminated by that (Camila, woman, lower socioeconomic group, 15 years old)

Overall, the construction of masculinity and femininity through health-related practices and the social norms associated with these practices, constrained the space men and women from different social groups have over their health-related practices. While the construction of masculinity encouraged men to engage with health-related practices that could damage their health under the belief that men are the strong gender, the construction of femininity constrained women's enactment of these practices. Even when the disincentive for women to smoke or drink alcohol could be considered beneficial for them since it could mean that they would engage with them less, as was seen in the extensive analysis provided on Chapter 4, it is important to state that it may

not be a deliberate choice. Women had to face social pressure coming from both men and women from the middle and working classes regarding the morality and correctness of their practices. Additionally, their male peers experienced the morality of ‘behaving like a man’, meaning their willingness to adopt practices that put their physical and mental health at risk. Thus, social norms associated with the construction of gender produced and reproduced a patriarchal order through individuals’ health-related practices.

7.4 Conclusion

This chapter explored the mechanisms through which the unequal social and cultural capital that men and women from middle and lower socioeconomic groups have affect their agency power over health-related practices, and their relationship with the Chilean neoliberal policy regime. The critical realist analysis duly developed, shows how individuals’ social capital, observed in the composition and heterogeneity of social networks, influences the space for agency that they have over health determinants and their health-related practices to varying degrees, mainly through three mechanisms: fear of crime, lack of free time, and habitus. In the first place, Santiago’s residential segregation, a result of neoliberal land market policies analysed in Chapter 4, constitutes social networks related to neighbourhoods in which people’s fear of being victims of crime decreases their physical activity and social contacts. This mechanism was particularly present in middle and working class women’s narratives, showing how they felt more vulnerable to crime than men, and how they experienced stronger limitations on engaging in outdoor activities. Secondly, the spatial dimension of this phenomenon meant long hours dedicated to commuting, creating additional barriers to exercise for those who have paid employment. The lack

of free time was especially a factor for women who were employed, since they were considered responsible for housework, as seen in previous chapters. Thirdly, individuals' habitus, expressed through their definitions of 'normal' and 'natural' health-related practices, also limited the space for agency they had over their practices. Respondents adopted those practices that made sense to them and which were similar to the people who constituted their bonding social capital, as well as those practices that their economic capital allowed. In this sense, people with shared habitus enacted similar health-related practices, giving place to what Bourdieu calls stylistic affinity (Bourdieu 1984, 173). These findings add evidence to the ambiguous character that group memberships and social networks may have on health, since both 'good' and 'bad' behaviour spread through networks (Cullen and Whiteford 2001). Additionally, they reveal the presence of a social gradient since these mechanisms affect individuals that belong to both middle and lower socioeconomic groups.

The second part of this chapter showed that the social norms and values that are present in people's social networks also create mechanisms that limit their possibilities to choose their health-related practices. The analysis showed a contrasting situation between social groups according to their hegemonic social norms, and their will to be socially differentiated from those who were below them in the social ladder. On the one hand, health-related practices of those who belonged to the middle socioeconomic group were guided by values of moderation and self-control. These values were considered to differentiate them socially from people from a lower socioeconomic background. On the other hand, practices of those who lived in *campamentos* emphasised the importance of enjoying the moment. Since this social group lived in a reality of hardship and scarcity, the way they had to differentiate themselves from

those who are 'really poor' was by engaging in health-related practices with no regard for moderation, except in the case of alcohol consumption.

The social norms associated with the construction of masculinity and femininity also constituted mechanisms that restricted the agency power men and women had over their health-related practices. In a society where patriarchal order is hegemonic in gender relations, as seen in the previous chapters, health-related practices become a space where gender roles are produced and reproduced. While men were expected to engage in practices that could be detrimental to their health as a way to show their toughness and superiority, women were supposed to be particularly careful with their health due to the perceived frailty and inferiority of their bodies.

These examples show how individuals' health-related practices may be more related to their internalised dispositions, which are different according to their socioeconomic level and gender, than to a concern about health. In this sense, adopting health-related behaviours, such as smoking or eating too much, may be something individuals aim for when it is understood through the rationale of social distinction. As seen in previous research, 'behaviours, even those which might seem most closely related to health, may have powerful springs which arise elsewhere' (Blaxter 2010, 92-3). Therefore, it is misleading to blame individuals for their health-related practices and to consider these to be exclusively the result of deliberate choices. In this sense, these findings challenge the theory of health behaviour, that is, the idea that health-related practices and choices respond to a rational choice.

Finally, the findings imply that the closed and low heterogeneous character of social networks that characterise the working and middle class realities in Santiago reinforce

the homogeneity of the social norms within the socioeconomic groups. This situation reproduces the social structure by reinforcing the adoption of health-related practices that produce social distinction between different social groups as well as health inequality. In the same way, the internalisation of patriarchal values that guide women's and men's practices reproduces gender inequality in health, and strengthens the hegemonic constructions of gender. Therefore, in order to understand the adoption of health-related practices it is necessary to consider the characteristics of the social networks in which people carry out their daily lives together with the social norms and values that predominate within these networks.

Nevertheless, the previous chapters have given evidence that their economic, social and cultural capital are all relevant in order to understand the space for agency individuals have over their health-related practices and how this changes according to their socioeconomic level and gender. They have also shown how the possession of these three types of capital, which determine people's social location within the structure, are closely related to the political economy of society and create a social gradient in which both socioeconomic groups are affected, not only the poorest one. The concluding chapter will be focused on summarising these findings and providing a comprehensive answer to the research question.

CHAPTER 8 - SUMMARY AND CONCLUSION

8.1 Introduction

Health inequity and its social character are aspects that have been widely studied. The social determinants of health inequalities methodology embraces different perspectives that explain how different social inequalities ‘get under the skin’, the importance of political economy, and how the accumulation of disadvantages through life generates inequity in health outcomes and quality of life. A range of studies have shown how the political and economic dimensions of a society impact people’s health outcomes, providing evidence that the models of policy regime are important (Navarro and Shi 2001; Coburn 2004; Coburn 2006). However, there is insufficient evidence regarding how much space for agency over health determinants people have, and this is especially true for a strongly neoliberal society like Chile. In response to this, the thesis explored the research question:

Through which mechanisms does the structure influence the space for agency that men and women from different social groups have over their health-related practices in their daily lives in a strongly neoliberal country such as Chile?

Specifically, I investigated a) the ways in which neoliberal policies on health-relevant dimensions create inequalities that affect people’s daily lives and how these are related to people’s health-related practices; b) the aspects of Chilean society that affect how people understand and experience health and their relation to people’s sense of responsibility for health outcomes and health-related practices; c) the mechanisms through which the unequal material circumstances of individuals affect their agency power in relation to their health-related practices and the relation of these mechanisms

to the Chilean neoliberal policy regime; and d) the mechanisms through which the social and cultural capital of these men and women influence their health-related practices and the sense in which these mechanisms are related to the neoliberal policy regime. Middle and lower socioeconomic groups were chosen for thorough intensive research as a way to examine the presence of a social health gradient in Chile. In other words, to show that health inequalities and constraints are not only experienced by the poorest groups, but also by the middle class.

In order to answer the research questions, I adopted a mixed methods approach. Following a critical realist perspective, I combined intensive and extensive approaches to analyse individuals' daily lives and practices through their discourses, as well as the broader political economic context shaping these. In other words, I analysed the generative mechanisms that influenced people's health-related practices. Firstly, I developed a contextual analysis of the social, political and economic situation to understand both the environment from which respondents were speaking, and also the wider political and economic forces related to the Chilean neoliberal regime underlying people's health-related practices. This was done mainly through bibliographical review and quantitative analysis of secondary data. Secondly, I performed an extensive analysis using different secondary data to analyse the extension of health-related practices inequalities and their statistical association with structural variables (socioeconomic group and gender), and to triangulate the data obtained through the interviews. Thirdly, I carried out a content analysis of the qualitative interviews conducted with men and women in Santiago de Chile from middle and lower socioeconomic groups in order to understand the meanings they gave to health and the factors that they believed affected their health-related practices. These

three data sources were combined to identify the broader generative mechanisms that shaped people's health-related practices, and to understand how these affected the space there was for agency in these practices. Chile, a country known as a landmark neoliberal policy regime (Taylor 2006) where high income per capita coexists with strong income and social inequalities, was chosen as a case-study to analyse the tension between agency and structure in relation to health-related practices and inequalities.

This concluding chapter is structured in 4 parts. Following this introduction, I summarise the main findings of each chapter and corresponding research sub-question. By placing these findings together, I provide an answer to the main research question. In section 3, I proceed to analyse the implications for and contributions made by this dissertation to theory, methodology and policy. To conclude, I state the research limitations and implications for further research.

8.2 Conclusions about research questions

8.2.1 The consolidation of an unequal structure

The analysis undertaken in Chapter 4 revealed that the Chilean neoliberal policy regime creates inequality in different health-relevant dimensions that affects individuals who belong to the middle and lower socioeconomic groups, and at the same time showed the relevance that structural variables – socioeconomic level and gender – have to people's health-related practices. It showed that the neoliberal policy regime established by a military dictatorship has remained unchanged after Chile returned peacefully to a democracy (Ffrench-Davies 2007, Taylor 2006) due to the support from and interests of strong economic groups. The continuity of this policy regime was

observed in central aspects such as the privatisation of social services (healthcare, education, and pensions) and the targeting of social policies.

This has produced contrasting realities. On the one hand, the analysis showed that from 1990's onwards Chile has been recognised for its considerable improvements in social indicators, such as falls in unemployment, poverty, child-birth and mortality rates (Illanes and Riesco 2007; Raczynski and Serrano 2005; Mesa-Lago 2002; OECD 2011a; Banco Central de Chile 2001; ECLAC 2011). In fact, during the 1990's Chile's Human Development Index moved from the middle level it occupied in the 1980's towards the highest (above 0.800), taking the lead amongst Latin American countries (UNDP 2009; UNDP 2014). Chile's improved indicators led to its incorporation into the OECD in 2010 and to be recognised as a high-income country by the World Bank in 2013. However, the analysis revealed that these promising figures hide a highly unequal reality and a strong social gradient. The stability of this policy regime has been accompanied by high and constant levels of income and social inequalities that make Chile an outlier when compared to the rest of the OECD (OECD 2011c).

By analysing three interrelated health-relevant policy areas – employment conditions, housing conditions and residential segregation, and educational opportunities – I showed the inequalities that this policy regime has created in Chile. Firstly, a considerable proportion of those employed do not have access to social security and have insufficient income, a situation that is worse in the case of women. Poor employment conditions and low income levels have previously been associated with negative health outcomes and health-related practices (Bartley et al. 2006). The mechanisms through which these conditions and health are related will be explained in detail later in this chapter. Secondly, Santiago's residential segregation, a problem

which became worse with the neoliberal reform of the land market, considerably reduces education and employment opportunities. As the socioeconomic diversity of neighbourhoods decreases, so does the quality of nearby schools and job offers, thereby having an indirect impact on health. Additionally, this segregation also implies that people have minimal contact with individuals from other social circles, which influences people's health-related practices through different mechanisms. Thirdly, it revealed how the neoliberal structure of the education system creates a system that is socially stratified, unequal, and delivers low quality education. The social gradient experienced by students from different socioeconomic levels with the quality of primary and secondary education results in lower probabilities of achieving tertiary education. This affects their probability of securing good quality employment, which constitutes an indirect impact on health. Overall, these findings showed that the implementation of a neoliberal policy regime and its perpetuation through a strong coalition between the domestic business elite and political powers, constitute a political and economic context that produces and reproduces inequity in areas that are intertwined and affect health. It does so through mechanisms that constrain the space for agency men and women from lower and middle socioeconomic groups have over health-related practices.

The chain of inequalities that the neoliberal policy regime and the generative mechanisms it derives, imply that health-related practices take place in economic, employment, educational and residential conditions that vary according to people's gender and socioeconomic level. This differing reality was reflected in the tendencies regarding health-related practices according to people's socioeconomic condition and gender. Through a cross-sectional statistical analysis, I showed a gradient in which, as people's income level and years of education decreased, the presence of health-related

practices which may increase the probabilities of suffering from non-communicable forms of ill-health increased. I also concluded that people's gender impacts their health-related practices, with a tendency for men to consume fewer vegetables and fruit than women. Men were also more likely to drink alcohol heavily and to smoke than women. In other words, I argued for the importance that individuals' socioeconomic level and gender have on the practices they adopt, challenging the individual responsibility approach encouraged by Chile's neoliberal policies, that is, programmes focused on prevention and education that encourage people to avoid 'risky' behaviours.

8.2.2 Lay knowledge of health: the contradiction of neoliberalism

Through an intensive analysis of lay knowledge of health developed in Chapter 5, I argued that Chileans experience a tension in their daily lives between a strong sense of responsibility for their health – agency – and some awareness of the social determinants of health analysed previously – income inequality, employment conditions inequality, residential segregation, unequal education opportunities and unequal healthcare. This tension was observed across individuals who had different income, housing conditions, years of education, working conditions, gender and age.

Two different aspects of Chilean society influenced the way people understand and experience health: its commodified character and the presence of traditional gender roles. Firstly, Chile's commodified character, a consequence of the neoliberal policy regime, was seen through the presence of functional comprehension of health and its relation to money and employment. Individuals conceived health as one of the most important preconditions to be able to work and/or raise a family, and it was associated, mainly by those who belonged to the middle socioeconomic group, with fears of going

bankrupt or becoming highly indebted. Secondly, traditional and patriarchal gender roles were also seen in the functional definition of health given by respondents. While men stated that health was necessary to work in order to feed their families, women argued that they needed to be healthy to be able to raise their children and family. Thus, health was considered indispensable to carry out gender-related duties and to secure wellbeing in a context of low social security, thereby revealing the importance of individual responsibility.

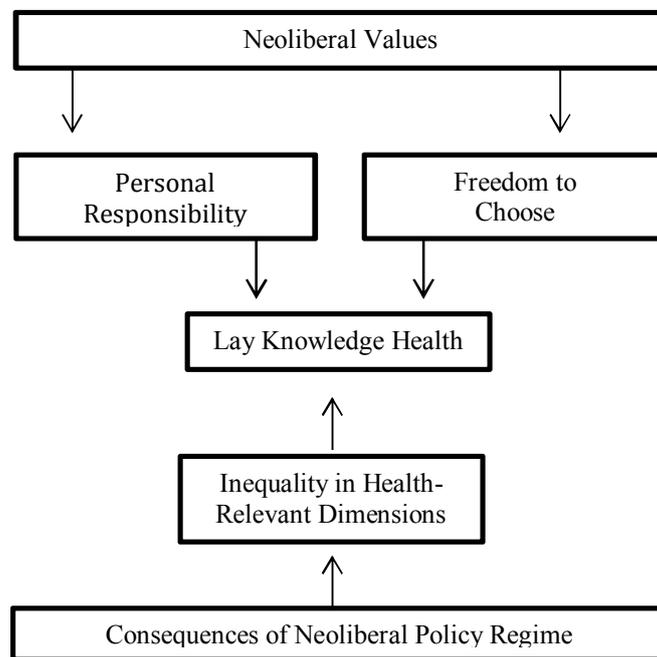
The fact that Chileans who suffered different levels of structural constraint over their agency power defended individual responsibility over health in the same way, suggests hegemony of Crawford's notion of 'ideology of individual responsibility' (Crawford 1977). The presence of this ideology within respondents' narratives indicated three relevant aspects. Firstly, it revealed the belief that rational individuals should know and be informed about the consequences that their health-related practices may have on their health outcomes. Even when there was some acknowledgement of the presence of inequalities, respondents believed that it was still the individual who should overcome the difficulties and change their practices. In other words, the belief in people as rational actors whose actions take place in a vacuum, neglecting the interaction of these practices with social structure (Crawford 1977; Minkler 1999). Secondly, as a result of this belief, health disparities between individuals who carry out different health-related practices were considered a matter of individual responsibility. This was revealed, for instance, in normative narratives with people who suffer obesity. Thirdly, it indicated how the neoliberal message of personal responsibility over political morality for economic and social wellbeing has been internalised by Chilean society, facilitating the success of the neoliberal policy regime

(Crawford 2006). It is important to state that the belief in individual responsibility for health and the importance of personal control and self-sufficiency were already part of the health discourse in the early 1800s (Minkler 1999). Already in the Middle Ages and Renaissance, there was the belief that diseases were caused by a disorder of the bodily humours, which were under people's control (Reiser 1985). However, even though this relationship is not new and has been observed in earlier times in non-neoliberal countries which, neoliberal values have helped to intensify the belief in individual responsibility. The findings show that while people acknowledged the structural constraints they might face in relation to their health-related practices, they still defended the idea that it was up to them to 'resist them' (Crawford 1977, 677) instead of changing the conditions that create these constraints.

The tension between agency and structure reflects an internal contradiction in people's belief in the level of control they have over their health and ways of living. On the one hand, men and women from both socioeconomic groups stated that health outcomes and practices were the result of social and material factors, showing their awareness of the social determinants of health. This finding contradicts, to some extent, critical realists' argument about people's unawareness of reality, and highlights the importance of considering lay knowledge when researching health inequalities. On the other hand, respondents contradicted this awareness by defending the idea that these outcomes and practices were a consequence of their voluntary behaviour. This internal contradiction may reflect a tension between neoliberal values of freedom to choose and individual responsibility, and the unequal reality that takes place under a neoliberal policy regime (Figure 14). The withdrawal of a welfare state in favour of market dependence is partially based on the argument of freedom to choose; e.g. people should

be able to choose freely – rationally and with no influences – which healthcare system they want to belong to. Consequently, individuals should be held responsible for the choices they make. Freedom to choose and personal responsibility are therefore the main neoliberal values. However, Chile’s neoliberal policy regime has failed to provide people with the conditions necessary to guarantee freedom to choose, as has been already argued. In fact, only a small proportion of the population have this freedom, while the majority’s choices are constrained by different types of determinants. Figure 14 shows that the contradictory relationship between neoliberal values and the consequence of the neoliberal policy regime, i.e. inequality in health-relevant dimensions were present in people’s lay knowledge of health.

Figure 14: Contradiction between neoliberal values and the consequences of neoliberal policy regime



Source: Prepared by the author

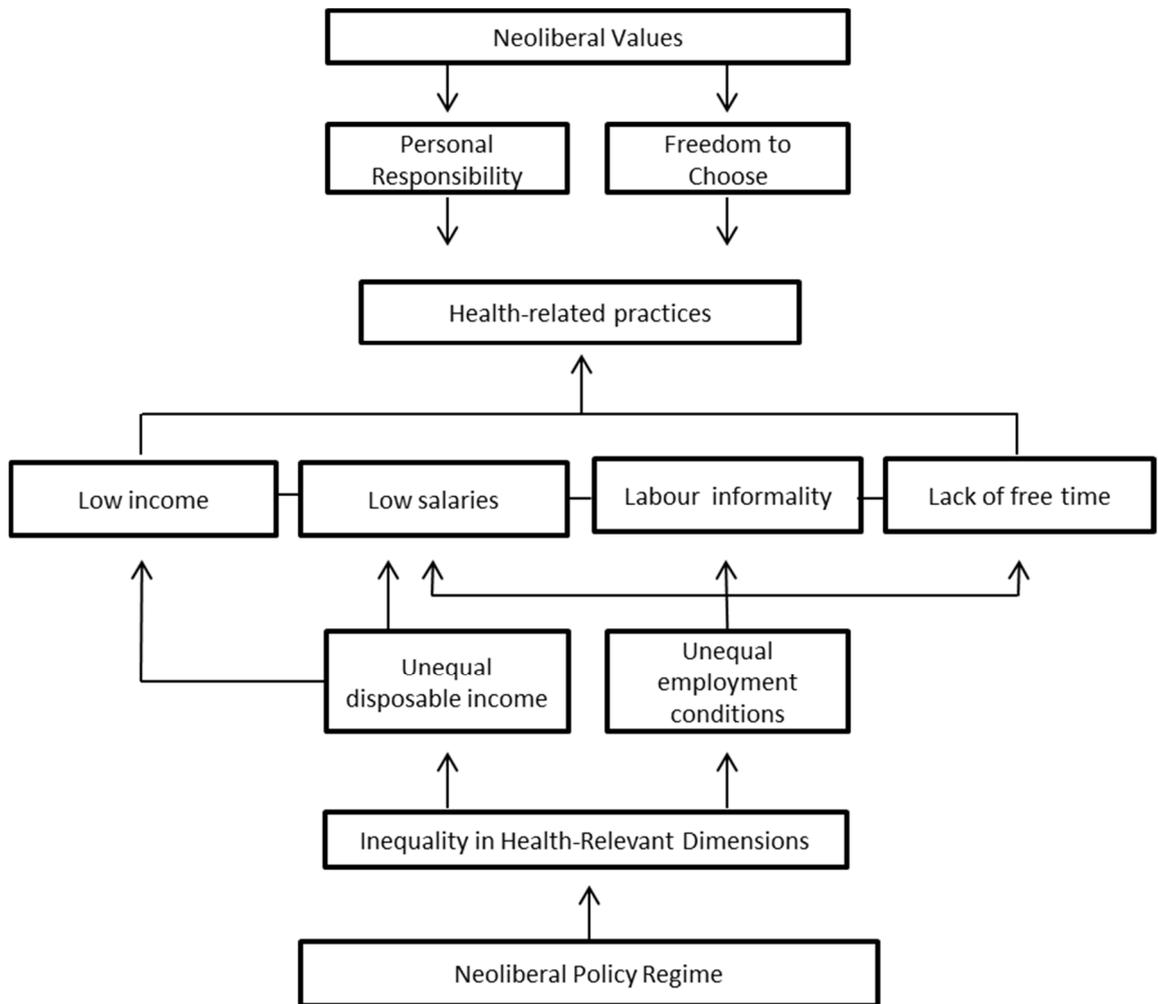
8.2.3 Unequal economic capital, unequal health-related practices

Through the analysis performed in Chapter 6, I identified the main mechanisms through which economic capital constrained the space for agency over health-related practices that men and women from middle and lower socioeconomic groups have. Different mechanisms that influence people's practices derived from unequal and insufficient incomes and poor employment conditions, some of the inequalities in health-relevant dimensions produced by the neoliberal policy regime.

Men and women from both socioeconomic groups reported having low income and tight budgets, which is a mechanism derived from Chile's income inequality. This mechanism constrained individuals' health-related practices in mainly two ways, as

showed in Figure 15. Firstly, by determining whether or not they could access the private system healthcare when the public system did provide a good quality service. While some of those respondents in the middle socioeconomic group had previously been able to pay for a private doctor, either by adjusting their budgets or asking for loans, none of the participants who lived in *campamentos* were able to do this. In the second place, low income constrained people's health-related practices to varying degrees according to their cost. For instance, as income decreased, so did the quality of food consumed, its variety, and the intake of fruit and vegetables, an aspect that was also observed in the extensive analysis presented in Chapter 4. Additionally, people's physical activity was restricted to their ability to pay to use facilities where they could exercise in a safe environment.

Figure 15: Mechanisms through which economic capital influences health-related practices



Source: Prepared by the author

Employment inequality was also a gradient in relation to people’s agency power over health-related practices. It did so mainly through three mechanisms: low salaries – connected to low incomes –, informality, and lack of free time (Figure 15). In a commodified society with privatised social services, such as Chile, salaries and employment contracts are essential to wellbeing. The uncertainty of not having a regular, reliable and prompt monthly income and access to social security, which are

aspects related to an employment contract (pension, health insurance and unemployment insurance), triggered anxiety and feelings of stress and influenced health-related practices of those who belonged to both socioeconomic groups. These feelings made individuals more prone to engage in practices such as smoking, eating junk food or drinking to excess, and occasionally, suffer from mental health problems. This situation became more acute when the lack of free time was considered. Working long hours and commuting long distances meant that people had no time or energy to do physical exercise or to cook traditional and more nutritious food, even if they could afford it. Women who had paid work reported to be more affected by this situation, due to the pressure of the double shift they undertook.

As seen in Figure 15, these mechanisms derive from the broader historical, political and economic context analysed in Chapter 4. This finding provides evidence that supports the neo-materialist explanations of health inequality seen in Chapter 2. According to this stream of the social determinants of health approach, explanations for this phenomenon should be based on identifying the factors that determine income and social inequality, and not exclusively on income inequality itself or psychosocial mechanisms (Coburn 2004; Coburn 2006; Lynch et al. 2000; Lynch et al. 2004). Through the analysis provided, I showed that the impact that material conditions or economic capital had on the space for agency that men and women from different socioeconomic groups had over their health-related practices was explained by broader generative mechanisms. These mechanisms are a result of different processes through which the neoliberal policy regime became hegemonic in Chile.

These findings also explain the health gradient that exists between the middle and lower socioeconomic groups. Even when material conditions influence the amount of

agency that individuals from both groups have over their health-related practices, the limits it imposes on those who belong to the lower socioeconomic group are greater. For instance, while participants living in *campamentos* stated that on occasions they did not have enough money to buy food, interviewees from the middle class could still buy a big variety of food. Their monetary restriction was mainly in relation to quality, not quantity, meaning a wider space for agency.

Additionally, Chapter 6 provided evidence of Chileans' internal contradiction, seen in Chapter 5. Even when respondents were aware of the impact that these factors had on their health, they were not necessarily conscious of the preventable nature of these inequalities. The combination of this unawareness, together with the internalised value of personal responsibility, led men and women from both middle and lower socioeconomic groups to assume personal responsibility when describing themselves as lazy and comfortable (Figure 14). In conclusion, the mechanisms that derived from people's unequal disposable income and employment conditions, both consequences of the neoliberal policy regime, constrained the space that individuals had to transform the structure through their agency power.

8.2.4 Social and moral boundaries

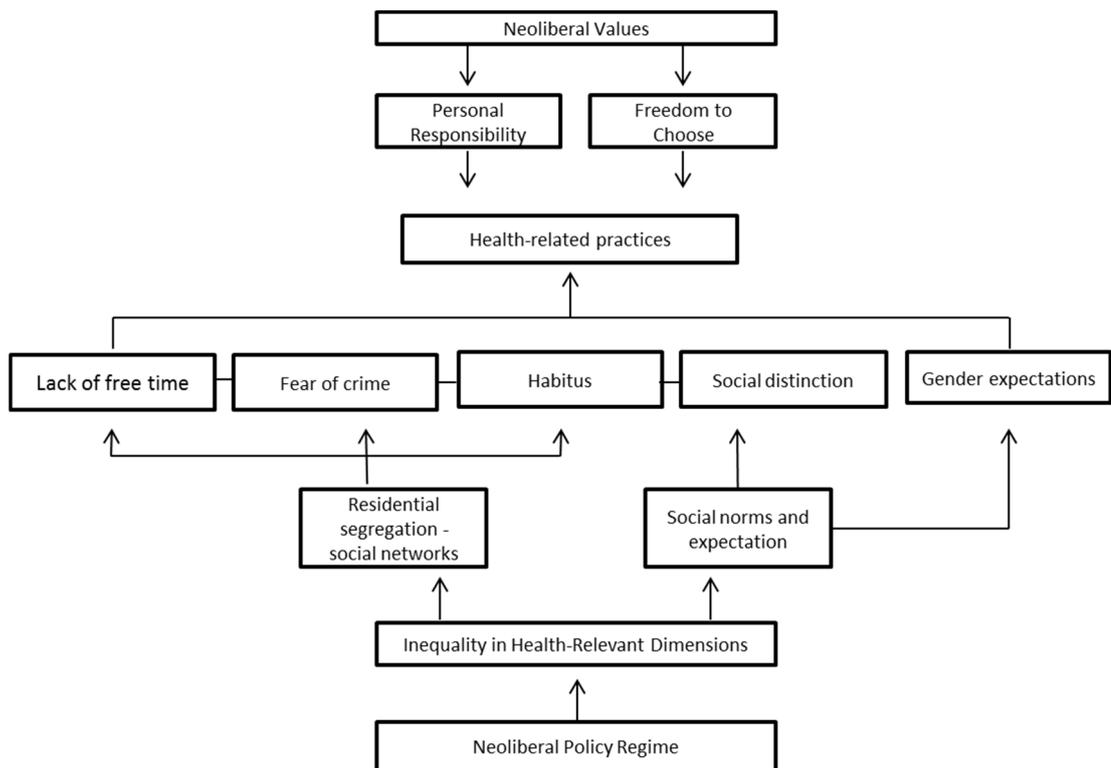
In chapter 7 I argued that people's social and cultural capital limited, to varying degrees, the amount of agency that men and women from different social groups in Chile had over their health-related practices .

People's social capital was observed through their neighbourhoods and social networks. These dimensions constrained their agency power over health-related

practices mainly through three mechanisms: lack of free time, fear of crime, and habitus (Figure 16).

Firstly, commuting between their home and workplace consumed most of people's free time due to the residential segregation, exacerbating the lack of free time from their employment conditions. This mechanism constrained middle and working classes' possibility to do physical exercise and was also associated with a higher intake of fast food than food with greater nutritional value. This mechanism influenced women more than men, due to the patriarchal gender roles present in this society: women were in charge of cooking and were under greater pressure about their body image. Secondly, individuals' fear of crime was a strong determinant that hindered people from doing physical exercise outdoors, that is, exercise they did not need to pay for. As explained, fear of crime was stronger in the case of women. Thirdly, the low heterogeneity of social networks, that is, the members within them had similar socioeconomic conditions and backgrounds, reduced mainly through habitus the space for agency that men and women from different social groups had over their health-related practices (Figure 16). The predominance that bonding social capital had over more heterogeneous forms of social capital, led individuals to consider their own practices and those of their families and friends as 'natural' or 'normal' – '... 'reasonable', 'common-sense' behaviours' (Bourdieu 1990, 55). Evidence of this was that individuals who lived in *campamentos* had a higher disposition to health-related practices such as smoking or drinking alcohol to excess, reflecting the high incidence and 'normality' of these practices in their neighbourhoods and social circles.

Figure 16: Mechanisms through which social and cultural capital influence health-related practices



Source: Prepared by the author

The analysis of counter-examples, that is, individuals who followed health-related practices which were not common in their social networks or neighbourhoods, reinforces the argument about the impact of habitus. The main strategy respondents had to change their health-related practices and ‘go against’ the group was to avoid social meetings or abandon social circles. This means that to facilitate a change to their health-related practices, people inevitably changed the composition of their bonding social capital. People were helped do this by having social relationships with people from different social circles whose ‘common-sense’ behaviour was different, that is, through their bridging and linking social capital. By having the chance to open their

social networks to include people with different dispositions, there was a possibility for individuals to change their health-related practices. This confirms that social capital may have a positive or negative impact on health-related practices depending on the practices that each network promotes, as well as the social norms each of them involve (Cullen and Whiteford 2001). This is why the last part of Chapter 7 was devoted to social norms and expectations of each social group.

The social norms and expectations of men and women from middle and lower socioeconomic groups – in other words their cultural capital – impacted their health-related practices through two mechanisms: social distinction and gender expectations (Figure 16). For both groups, the wish to be easily differentiated from people from a lower socioeconomic level was translated into a strong concern about their body image and practices. People in the middle socioeconomic group experienced a strong pressure to demonstrate self-control and moderation in their actions and bodies. This was in opposition to the lower socioeconomic group, which in their opinion, were individuals who acted without moderation and in a cheap way. For people from this socioeconomic group, as stated by Crawford, ‘the thin person is an exemplar of mastery of mind over body and virtuous self-denial’ (Crawford 1984). It is a social class whose health-related practices were influenced by their material conditions and the need for social distinction, creating social expectations which result in moral judgements when not met.. This situation emphasised the individual responsibility that each person had for his or her own actions, which increased the anxiety and pressure that this social group experienced. For people who lived in *campamentos*, social distinction as a mechanism shaping their practices was seen through their ‘excessive’ character. These individuals wanted to be easily differentiated from those beneath them in the social ladder, that is, people who were so poor that they had no money to buy food or cigarettes. However,

instead of social pressure for self-discipline, when they had the money, they needed to eat with no moderation and treat themselves to junk food and cigarettes, thereby showing others that they could afford these practices with no restrictions. At the same time, they also showed the need to distinguish themselves from working class people that consumed drugs or spent their scarce money on alcohol. They wanted to be considered 'clean' and innocent for their situation and lack of resources.

The second mechanism associated with cultural capital that shaped people's health-related practices was gender expectations (Figure 16), revealing traditional concepts of 'masculinity' and 'femininity'. The social expectation that women would be healthier than men placed them under a different type of pressure than men. Women were morally constrained from eating in great quantities, or drinking and smoking as they wished, since they were supposed to look after their 'delicate' bodies. This placed them in a position in which female bodies were thought to be inferior and fragile, reinforcing the patriarchal concept of 'femininity' and gender roles. Men were also constrained by the social expectations of them. It was considered 'normal', therefore, for men to eat in great quantities, especially red meat, to drink alcohol, to smoke, and to play football with friends. Men 'should' want to engage with these health-related practices, since these were the ones associated with the traditional male image of being fearless and strong.

The social norms associated with socioeconomic groups interplayed with the social expectation that encouraged men to drink alcohol. Men were expected to enjoy consuming alcohol, usually in great quantities, but they were under pressure not to get drunk because they could lose either their middle class distinctive self-denial character or their 'innocence' for poverty. Therefore, both men's and women's health-related

practices coincide with patriarchal gender roles as well as their socioeconomic group norms and values.

The mechanisms that derived from Santiago's residential segregation and people's unequal social networks and social norms constituted social and moral boundaries to their health-related practices. The nature of these mechanisms made it even more difficult for people to change their health-related practices through their agency. Habitus, social distinction and gender expectations were mechanisms which people did not normally reflect upon, which is why individuals were mostly unaware of the impact these had on their practices. This situation facilitated the reproduction of health-related practices as well as the structure that influenced them.

The importance of social distinction and gender expectations as mechanisms that influenced the space for agency individuals had over their health-related practices supports the psychosocial stream within the social determinants of health approach, defended by Wilkinson (Wilkinson 1996; Wilkinson and Pickett 2009). As explained in Chapter 2, defenders of this stream argue that once societies have reached a certain basic standard of living measured by an absolute level of the gross national product per capita, relative income and social status become the most important social determinants of health. While the analysis provided in Chapter 6 challenges this perspective, the relevance of social status is confirmed by the way in which social expectations of social class and gender shaped people's health-related practices . Therefore, even when social status could be explained by the presence of wider processes, the direct impact it had over people's health-related practices cannot be denied.

8.2.5 The complete picture

By considering these findings and analyses together, I conclude that the structural mechanisms that constrain or enable people's choice of health-related practices derive from their economic, social and cultural capital, which are unevenly distributed and create a social gradient. The Chilean neoliberal policy regime constitutes a structure with high levels of inequality in health-relevant dimensions observed through unequal disposable income, employment conditions, social networks, social expectations, and residential segregation. These inequalities affect people differently according to their socioeconomic level and gender, through different structural generative mechanisms: low income, labour informality, lack of free time, fear of crime, habitus, social distinction and gender expectations. All of these mechanisms were found to significantly impact the extent to which people's health-related practices were enacted in different ways, as I have previously summarised.

Additionally, these mechanisms interact with each other, increasing their impact on health-related practices. Residential segregation not only constrains people's agency over health-determined practices through, for instance, lack of free time but also through the interaction it has with other dimensions, such as unequal employment conditions. The low heterogeneous social networks linked to residential segregation and preponderance of bonding social capital, implies that people do not have access to information about job opportunities that could lead them to better working conditions. This means that people's social capital has an impact on their employment conditions, which in turn influences their disposable income, all dimensions that constrain health-related practices. At the same time, having a low paid job, with no access to social security, makes it more difficult for individuals to move to a better-off neighbourhood,

which offers less time commuting less fear of crime. The difficulty of paying rent in a better connected neighbourhood due to insufficient income restricted people's opportunity to access more heterogeneous social networks. This could mean not having information about better job opportunities or not experiencing conditions that would make it easier for them to adopt health-related practices, omissions that could impact their health positively.

A similar vicious circle may be seen in the relationship between women's access to low paid employment and the traditional division of labour, and gender expectations of women's socially accepted body shape. As the evidence showed, women usually earn lower salaries and have more precarious working conditions than men. Additionally, they are the ones responsible for the domestic labour and sometimes even take occasional jobs in order to increase their income. In this sense, it is more likely for females to have two full-time jobs, paid and unpaid, than males. This situation creates a reality in which women have no free time to exercise or to cook healthy meals. This work overload may lead to high levels of anxiety, which can trigger an increase in fast food consumption or smoking as a way of coping with stress. At the same time, these coping strategies are usually translated into heavier bodies, which contrast with the slim female figure highly valued by society. The fact of not meeting the social standards of the hegemonic female body shape usually means an additional increase in anxiety. Therefore, women's access to economic capital and the social norms about the way their bodies should look create a reality that can have a strong negative impact on their mental health and their health-related practices.

The interaction between mechanisms reveals that they are strongly intertwined and that they condition each other. This means that although the different dimensions have

been considered separately throughout this thesis for the purposes of analysis, they should not be understood as independent. The process through which structure impacts the space that people have for agency over their health-related practices is highly complex and should be studied by analysing all health-relevant inequalities, material and non-material, alongside the characteristics of the policies that produce these inequalities.

Even when health-related practices may be considered the result of the interplay between agency and structure, agency appeared to be strongly restricted by structure. The analysis of the Chilean case revealed that the high levels of inequality that neoliberal societies tolerate together with the internalisation of the moral message of personal responsibility and individual freedom, in other words, neoliberalism's internal contradiction, increase the likelihood of the reproduction of social structure through agency. The fact that people's health-related practices were strongly influenced by several mechanisms caused by inequality, together with an insufficient awareness that individuals had of this, created a context in which people's actions reinforced the necessary conditions for the reproduction of the structure. It could be hypothesised that if the population became aware of the mechanisms that influence their health-related practices and their unnecessary and avoidable character, they would question the ideology of individual responsibility and freedom to choose together with the alleged inevitable or fair character of health disparities. Time will tell if Chileans' become aware of the social, unfair and avoidable character of the inequalities that constrain their health-related practices and whether this will be a catalyst to transform the social structure.

However, the presence of possible alternative interpretations to relevant aspects needs to be acknowledged. Firstly, what has been considered as internalization of neoliberal values of personal responsibility could also be interpreted as an effect of the interview process. When people know that certain health-related practices have a moral value and may be morally judged, interviewees may be stating their personal moral value. For instance, by criticising obese people and by emphasising that they have complete control over their diets, participants were asserting their own values and proper moral attitude to the researcher. Therefore, what could be interpreted as the unquestioning internalization of the ideology, could be awareness about the moral value of personal responsibility during the interview process.

Secondly, the mechanism of social distinction could also be considered to be an expression of resistance. For example, the way in which participants who lived in *campamentos* stated that they enjoyed eating food in unlimited amounts or that they would not give up their only luxury, i.e. smoking, were interpreted in this research as a pursuit of social distinction from those that could not afford eating or smoking. Nonetheless, these statements could also be considered a form of resistance, that is, a way to challenge dominant social norms about health-related practices from their vulnerable and oppressed situation. In other words, it could be seen as a statement about their possibilities to fight the system individually by going against social rules about health-related practices.

Nevertheless, even though people could be intentionally claiming moral worth or challenging the social norms of responsible behaviour, these alternative interpretations still confirm the importance of the moral influence that freedom and personal responsibility have on people's health-related practices.

8.3 Implications for theory, methodology and policy

These findings and conclusions hold a number of implications in terms of theory, methodology and policy. Firstly, this thesis challenges the concept of individual freedom and responsibility present in the behavioural approach as well as in neoliberal ideologies and policies. By providing evidence of the way in which economic, cultural and social capital strongly influence the health-related practices that men and women from different social groups engage with in Chile, this thesis rejects the argument that people's practices depend exclusively on their will power and knowledge about 'health risks'. On the one hand, even when individuals knew, for instance, which foods were considered to be healthy or the potentially damaging effect of cigarettes, their precarious or unstable employment conditions constrained their chances through their low salaries or lack of free time. Additionally, individuals' health-related practices were more related to their internalised dispositions, which were different according to their socioeconomic level and gender, than to a rational concern about health. In this sense, adopting health-related practices deemed to be harmful, such as smoking, was seen as something rational when it was understood, for instance, under the logic of social distinction. As seen in previous research, 'behaviour, even those which might seem most closely related to health, may have powerful springs which arise elsewhere' (Blaxter 2010, 92-3). This is why it is misleading to place responsibility for health-related practices exclusively on individuals. The study of Chile allowed us to see that people's choices regarding health-related practices were constrained by the chances that their material, social and cultural conditions offered them.

Secondly, the analysis showed the importance that material conditions – economic capital – have in relation to health-related practices, even when Chile has recently

reached a level of basic standard living according to its GDP per capita which would make material conditions irrelevant to health inequalities according to the psychosocial theory of health inequality (Wilkinson 1996; Wilkinson and Pickett 2009). The analysis showed how economic capital impacts health-related practices through different mechanisms, and how it constrains the space that people have for agency over their health-related practices through its relation with social and cultural capital. Even when these forms of capital cannot be reduced to material circumstances, they are highly conditioned by them. The particularity of Chilean reality, in which rapid material improvements coexist with persistent and wide inequalities, implies the need to study health inequalities in other newly emerging 'rich' countries by combining both neo-materialist and psychosocial approaches. In other words, by focusing the analysis both on the psychological burden that income inequality imposes on its inhabitants, as well as the role that the political and economic context plays, and the presence of other significant health-relevant social inequalities.

Thirdly, this work has added to the knowledge there is about the negative impact that neoliberal regimes have on health inequality (Coburn 2004; Navarro and Shi 2001; Chung and Muntaner 2007; Navarro et al. 2006). This dissertation provided a detailed analysis of how different structural mechanisms influence the space for agency that people have over health-related practices in a strongly neoliberal country. By doing so, it revealed how inequalities in health-relevant dimensions, tolerated and created by a neoliberal policy regime, produce mechanisms that impact people's health-related practices. This thesis also argued that neoliberal values of freedom to choose and personal responsibility contrast with people's constrained possibilities to choose their health-related practices, giving place to an internal contradiction experienced by

Chileans. In this sense, Chile appears as a case that particularly shows the contradictions that take place between ideology and reality, alongside the internal and external struggles that people have reconciling these issues. Finally, this internal contradiction observed between the importance given to personal responsibility (agency) and the awareness of social determination of health (structure) – though low – leads to the enactment of health-related practices that reproduce the structure.

Additionally, this research has made an analytical and theoretical contribution by analysing health-related practices in terms of agency and structure combining Bourdieu's theory on people's social location and the relationship between 'habitus' and practices (Bourdieu 1977, 1984, 1986, 1990) with Archer's argument about the interdependency between structure and agency (Archer 1995, 2000). In terms of its analytical contributions, it observed the impact that the social structure has on people's health-related practices through different mechanisms that derive from the unequal distribution of economic, social and cultural capital, and considered, at the same time, the space there is for agency to reproduce or change this structure. Thus, while on the one hand it revealed how structure constraints health-related practices, on the other it showed that the insufficient awareness of these constraints alongside the internalisation of neoliberal values reduce the space for agency to demand or modify the structure. Theoretically speaking, the combination of Bourdieu's and Archer's theory permitted the utilisation of a social determinants of health approach avoiding the reduction of human beings to the social structure, i.e. a 'downward conflation' (Archer 1995). This means that while emphasising the importance and impact of social determinants on health, the dissertation recognises that agency might modify these under conditions that allow reflection and the demand for social change.

Regarding the methodology, the impact of using a mixed methods approach under a critical realist perspective was twofold. On the one hand, it showed that critical realism is able to overcome the limitations that positivist and interpretivist approaches suffer from. It was only by combining intensive and extensive analyses and considering the stratified character of reality, that it was possible to observe that individuals' discourses do not necessarily coincide with reality. Even when people were aware to some extent of the social determinants of health, an aspect that claims the importance of lay knowledge, they were not aware of the unnecessary character of these determinants. In fact, people's poor knowledge about the fact that their practices were highly influenced by mechanisms that emerge from inequality is one of the reasons why the structure is reproduced by agency. The contradiction between ideology and experienced reality, particularly for Chileans, may hinder their knowledge about this reality. On the other hand, the use of this methodology contributes to the growing narrative on the use of critical realism within health research. The research design and analysis may be used as an example of how the ontological and epistemological principles of this approach are very appropriate to understand the production and reproduction of health inequity.

In terms of the case study, this thesis has contributed to a specific understanding of the Chilean case. The combination of an intensive analysis of narrative from men and women who belonged to the lower and middle socioeconomic groups in the light of the extensive analysis of health-related practices and the contextual analysis of the country's neoliberal policy regime and reality in health-relevant dimensions, led to evidence that has not been considered until now. For instance, the fact that mechanisms which derive from Chile's labour market conditions, such as labour informality or lack

of free time, constrain people's health-related practices, had not been stated by research previously. In this sense, this thesis provides policy makers, in Chile and other neoliberal countries, with valuable evidence to be considered when designing and implementing social policies that aim to reduce health inequity. These entail two main policy implications.

In the first place, by showing the interplay that takes place within health-related practices between social structure, in terms of material circumstances, social and cultural capital, and people's agency, the research argues for the complexity of health-related practices and the need to consider an intersectoral perspective. The World Health Organization has called previously for an 'intersectoral action on health', making reference to 'working together across sectors to improve health and influence its determinants' (WHO 2011a, 3). This means that in order to tackle health inequity, action from all sectors of society is needed, not only from the health sector. As this thesis has shown, in order to increase the space for agency that people have over their health-related practices, action on aspects such as the transport system, working conditions in terms of both salaries and working hours, and residential segregation is needed. For instance, improving the public transport system not only increases the probability of people having more free time, but it is also possible that the effects of residential segregation could decrease due to better connections between different parts of the city. Therefore, action should not be focused on health-related practices exclusively, but on all its determinants.

This leads to the second policy implication, the need to tackle the root cause of health inequity: the neoliberal policy regime. It is necessary to modify the political and economic principles that guide policies in different sectors of society, in order to

effectively modify or influence the mechanisms that shape people's health-related practices and reproduce inequality. However, this is a long-term challenge, not only due to the way in which the messages from this policy regime have been internalised by people, but also because of the strong relationship that domestic and foreign business groups have proven to have with political power.

8.4 Limitations and further research

Even though this thesis makes several contributions, it also has its limitations. This last section will analyse the two main limitations of this work, and will state how these are a useful starting point for future research.

The first evident limitation is that the research does not include all the socioeconomic groups of Chilean society, only two. Even when the study of these two groups allowed vision of the influence of the social health gradient, it would have benefited from an insight into how health-related practices are shaped within a social group which supposedly benefits from the neoliberal policy regime, that is, the upper socioeconomic group. In this sense, it would be relevant in future to analyse the mechanisms through which the structure reduces or increases the space for agency the upper class has over their health-related practices in a strongly neoliberal society. How do they experience and influence, for instance, the social norms of self-control and moderation followed by the middle class? To what extent do the practices or body images aspired to by those in the middle socioeconomic group respond to an aspiration to belong to the upper social class? How do individuals who belong to the upper class differentiate themselves from those who are part of the middle socioeconomic group? Do the health-related practices enacted by men and women from high socioeconomic

level reproduce neoliberal values? These are only some of the questions that are left open for further research.

Additionally, the respondents who belonged to the lowest socioeconomic group were all *campamentos* residents, which implied living under worse housing and material conditions than the majority of the Chilean population that belong to the lowest socioeconomic group. However, they did not represent the most socially excluded sector of society since they have a strong relationship with the NGO UTPCH meaning that they received different types of support: help to apply to public housing, educational workshops, and leisure activities, among others. Therefore, by choosing *campamentos* residents as respondents, I left out people from social groups who lived under similar conditions as *campamentos*, but were not socially integrated via the NGO. It would be very interesting to compare the amount of agency that individuals from both social groups – supported and not supported by the NGO – have over their health and health-related practices and to analyse the impact that this type of social relationship has.

As for the research methods, it is possible that the interview structure may have influenced participants' responses and narratives. Even when the topic guide was flexible and allowed respondents to add new topics there was a strong focus on health-related practices. This focus may have led interviewees to emphasise or over-state the importance of these practices on their health outcomes. However, it is interesting to note that the participants themselves would usually mention the health-related practices I was interested in researching. In other words, they said that their eating habits or their physical activity were the main aspects that influenced their health and we would take the conversation from there. Nevertheless, I did not stop in every

practice they mentioned, only in those I wanted to focus on. Therefore, the structure of the interview showed the respondents which topics were more relevant for the research which may have shaped their answers.

The fact that the research is based in one country constitutes the second limitation. Although Chile was chosen as a representative of a strong neoliberal society and the findings presented corroborate in a Chilean context what many researchers have found elsewhere, there are specifics with this case that might restrict its generalisation. On the one hand, even though this country is an OECD member, it is an outlier in terms of income inequality within this group and has only recently been considered a high-income country. This means that the distribution of its wealth (GDP) throughout the population is significantly worse than that of countries with similar GDP per capita, which implies that income structure may impact health-related practices through different mechanisms. Therefore, it would be risky to apply the findings without important considerations to other neoliberal nations with a similar economy. On the other hand, while not a limitation, the generalisation to Latin American countries is also limited due to their diversity of policy regimes and levels of socioeconomic progress. This does not mean that these results are irrelevant when studying different societies, but rather that they should be used as an hypothesis to be rejected or confirmed. In this sense, further research could focus on a comparative analysis of the mechanisms that underlie health-related practices in countries, on the one hand, with similar and different policy regimes, and on the other, with similar and different levels of socioeconomic progress. By doing a comparative analysis, it would be possible to identify which aspects correspond to the specificity of each country, and which are a consequence of the political economy of each society.

APPENDIX

1. Construction of health-related practices' indicators

This section presents the variables used as indicators of health-related practices used in the extensive analysis provided in this thesis. The questions and data were taken from the Chilean survey named 'National Survey Quality of Life' (Encuesta Nacional de Calidad de Vida – ENCV), which was carried out in 2006 by the Chilean Ministry of Health in collaboration with the National Institute of Statistics and the Catholic University of Chile (Departamento de Epidemiología - MINSAL 2006) described in Chapter 3. I did the translation of these questions from Spanish to English.

1.1. Diet Index

Questions of survey used to construct the index:

During the last week, how frequently have you eaten these foods?

- Vegetables
- Legumes
- Fruits
- Fish
- Milk, cheese, and yoghurt
- Fried Food

Eating the amount recommended by WHO (2004) and MINSAL and INTA (2004) meant one point in the diet index, which ranged from 0 to 6. In the case of eating fried food, it meant one point less.

1.2. Physical activity

Question of survey used:

- During the last month, did you do any sport or physical activity, outside from your working hours, for 30 minutes or more?

Anyone who answered '3 or more times a week' was considered to carry be physically active. This was decided based on WHO (2004) and the Chilean Ministry of Health (REF) guidelines.

1.3. Alcohol consumption deemed problematic

Questions of survey used to construct the indicator:

Respecting alcohol consumption, answer yes or no:

- Have you had problems with your partner or relatives because of drinking?
- Have you lost friends because of drinking?
- Do you feel like you need to drink less?
- Does is happen to you that without noticing, you drink more than what you expected?
- Have you had the necessity of having a drink during mornings?
- Has it happened to you that when you wake up after drinking in the previous night you are not able to remember what you did or happen?
- Does it bother you that people criticise you by the way you drink?

Following guidelines to this indicator (Orpinas et al. 1991), anyone who answered 'yes' to two or more of these questions was considered to have problematic alcohol consumption.

1.4. Tobacco consumption

Questions of survey used:

- Have you smoked at least one cigarette during the last month?

Anyone who answered 'yes' was considered to consume tobacco.

2. Topic guides interview

This section presents the two topic guides used for the interviews. As explained in Chapter 3, it did not follow a fixed structure in order to allow a conversation dynamic rather than answer-question.

2.1. First interview

Good morning/afternoon/evening. First of all, I would like to thank you for taking part in my research. I am a sociologist and I am studying in the UK. I am researching topics related to social inequality in Chile, how this is live in everyday life by different families mainly in relation to health.

In this first interview, I would like us to talk about your life, which have been the main changes and difficulties you have experienced in different aspects of your life.

It is very important that you know that no one will have access to what you tell me. This interview is confidential and anonymous. It is also important that you know that our conversation will be recorded. The only reason for this is that it allows me to pay full attention to your words and not being worried about taking notes. If there is any question you do not want to answer, there is no problem.

Is there any question you would like to ask me before we start the interview? Anything you would like to know?

Let us start talking a little bit about your past. How was your education?

- Educational level?
- Transition from primary to secondary school?
- Any personal or familiar experience that affected your studies?
- Which elements/people helped you to take important decisions regarding your education?
- Which were the main difficulties you faced? How did you overcome them?

Now let us talk about where you grew up, your neighbourhood.

- Did you have friends there? Do you still meet them?
- Did your parents also have friends there? How was their relationship with the neighbours?
- Did you have relatives living nearby?
- Did you feel safe? Could you play by yourself or go out without your parents?

How is your employment history?

- How old were you when you started working? In what did you work? What did you spend that income in?
- Are your jobs usually stable or have they changed a lot?
- Do they include contract and access to social security?
- Have you been unemployed? For how long? Could you tell me about that experience?
- How did you hear about your jobs? Friends, relatives, newspaper?
- Which have been the main difficulties you have faced? How did you overcome them?
- Current situation

Let us talk now of when you became a parent.

- How old were you?
- Where did you live?
- Which were the main difficulties you faced? How did you overcome them?

Could you talk to me about your family (children, partner, parents, in-laws)?

- Who do you live with?
- Do your children go to school/university?
- What do you think about the education they receive? Do you like it?
- How is their education funded?

Could you describe me the economic situation of your family?

- Who are employed?
- Do you have access to any subsidy?
- Do you have enough money to live well? What things do you lack?
- Does your house have access to drinkable water, electricity, dwellings, heating?

Let us talk about your current neighbourhood. Do you like living here?

- Do you feel safe?
- Do you know your neighbours?
- Is it well located in relation to the transport system, schools, GPs?
- Do you think it is a pretty area?

When you think about your friends and social life, which is your main social network?

- Neighbours, relatives, friends from life, school, work
- Who helps you if you have an economic problem?
- Who helps you if you have a family or personal problem?
- Do you have friends or acquaintances that have a different socioeconomic situation than yours? How is your relationship?
- Do you have friends or acquaintances with people that work for the government or an NGO? How is your relationship?

Finally, could you tell me a about your family's and your health?

- Any important disease that was difficult to overcome?
- Chronic diseases?
- Accidents that caused chronic conditions?
- General problems?

2.2. Second interview

Good morning/afternoon/evening. On the first interview we talked about your life in different aspects. On this occasion, I would like us to focus more on health. Therefore, I will propose different topics related to it so that we can talk about them.

In the same way as in the previous interview, no one will have access to what you tell me. This interview is confidential and anonymous. Again, our conversation will be recorded so that I can pay full attention to your words without worrying about taking notes. If there is any question you do not want to answer, there is no problem.

Is there any question you would like to ask me before we start the interview? Anything you would like to know?

Let us start talking about health.

- What does it mean to you? What comes to your mind when I say the word health?
- What are the main things in life that you think affect our health?
- Do you know anyone you would describe as a healthy person? Who? Why would you describe him/her with that word?

As you said (if the person mentioned them) there are practices that have an impact in our health. I would like us to talk about them.

First of all, diet.

- What comes to your mind when you think about food?
- What do you usually eat? Does it change for special occasions like birthdays, parties, social meetings? How?
- Who is responsible for cooking in your house?
- What food do your children take to school? Do they have lunch there or at home?

- If you could change your diet, which things you would decrease or stop eating and which would you increase or add to your diet? Why?
- Which aspects do you think avoid or make it difficult for you to carry out these changes?
- Do you think that there are some types of food more related to women than men and vice-versa?
- What do you think is a healthy diet? Where did you learn this from?
- Do you think your diet is better or worse than an average Chilean?

You also mentioned doing sports (if the person mentioned it). Let us talk about physical activity.

- What do you understand by it? What activities do you consider to be physical activity?
- Do your children carry out physical activity only at school or also outside?
- If you could change the amount of physical exercise that you carry out, would you do more or less? Which type of exercise? Why?
- Which aspects do you think avoid or make it difficult for you to carry out these changes?
- Do you think that there are some types of physical activity more related to women than men and vice-versa?
- How much exercise is it recommendable to carry out for your health? Where did you learn this from?
- Do you think that you carry out more or less physical exercise than an average Chilean?

Another activity that could affect our health is tobacco consumption.

- What comes to your mind when you think about smoking?
- Do you smoke? In what occasions?
- (If the person smokes) when did you start smoking? Trajectories: moments when you left it, when you started again, etc.
- Are you frequently around smokers? (family, friends, it is allowed to smoke at home and at work)

- If you could diminish the amount of cigarettes you smoke, how much would you smoke? Why? (inquire 'healthy')
- Which aspects do you think avoid or make it difficult for you to do it?
- Do you think that smoking is something that suits better men or women, women than men, or are there no differences? Why?
- Do you think that there is a certain amount of cigarettes which is non-detrimental to health? Where did you learn this from?
- Do you think that you smoke less or more than an average Chilean?

Now let us talk about alcohol consumption.

- What comes to your mind when you think about alcohol drinking? What do you relate it with?
- Do you drink alcohol? In what occasions?
- (If the person drinks) when did you start drinking? Trajectories: moments when you stopped, when you started again, etc.
- Are you frequently in situations where people are drinking?
- If you could diminish your alcohol consumption, how much would you drink? Why?
- Which aspects do you think avoid or make it difficult for you to do it?
- Do you think that drinking is something that suits better men or women, women than men, or are there no differences? Why?
- Do you think that there is a certain amount of alcohol drinking which is non-detrimental to health? Where did you learn this from?
- Do you think that you drink less or more alcohol than an average Chilean?

To end this interview, I would like us to talk about stress.

- What does it mean to you to feel stress?
- What things you consider that triggers it?
- Have you ever felt stressed? In what occasion?
- What do you do when you feel like that?
- Has it ever been translated into physical health problems?
- Do you think that Chileans frequently suffer from stress?

3. Interviewees' profile

Joana was a 41 year old woman who was interviewed twice. She was in the lower socioeconomic group and lived most of her life in a *campamento*. Joana had four children – a 14 years old, 16 years old and 19 years old girls and a 21 years old boy. She worked in her own grocery store that was inside the *campamento*. She never attended full-time education, she said she was educated by her grandparents. Both her husband (Pedro) and one of her daughters (Daniela) were also interviewed. Joana reported that she had experienced domestic violence within her marriage, a situation that had stopped at the time of the interview.

Sara was 34 years old at the time of the only interview we had. As part of the lower socioeconomic group, she lived most of her life renting a room due to her low income. After one of her children had an illness that required an expensive treatment, she and her family went to a *campamento*. During her previous marriage, she had three children – a 15 years old girl and 7 and 5 years old boys. She got a divorce after experiencing domestic violence from her ex-husband for several years. When we met, she worked in a popular market selling fruits and vegetables. She never went to school, a condition that made it hard for her to find an employment with a formal contract. None of her relatives were interviewed.

María was a 39 years old woman living in a *campamento* who was interviewed two times. She lived with her second husband and their two boys who were 5 and 7 years old at that time. She also had a 20 years old son from her previous marriage, which ended since she suffered domestic violence from her ex-husband. Even when she finished school, she always belonged to the lower socioeconomic group and worked doing handcrafts as self employed. Her husband (Rodrigo) was also interviewed for this study.

Ana was 36 years old at the time we had two interviews. She was in the lower socioeconomic group and came from a very poor family. She had four children – a 20 years old son, 16 years old daughter, 14 years old son and 1-year-old son. At the time of the interview, she was expecting a new baby. She also lived with her second partner; she suffered domestic violence from her ex-husband and got a divorce. She had worked her whole life, since she was 12 years old, as domestic service in different houses, the reason why she did not finish her primary school. At the time of the interview, she did not have a contract, which meant that she did not have a paid maternal leave. Her husband (Juan) and her daughter (Camila) were also interviewed.

Carmen was a 62 years old woman living in a *campamento*. We met twice at her place. She belonged to the lower socioeconomic group and came from the south of Chile. She always belonged to this socioeconomic group. She did not finish her primary school and was unemployed. She had never, but once, worked. She had two grown up children and always stayed at home with them, even now when they had already left.

At the time of the interview she lived with her second partner. She divorced the father of her children since he was alcoholic and beat her frequently. Her daughter (Paola) was also interviewed.

Paola was 38 years old at the time of the interview. She was mother of three children: a 19 years old girl, 15 years old boy and a 10 months old baby. I interviewed her twice at the *campamento* where she lived with her children and husband. According to her story, she always belonged to the lower socioeconomic group. She did not finish her secondary school because she got pregnant as a teen and her mother did not allow her to go to school after that. She was unemployed at the time of the interview. She had worked a couple of times as domestic service, but did not feel she was good at it. Therefore, she stayed at home with her children. She told me she had suffered domestic violence from her husband during many years, but that at the time of the interview he did not hit her any more. Her mother (Carmen) was also interviewed.

Margarita lived in a *campamento* with her two sons and her husband. She was interviewed twice. Her children were 6 and 4 years old and she was 45 years old. She came from the south of Chile and had always belonged to the lower socioeconomic group. She did not finish her secondary school because she moved to Santiago and started working as domestic service. At the time of the interview she was not working and was in that situation for a long time. According to her narrative, she had not experienced domestic violence. None of her relatives were interviewed.

Pedro was a 42 years old man who had always belonged to the lowest socioeconomic group. We met for the interview at this grocery store which was outside his house at the *campamento*. He was married and had four children which were a 14 years old, 16 years old and 19 years old girls and a 21 years old boy. He did not finish his primary school because he started to work very early. He worked as self employed at the time of the interview. He expressed he had problems with alcohol in the past, which lead him to be violent with his wife. However, he said that did not happen any more for several years. His wife (Joana) and his daughter (Daniela) were also interviewed.

Rodrigo was a 46 years old man who lived with his second wife and 5 and 7 years old boys at a *campamento*. He told me how in the past he had a somehow better socioeconomic condition, but once he left his parents house it got worse. He finished his secondary education in a technical school, but was not able to find employment in that area. At the time of the interview, he worked selling outside schools necklaces and key rings that his wife would make. He had experienced domestic violence from his previous wife as well as his father in law. This was the main reason why he got a divorce. His wife (Maria) was also interviewed for this study.

Juan was a 38 years old man who lived with his three children and second wife at a *campamento*. He did not finish his primary education since he had to help his family economically when he was a child. He had not experienced any upward social mobility through his life. At the time of the interview he had an employment with a formal contract at a cemetery. We met twice at his house for the interviews. His wife (Ana) and daughter (Camila) were also interviewed.

Pablo was a 48 years old man who was living with his second family at the time of the interview. He was a man who previously belonged to the middle class. He finished his secondary education and grew up in a family with a higher socioeconomic condition to the one he belonged when we met. We met twice at his house located in a *campamento*, where he lived with his second partner and their two children (7 and 5 years old). His partner had always lived there and they couldn't afford another place to live since Pablo continued to support his previous partner and children economically. He had two employments with contract at the time of the interview. No relatives were interviewed. Pablo was interviewed twice.

Daniela was a 19 years old teenager who lived at a *campamento* with her parents and siblings. At the time of the interview she was 8 months pregnant and had suspended her higher education because of her pregnancy. She was unemployed since she was dedicated to her studies previously, but when we met she was considering working as a seller or any job that could provide her flexibility once her child was born. She had always lived at that *campamento* and had not experienced any type of social mobility. Her mother (Joana) and father (Pedro) were also part of this study. She was interviewed twice.

Camila was a 17 years old teenager who belonged to the lower socioeconomic group. We met once at the *campamento* where she lived with her parents and siblings. At the time of the interview she was at her secondary education and was not working. Her narrative made no reference to any type of social mobility as well as no experience of domestic violence. Her mother (Ana) and father (Juan) were also interviewed.

Yasna was 16 years old at the time of the interview. She was at her secondary education and she was employed at a fast food restaurant as part of her school program. She had always lived at the same *campamento* with her father, his partner and her siblings. None of her relatives were interviewed.

Benjamin was 15 years old and was the only teenage male who agreed to be part of this study. He had always belonged to the lower socioeconomic group. At the time of the interview, he lived with his parents and siblings and had an informal job in order to help them economically. He stopped attending school when he was 14 years old. None of his relatives were interviewed and we met one time.

Soledad was a 53 years old middle class woman. We met twice at her house, where she lived with her younger daughter, who was 19 years old and had a 6 months old son. She was a widow and had two sons who 25 and 29 years old and lived with their partners and children. She was raised in a high socioeconomic group family and had the opportunity to study some years of higher education. She had experienced a downward social mobility, mainly due to economic difficulties caused by the medical treatment her husband received. At the time of the interviews, she had an employment with formal contract and complemented her income through other activities, such as baking. No mentions towards domestic violence were made. None of her relatives were interviewed.

Claudia was a 34 years old middle class woman who lived with husband and her two daughters (15 and 7 years old). She completed her higher education but had several difficulties in finding an employment with formal contract. She said that this was because she suffered from obesity and was discriminated by employers. Therefore, she was self-employed and sold pastries at the time of our interviews. Her husband (Nicolas) and daughter (Trinidad) were also interviewed. Her narrative did not mention any experience of domestic violence.

Jessica was a 41 years old middle class woman who was interviewed twice. She had completed her secondary education and had been employed for several years by the same company. She was divorced and lived with her two children, who were in higher education at the time of the interview. She had raised them as a single-mother. She had always been part of the middle socioeconomic group. None of her relatives were interviewed.

Paula was 45 years old at the time of the interview. She belonged to the middle socioeconomic groups and lived with her only daughter (19 years old). She had divorced her husband because he became drug addict. She had finished her secondary education and had an employment with formal contract at a very big company. She had not experienced any type of social mobility and made no references to domestic violence. None of her relatives were interviewed. We met twice.

Juana was a 35 years old middle class woman. She was married and had two children (7 and 5 years old). She had her secondary education complete and had a good employment with a formal contract. She had not experienced any type of social mobility and made no references to domestic violence. None of her relatives were interviewed. Two interviews were made.

Oscar was 65 at the time of the interview. He belonged to the middle socioeconomic group and had experienced no upward or downward mobility through his life. He lived with his second partner. He had two grown up sons who were 28 and 31 years old, both of them with higher education degrees. He had secondary education degree. He was retired, but worked as a taxi driver in order to earn more money. None of his relatives were interviewed.

Nicolas was a 32 years old middle class man. He had grown up in a lower socioeconomic group family. He had a secondary education degree even though he wanted to go to university. He lived with his second wife and their two daughters (15 and 7 years old) and belonged to the middle socioeconomic group. He was employed and had a formal contract, but since his income was low, he also worked as freelance. His wife (Claudia) and daughter (Trinidad) were also interviewed. Two interviews were made.

Jose was 31 years old at the time of the interviews. We met twice at his place of work. He grew up in a middle socioeconomic group and still belonged to this social class. He had a secondary education degree and worked at a big company with a formal contract. He was married and had a 10 years old daughter and a 7 years old son. None of his relatives were interviewed.

Felipe was a 37 years old man who belonged to the middle socioeconomic group. He was married and had one child (12 years old). He had a secondary education degree and had always worked with formal contracts for the Chilean government. His narrative made no reference to experiencing upward or downward social mobility. None of his relatives were interviewed and we met one time.

Jorge was 52 years old at the time of the interview. He belonged to the middle socioeconomic group and had experienced no upward or downward mobility through his life. He lived with his second wife and their youngest daughter (24 years old). He had three daughters, all of which had a higher education degree. He had secondary education degree and had never wanted to go to university. He was self employed at his father's company. None of his relatives were interviewed.

Catalina was a 17 years old middle class teenager. She lived with her 4 months old baby, her parents and her older sister. At the time of the interview she was finishing high school and had plans to start her higher education soon. Her parents and her boyfriend's parents helped her economically. She had not experience any type of social mobility. None of her relatives were interviewed. She was interviewed twice

Trinidad was 15 years old at the time of the interview. She had belonged her whole life to the middle socioeconomic group. She was at high school when we met and was not working. She lived with her parents and her younger sister (7 years old). Her mother (Claudia) and father (Nicolas) were also interviewed. She was interviewed twice at the house.

Andres was a 18 years old middle class male teenager. He was finishing high school at the time of the interview and was not working. He lived with his parents and younger brothers and had always belonged to the middle socioeconomic group. We met twice at a place nearby his school and none of his relatives were interviewed.

Ignacio was 16 years old at the time of the interview. He belonged to the middle socioeconomic group and lived with his parents and two siblings. He was father to a baby but did not live with him. He was at high school and was not working. We had one interview. None of his relatives were interviewed.

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