Economic Inequality, Development, and Global Health

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The social and economic situation of countries is directly related, among other factors, to the health status of their population (Hertzman, 2001), even before birth (Barker, 1995). This relationship is widely documented in the literature. The perspective of Public Health and Global Health predicts that more "developed" countries (those with higher per capita income levels and more advanced institutional frameworks) generally show much better health indicators than their counterparts with fewer resources (Haring, 2021). One explanation is that a higher level of income allows for more resources to be allocated to health prevention and disease treatment in the health sector, improving people's health outcomes. In general, there is a positive correlation between health and nutrition indices and per capita income, although this relationship is not linear.

Income inequality within countries also reflects differential access to health services and quality of healthcare based on income, with wealthier middle-class sectors and high-income individuals obtaining better healthcare services than lower-income and poorer sectors.

There are also various mechanisms that mediate this relationship (health levels and the economic development of nations) at the population level. At conceptual level we have theories of allocation of public resources to the health sector, household decision-making regarding health spending, the availability of fiscal resources connected to the tax system structure and the overall development levels of countries. Complementary approaches include the theory of the construction of reality (Berger & Luckmann, 1966); the unintended consequences of actions considered beneficial (Merton, 1936), theories oriented towards the construction of health in the world, such as governance and biopower theories (Foucault, 2004) or the theory of suffering (Kleinman et al., 1997) and economic aspects of health determinants, the concept of commercial determinants of health (Kickbusch, 2012), allowing us to advance in the understanding of the relationship between the economy and health[14].

This article examines broad economic and social considerations in the relationship between economic development and health for the case of Chile and the Latin American region from a historical perspective. A mostly economic approach including an analysis of income and wealth inequality is used as background for the understanding of Global Health issues addressed in this book.

The case of Chile and the Latin American region

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[14] See Haring, R. (2021).

The economic and social development of Chile in the past decades is a process with advances, contrasts, and shortcomings. On one hand, the country has achieved a respectable level of per capita income close to $28,000 annually (2022) showing a significant degree of macroeconomic stability although this process of economic modernization is uneven (Solimano and Zapata-Roman, 2024). Chile is a member of the prestigious OECD group of mostly advanced economies although at the same time is a country characterized by high economic and social inequality. This feature has historical roots coming from the colonial period marked by unequal land ownership and valuable natural resources such as gold, silver, saltpeter, copper, and others, mostly in the hands of foreign English or American owners although several attempts at reducing inequality took place in the 20th century. Additionally, Chile's pattern of economic growth relies on the exploitation of non-renewable natural resources, agro-industrial and forestry products, and maritime resources. Since the mid-1970s, the country has experienced a persistent decline in the relative importance of the manufacturing sector, a phenomenon known as deindustrialization.

Social spending financed by the State in healthcare, education, public transportation, pensions, science and technology, and environmental protection is constrained by limited fiscal revenue and other public policy constraints. As a percentage of GDP fiscal revenues represent around 20 percent a much lower figure than the OECD average, closer to 35 percent[15].

Health spending per capita in Chile is USD 2,200 (2018) in purchasing power parity, representing approximately 8 percent of GDP, placing it on the upper range in Latin America and the Caribbean, after Cuba, Argentina, Brazil, and Uruguay. Chile also has an extensive primary care network that has played a significant role in various public vaccination campaigns for decades, including the recent COVID-19 vaccination campaign.

The healthcare sector in Chile has a mixed system, consisting of a segment of private healthcare (Isapres) and a segment of public healthcare (Fonasa). Adherence to each system largely depends on the socioeconomic level of the affiliates, replicating the inequalities observed at the macro-social level. However, Fonasa plays a leveling role in providing access to healthcare services for the middle class and lower-income populations.

Chile is a highly segmented society with varied social circles that generally do not connect with each other and live in different economic, social, territorial, and cultural realities. Economic elites and high-income groups reside in neighborhoods with houses and services that are not far from those offered in developed countries and have access to high-quality healthcare services. The middle classes have made progress in accessing to a wide

[15] Social spending competes with a level of military spending (over USD 5 billons in 2021) above that of its neighboring countries (Argentina, Bolivia y Perú, see Stockholm International Peace Research Institute, SIPRI 2022).

range of goods and services but also depend on borrowing and debt with banks and commercial stores to acquire them. They have acquired new homes, send their children to private schools and are exposed to the allure of consumer society but incurred in high debts along the way as well. In turn, lower-income sectors composed of the working class and marginalized groups live in a country with modest wages, job insecurity, and unsafe neighborhoods, which has become generalized to other sectors as well. Furthermore, working class populations are also indebted with the financial and commercial sector. In terms of healthcare access, most of the population who receive their health services from the public sector is affected by waiting lists for surgeries and more complex treatments. Additionally, in highly congested cities, particularly in the capital city of Santiago, most residents spend long hours commuting to and from their workplaces.

Neoliberal modernization in Chile has enabled access to material goods in a larger scale than in the past but a host of significant problems associated with this development strategy remain (see Solimano and Zapata-Roman, 2024). A big challenge for a post-neoliberal economic transformation project is building an economy that combines economic prosperity with social equality, , better access to healthcare for the population and environmental sustainability within a more participatory democracy.

Income and wealth inequality

As mentioned, a structural characteristic of the Chilean economy and society is its high inequality in income, wealth, opportunities, and access to social services, including healthcare. This inequality is reinforced by economic and institutional mechanisms that are difficult to change in the short term. In the past 50 years, income inequality reached its lowest levels during the Allende government but reversed to its highest levels during the military regime. It has gradually decreased in the decades following the reestablishment of democracy but has remained high (by international standards), especially wealth inequality.

The Gini coefficient of income, a widely used measure of the distribution of gross incomes (incomes before taxes and transfers), is close to 0.50, a level considered high internationally. On the other hand, the Gini coefficient of personal wealth is much higher reaches 0.70, according to calculations from the Household Financial Survey of the Central Bank of Chile.

Personal wealth is the sum of physical wealth, such as properties, land, vehicles, artwork, gold, jewelry, and financial wealth, including stocks, bonds, bank deposits, and other financial assets. Net personal wealth is total gross wealth minus individuals' liabilities (debts). An empirical regularity across Latin America and around the world, is that wealth inequality (Gini coefficient of personal wealth) is substantially higher than income inequality (Gini for wages and salaries, interest, dividends, rents). Therefore, a comprehensive analysis

of inequality must incorporate not only income distribution but also wealth distribution[16].

The following factors contribute to and reflect the high and persistent economic inequality in Chile:

a) high concentration in the ownership of physical and financial assets by of small economic elites and productive and financial conglomerates,
b) weakness and atomization of labor organizations, which prevent them from negotiating higher wages and receiving a fair share of companies' productivity gains,
c) the absence of a progressive tax system that proportionally taxes more higher incomes,
d) the absence of a wealth tax on high-net-worth individuals,
e) the existence of a highly privatized and stratified education system, where access to quality education is largely determined by the socioeconomic level of families (ability to pay), leading to persistent disparities in public education. Historically, say from the 1940s to the 1970s, access to public education was an equalizing mechanism of opportunities and upward mobility in Chilean society,
f) high profits earned by companies operating in sectors with limited competition (banking, private pension funds, private healthcare insurance, natural resources).
g) A segmented health sector in which private health providers (ISAPRES) that serves around 15 percent of the population co-exists with a public health system (FONASA) that serves the 85 percent of population.

Latin America: A Brief Historical Perspective

Latin America is a region that has maintained roughly constant its ratios of per capita income to advanced economies for several decades showing its difficulties for converging to higher living standards in the world economy. At the same time, its economies are prone to economic cycles associated with fluctuations in terms of trade, financial flows and the ups and downs of the global economy. These macroeconomic cycles have also been linked to expansive fiscal and monetary policies adopted by governments that faced limitations in foreign currency availability (known as the "external gap"), generating balance of payments fagility, inflationary pressures and stop- and- go policies. Social policies face constraints in fiscal financing, which also affects the healthcare sector. Additionally, in certain countries (e.g., Latin American countries in the 1980s and Greece between 2009 and 2017), austerity measures and adjustments were accompanied by a reduction in public healthcare spending (Solimano, 2022, 2023).

A structural characteristic of the region is high inequality, which is a phenomenon

[16] Available estimates show that the income Gini for Latin America and the Caribbean c. 2015-2018 was 0,46 while the net wealth Gini was close to 0,80. In turn, the income share of the top 1 percent was 20 percent (Latin American average) and the wealth share of the top 1 percent, 35-45 percent for those years.

with historical origins associated with the conquest of America. The Iberian colonization of the New World in the 15the century and beyond involved granting land and indigenous people, known as "encomiendas," to conquerors and adventurers from the Old World. This led to the accumulation of immense agricultural wealth and lands containing precious minerals such as gold and silver, particularly abundant in Mexico (Viceroyalty of New Spain) and Peru (Viceroyalty of Peru), in the hands of a few, contributing to pronounced economic inequalities in the territories of America (Solimano, 2021b). A significant portion of the gold and silver was transferred to the Spanish crown, specifically the Habsburg and later the Borbon families[17].

The colonial era created a rigid social hierarchy consisting of peninsulares (whites born in Spain) at the top, accompanied by a dependent local ruling class known as criollos or the "creole aristocracy." There was also a middle stratum composed of merchants, artisans, and public officials, and a lower class comprised of laborers, indigenous people, mulattoes, black slaves, and zambos. Internal economic inequality in Latin American countries did not change significantly after the wars of independence in the early 19th century and the formation of independent Latin American and Caribbean republics, although the dominant Iberian elites were replaced by local elites. Land ownership was based on large extensions of land known as *latifundio*, a system that had replaced encomiendas after the Borbon reforms. The new ruling classes of the republics consisted of landowners, merchants, and local and foreign financiers and industrialists who thrived alongside an emerging domestic industry. Booms in primary product prices primarily benefited the mining, trade, and agricultural elites compared to laborers, peasants, and manual workers.

The very limited democracies of the 19th century in Latin America allowed for the political independence from Spain to be led by these new propertied and local elites, without experiencing serious challenges from excluded sectors. Sokoloff and Engerman show that between 1840 and 1900, the percentage of people who voted in elections (where the vote was not secret) did not exceed, at best, 5 percent of the population (Sokoloff & Engerman, 2000). Furthermore, only landowners and literate individuals were eligible to vote, meaning the wealthier sectors of the population[18].

Health services for the lower-income population were provided, mostly, by religious entities and mutual aid societies. Infant mortality rates were high, and life expectancy did not exceed 40 years.

In the early decades of the 20th century, inequality fluctuated with economic cycles

[17] During the colonial period Latin American nations could only engage in (legal) foreign trade with the Spanish Crown; this system retarded economic development in Latin American and Caribbean countries and consolidated inequalities.

[18] Towards 1940, voting shares reached to 15-20 per cent in Argentina, Uruguay and Costa Rica. In contrast, of voting levels close to 40 percent in Canadá and the USA in those years.

and recessions, with the most severe one being the Great Depression of the 1930s, which heavily affected the economies of Latin America and the Caribbean: in turn, according to the League of Nations, Chile experienced the most severe economic contraction in the world between 1930 and 1933 (Solimano, 2020).

Between 1940 and 1970, various Latin American governments adopted a strategy of import substitution and state-led industrialization, with private sector participation, to reduce the economic vulnerability of countries to international fluctuations in main economic variables of trade and finance. Economic development was accompanied by a process of social modernization, including rapid urbanization, the expansion of public education, the strengthening of labor unions, an increased access for the middle class to the state apparatus, and the creation of social security systems. Between the 1930s and 1950s, different Latin American countries established public health systems for their population and health indices improved.

In the second half of the 1960s and early 1970s, there were attempts at progressive income and property redistribution in Chile (under the governments of Frei Montalva and Salvador Allende), with similar policies adopted in Peru under the government of Velasco Alvarado. These policies also spread to Uruguay with the Frente Amplio of Liber Seregni and to Argentina with Cámpora and Perón. However, the wave of democratization and progressive redistributions in the southern cone was stopped and reversed by right-wing military coups in Chile, Argentina, and Uruguay with the help of US intervention. The new military dictatorships adopted neoliberal economic policies that benefitted the rich and wealthy and protected the economic interest of foreign investors.

Other events were the oil shocks of 1973 and 1979 that benefited Mexico, Venezuela, Ecuador, net oil-exporting countries, and the recycling of petrodollars allowed for increased investment and economic activity in several countries in the 1970s. However, the recycling of petrodollars to Latin America also contributed to the accumulation of higher levels of external debt that forced costly adjustment policies in the 1980s (Solimano, 2021a, 2021b, 2023)[19].

External Debt Crisis, Adjustment, and Neoliberalism

The high external debt accumulated in the 1970s along with external and fiscal imbalances led to the external debt crisis in the 1980s, which reduced the region's economic growth, accelerated inflation, contracted real wages, and had serious effects on investment and employment. A report by UNICEF, a United Nations agency, titled "Adjustment with a Human Face," documented the deterioration in health indicators of the population because of the adjustment policies adopted in Latin America during the 1980s, including the reduction of social spending in healthcare.

[19] The income Gini (average of 15 países) went up from 0,503 in 1950 to 0,537 in 1990, confriming the high levels of inequality in the latin American region.

In the 1980s, income inequality increased in Argentina, Brazil, Chile, Colombia, Peru, Paraguay, although it decreased in Uruguay and Costa Rica (Cornia, 2015). International historical evidence shows that, in general, inequality tends to increase during and after economic crises (Solimano, 2020) and may decline in booming periods. In the following decade, the 1990s, inequality increased again, this time the trend was associated with the adoption of neoliberal economic reform policies known as the "Washington Consensus." These reforms focused on macroeconomic stabilization (e.g shock treatment), privatization of public assets and companies, and, in several countries, also the privatization of the pension system (Solimano, 2021b, 2023), as well as deregulation and opening of trade and financial sectors to the outside world. At the same time, labor unions weakened while business associations strengthened. Informalization of the labor market increased, and wage and benefit gaps widened between managers and high-level administrative positions on one hand, and middle-level employees and shop-floor workers on the other. Prices of assets such as stocks, bonds, and properties also surged benefiting wealth holders.

From the early 2000s, a post-neoliberal period of political change (the “pink wave”) occurred in Argentina, Brazil, Bolivia, Venezuela, and Ecuador, where the governments of these countries sought to move away from Washington Consensus policies. Between 2002 and 2012/13, there was also a boom in the prices of primary commodities such as oil, copper, soybeans, and various metals, which benefited Latin American economies heavily reliant on primary products for export. Post-neoliberal governments also intensified poverty alleviation programs and, in several cases, increased public investment. This period saw a cycle of higher economic growth and reduced inequality but not of economic diversification away from natural resource-based exports and reduction of overall external dependence.

Concentration of Economic Power and the Weak Redistributive Role of the State

The high concentration of wealth among the richest segments of the population leads to excessive influence of economic elites—who control a significant portion of financial and productive wealth and the ownership of mass media in countries—over public policies. Several mechanisms can be identified to exert this influence, such as donating to political campaigns, controlling media outlets, influencing experts and intellectuals, and other methods (Solimano, 2022). Particularly in Latin America, economic elites have historically and presently effectively blocked progressive redistribution, denying increases in income and wealth taxes, resulting in reduced fiscal resources for social sectors, including healthcare.

The State in Latin America is weak in using the tax system and state transfers for correcting inequalities generated endogenously by the economic system. This is reflected in the fact that in Latin America, indirect taxation (value-added tax and specific taxes) accounts for about 50 percent of total tax revenue, contrasting with less than an equivalent

share of one-third in the OECD. In the latter, the contribution of direct taxes (personal income and corporate taxes) to total state income is significantly higher than in Latin America. Moreover, social transfers have lower coverage compared to developed countries. The European welfare state—with universal provisions for healthcare, education, and pensions— is associated with taxation revenues close to 35 percent of GDP, with Scandinavian countries reaching 50 percent. In contrast, the average tax-to-GDP ratio in Latin America is only around 20 percent. With fewer tax resources, there is less capacity to finance higher-quality and wider-reaching social expenditures[20], including healthcare. It is a long-standing structural characteristic of the Latin American state to have an endemic inability to ensure that economic elites contribute more through taxes to finance social spending that benefits the poorest sectors. Naturally, healthcare spending also falls within this social expenditure.

Final Thoughts

One of the most important characteristics of inequality in Chile and the rest of Latin America is its persistence and continuity over time. This inequality is reflected in the healthcare sector, with lower resource allocation to this sector both in absolute amounts and relative terms compared to nations with higher levels of economic development (an exception in the Latin American and Caribbean context is Cuba with a higher ratio of health spending to GDP than the average corresponding share given its per capita income level) .

The colonial period laid the foundations for a significant inequality in land ownership and natural resources within socially stratified societies. After independence and the formation of independent republics in the 19th century, the ownership of key physical economic resources remained in the hands of local elites maintaining high economic inequality in the now independent nations. Nevertheless, economic elites benefited from weak democracies with minimal electoral participation by the population at large that allowed these elites to maintain their concentration of economic and political power. In the 20th century, income inequality remained high and even increased compared to the 19th century, with average Gini coefficients around 50 percent. The "great leveling" that occurred in Europe and North America between 1913 and 1970 did not take place in Latin America, despite advancements in electoral participation, democratization, autonomous development, expansion of public education and middle classes, the creation of social insurance systems, the expansion of public health, and workers' unionization. The 1970s were politically turbulent in Chile and Latin America. Waves of democratization and progressive redistribution early in that decade were followed by authoritarian retrogression and the adoption of the socially regressive neoliberal model. Inequality increased during

[20] La diferencia promedio entre el Gini de ingresos de mercado y el Gini de ingreso disponible (ingresos de mercado ajustados por impuestos y transferencias realizados por el Estado) es de 3-4 puntos porcentuales en América Latina; en contraste, en los países de la OCDE, en promedio esta diferencia es de 12-14 puntos porcentuales, asociados a la acción del Estado a través de tributos y transferencias.

the period of 1980-2002, which included the external debt crisis (1980s) and the implementation of Washington Consensus policies in the 1990s. However, in the first decade of the 21st century, several countries experienced a "post-neoliberal" shift, helped by improved terms of trade, increased capital inflows and remittances, a slight compression of the wage scale, and increased cash transfers to the poor. As a result of these changes, the upward trend in inequality of the last two decades of the 20th century started to reverse between 2002 and 2012, with effects extending until 2018-19 before the onset of the Covid-19 crisis.

The distributive progress of the first two decades of the 21st century, including public health policies, has its limits due to the persistence of informality in the labor market and the lack of consistent policies oriented to build an effective social state in Latin America that guarantees social protection, the advancement of economic democracy and the upgrading of public education, public health, housing, and pensions. The focus of governments in the last three decades has been on poverty alleviation and partially improving income distribution. Reducing wealth concentration has been an absent goal likewise improving the redistributive role of the Latin America state characterized by the lack of progressivity in the tax system and the fragmentation of social spending.

An effective pro-equity strategy for the coming years and decades should focus on the provision of good-quality jobs, decent wages, and expand access to healthcare, credit, and knowledge for the population. Additionally, universal income floors for the active and passive population should be guaranteed within the framework of a comprehensive and consistent strategy to reduce structural inequality in the region.

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