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Does Community Participation Work? : A Study on the Impact of Health Care Reform in Chile*

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〈Abstract〉

Does Community Participation Work?: A Study on the Impact of Health Care Reform in Chile

Community participation in health has been praised as a new way of improving health inequality in developing countries for many decades. This paper is an attempt to evaluate community participation programs in health focusing on two intercultural health hospitals in IX Región of Chile. After exploring the process of program building and its impact on the quality of service, this paper concludes that a community participation program with stronger participation resulted in higher patient satisfaction. The author expects such finding to contribute to more comprehensive understanding of the impact of participation in health programs.

[Key Words: Health Reform/ Community Participation/ Intercultural Health/ Chile/ Mapuche]
[주제어: 의료개혁/ 주민참여/ 다문화의료/ 칠레/ 마뿌체]

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Ⅰ. Introduction

The idea of community participation in health system has been around for decades as one of most important issues of public health care reform. Even though community participation in health system became more popular with neoliberalism, its history started with the Declaration of Alma-Ata of 1978, which is a result of realization of the fact that the main problem of the health in recent years is not about a general supply of health care but about its unequal distribution and exclusion of the poor, especially in the poor countries (Badgley 1992). Therefore, the Alma Ata declaration's central organizing principle was a low-cost strategy utilizing paraprofessional health workers to administer preventive and simple curative measures in the countryside. With this approach, world leading health organizations have intended to extend inexpensive health coverage to rural areas, to promote community participation in health, and to achieve no less ambitious a goal than "health for all by the year 2000" (Morgan 1993).

Community participation in health is a relatively new way of administering health and gave rise to several sociological inquiries: Besides the normative argument for community participation in health due to its democratizing nature, is it an effective way of reforming health system? And how and when does it actually work? To answer these questions, I looked into intercultural health programs[1] in Chile where participation from

1) These programs seek to recognize indigenous people's need in the health sector, redefining the state as democratic, humanitarian and pro-cultural rights. At the same time, by building bilingual offices in the public clinics and hospitals and hiring bilingual workers, the state seeks to increase the accessibility of health service for

Mapuche[2] communities has been imperative due to lack of knowledge on Mapuche medicine on the part of the Chilean government. By comparing two different cases with different degrees of participation, this paper elucidates how participation works for or against the improvement of health services in Chile.

Ⅱ. Literature Review

One of the few examples of research on community participation in health policy is Morgan's work (1993) on community participation in Costa Rica. In this work, Morgan showed the limits of community participation due to the political agenda that the state pursued in community participation programs, which is neither democratizing nor empowering the community but introducing inexpensive health care program. She states that community participation programs in Costa Rica was a part of political gesture to show the world that Costa Rica complied with international efforts to reduce inequality in health because the country has to compete with the other developing countries in achieving grants, loans, and favorable terms governing debt repayments. As a result, the state adopts more participatory measures in primary health care, not in an effort to democratize social sector but in effort to please international health

indigenous populations who show the worst health indicator among various population groups.

2) Mapuche is the largest indigenous population in Chile, which consists of 4.6% of the total population according to 2002 census.

agencies. Therefore, she states that it is not surprising that "participation" in these programs only ended up being "induced participation" which is "sponsored, mandated and officially endorsed" by the state (Morgan 1993: 5).

Ugalde's study on community participation (1985) also approaches community participation in health in a more political and sociological way emphasizing on the state's true political and ideological agenda behind the community participation programs. He argues that states promoted community participation as a smokescreen using it to legitimize their own policies while aiming at other policies unfavorable to the poor. He states that community participation has been used to hide the abusive purpose of national elites.

Paley's work (2001) on participation in primary health care service in Chile shed lights on how to understand community participation in health under certain political and economic conditions. In her book *Marketing Democracy: Power and Social Movements in Post-Dictatorship Chile*, she argues that the participation of communities encouraged by the state serves mainly to reduce the cost of health service provision and to effectively eliminate mobilization against neoliberal economic policy. In her case study of the self-help program of the Ministry of Health to promote preventive care, she illustrates how active encouragement of the state to participate serves mainly to reduce the burden on the public health sector. Citizens who participate in the health programs often end up doing the work for the state, filling the gap that neoliberal policy produces due to the withdrawal of the state from the social sector (Paley 2001: 168). She also

maintains that, transforming community organizations as a part of public sector through participation, the Chilean state succeeded in demobilizing the resistance against neoliberal state reform.

Paley's work shares the same perspective on community participation with Morgan and Ugalde in terms of its emphasis and criticism of state-sponsored participatory programs which often produce quite reactionary effect on existing grassroots organizations. She argues that the question is neither whether there is participation in the program or how to measure its short-term empowerment effect on community, but "how participation functions as a form of power-as a kind of governmentality-within the context of political democracy" (Paley 2001: 170). Like Morgan's and Ugalde's works on community participation in health, Paley offers a very critical view on community participation emphasizing the political and economic conditions which impede grassroots participation from truly democratizing the society through empowerment.

However, even if we admit the political and economic conditions which constantly put pressure on communities to act as a part of the neoliberal agenda, is it enough reason to assume that communities, which have long history of resistance and challenge against the dictatorship in Chile, became totally "demobilized" and "subordinated" to the state? As much as it is important to consider the structural conditions that limit the democratization of the society via grassroots mobilization, it is also important not to forget that there is still - even not always winning or prevailing - a struggle resistance of the grassroots against absorption by the state.

In addition, these researches on the community participation in health

failed to empirically measure the impact of participation in improving health services. Without understanding the actual impact of participation on health services, the analysis of political and social implication of participatory health programs cannot give us comprehensive evaluation of participation in health.

This paper aims at measuring participation in both cases and to show how the different levels of participation relate to different level of patient satisfaction in each hospital setting. By analyzing the empirical impact of participation in health, this paper will be able to strengthen existing literature on community participation in health.

Ⅲ. Research Method

In 2002, I conducted surveys in Makewe and in Nueva Imperial where two intercultural hospitals are located. The surveys were an effort to evaluate the intercultural health programs. One hundred and three households from Makewe-Pelale area and ninety seven households from Nueva Imperial municipality participated in the survey. All the households are Mapuche. I used cluster sampling based on the map provided by Corporación Nacional de Desarrollo Indígena (CONADI). The survey explored 1) demographic information of the users of each institution; 2) level of satisfaction expressed by residents of the area for regional and local medical facilities; 3) level of knowledge about intercultural health programs in each institution and; 4) level of participation in administrating intercultural health programs of the area.

In addition, I conducted semi-structured and open-ended interviews. These were conducted with Mapuche patients, doctors, nurses, paramedics in two hospitals. Respondents were selectively sampled based on their representativeness and willingness to participate.

Ⅳ. Cases

This paper is a comparative study of two intercultural programs in Chile Hospital Makewe and Hospital Nueva Imperial in IX Región. Each institution has different historical, social and political backgrounds and different types of community and their relations with the state.

IX Región is the site of research. IX Región provides a strong site for this research because the region has the poorest health situation in Chile and a large indigenous population. IX Región has total population of 552,843. Among them, 143,769 are Mapuche, which is 26% of the total population of the region. Nationally, IX Región has the highest percentage of Mapuche population (Instituto de Estudios Indígena 1998). Not only does the region have a demographic concentration of indigenous population, it has created concerns for the governments because the region has one of the most serious poverty problems and suffers drastic deterioration of health. For example, according to 1992 National Census, the Comuna de Padre Las Casas has the highest level of poverty in the country (Instituto Nacional de Estadística 2003). Due to the serious health situation, Chilean authorities felt an urgent need to implement a "new" remedy to improve health in the region.

Hospital Makewe and Hospital Nueva Imperial share similarities in their location: both of them are located in a poor municipality with large indigenous population. Hospital Makewe is located between the municipality of Padre las Casas and the municipality of Freire. And the total population of the two municipalities is 64,003. Out of this population, 30,932 are Mapuche, which is 48.3%. More than 90% of the population lives in a rural area (INE 2003). Hospital Nueva Imperial is located in the municipality of Nueva Imperial but the hospital also covers the municipality of Saavedra. The total population of the two municipalities is 35,287. Out of them, 19,740 are Mapuche, which is 56%. Also more than 90% of Mapuche population lives in rural area (Instituto de Estudios Indígenas 1998).

The first case is Hospital Makewe. In 1985, evangelical missionaries came to the area of Makewe-Pelale and built Hospital Makewe right next to their church. However, the hospital went bankrupt in 1993 and the church decided to close it. Against the closure of the hospital, thirty five communities in the area mobilized themselves to protest to the Servicio de Salud de Araucania while developing a project to establish an intercultural hospital and to manage by themselves (PAHO 2001). In 1997, the indigenous communities and religious groups of the area established an agreement to allow the Asociación Indígena de Salud, an indigenous community organization, to run the hospital. The hospital developed a strong intercultural program to become the first intercultural hospital in Latin America.

The second case is Hospital Nueva Imperial. Despite the fact that this hospital shares cultural and ethnic conditions with Hospital Makewe, it

differs from Hospital Makewe due to strong government initiatives in building an intercultural program. In 1992, the Servicio de Salud de Araucanía(SSAS) launched a health program for Mapuche communities, Programa de Salud con Mapuche (PROMAP). As a public hospital, Hospital Nueva Imperial organized Mapuche communities around the hospital under a committee, Coordinadora de Salud (the Coordinadora), in 1995 and in the same year the indigenous communities submitted a petition to have a Bilingual Office of Mapudungun, which is the Mapuche language. The Coordinadora de Salud consists of la Comisión Técnica (Technical Commission) and el Consejo de Lonkos (Advisory of Community Leaders). Originally the Coordinadora was formed by health workers of Hospital Nueva Imperial with residents of the municipality of Nueva Imperial. However, soon after they formed the organization, Mapuche health workers of the hospital began to dominate the organization insisting that the real need for the hospital is to answer the demand from Mapuche population of the area. In 2000, there was a call for the strengthening of indigenous organizations and in 2001 the hospital was selected to receive funding from the Ministry of Health to establish a "public" intercultural hospital.

Ⅴ. Participation

1. Makewe: Galvanizing Participation via Multiple Channels

The case of Makewe shows that the initial strong participation from communities and the relatively low level of intervention from the state have

furthered the participation from communities in the intercultural health program. Since the participation from communities played such an important role in increasing the negotiating capacity of the communities, communities continue to develop various mechanisms to induce more participation. First of all, the hospital has various committees to hear voices from the communities. One of them is the Committee of the Wise (Comité de los Sábios), which consists of *lonkos* of the communities. A *lonko* is usually an elderly person who has political and social authority in each community. The Committee of the Wise plays a significant role in shaping the health model of the hospital and gives legitimacy to the hospital. Francisco Chureo, the director of Makewe Hospital and the president of the Asociación Indígena, emphasized the importance of the Committee of the Wise in the interview.

> I personally learned a lot from the elderly people of the communities•••I always ask *lonkos* how I am doing and they will tell me how I am doing. They are very important. Especially doing intercultural health, I always ask them what to do and how to do it. They are very wise and they know Mapuche culture. They know how to work with the state because they know the history of Mapuche.
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> (Interview with Francisco Chureo March 11, 2002)[3]

The Committee of the Wise meets whenever an important issue emerges. Often the administrators of the hospital visit important *lonkos* in the area when *lonkos* could not visit the hospital for a meeting.

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3) The interviews were done in Spanish and translated by the author.

Secondly, Makewe organizes frequent general meetings inviting all members of communities. Those meeting are held occasionally when the hospital needs support or inputs from the communities. When I was in Chile, the hospital organized two general meetings to discuss the future of the hospital. For the second one held in July 2, 2002, community members and the hospital discussed the funding situation of the hospital. Also the officials of the Asociación Indígena invited the mayor of the municipality of Padre las Casas, the director of SSAS, and various Mapuche organizations such as KONAPEWMAN, which is an organization of young Mapuche professionals.

In this meeting, representatives of two communities in the area of Rañintulef in the municipality of Nueva Imperial handed an open letter to the hospital asking the medical team to provide services to their area. It was a surprise not only for the health officials but also for the hospital because nobody anticipated such a request from communities during the meeting. However, it showed how the hospital was perceived by the communities and, at the same time, how participation from communities directly influenced the decision making process of the hospital. The director of the hospital received the letter and gave it his support. Public health officials responded that they would discuss the issue with the municipality of Nueva Imperial. Later, the communities succeeded in establishing an intercultural health post in their area with technical supports from Makewe Hospital.

In addition to the Committee of the Wise and the general meetings, every last Fridays of the month, the officials of the hospital, representatives

of the Asociación Indígena and the doctors of the hospital, have a meeting at the hospital. These members are usually representatives of communities in the area Makewe-Pelale. Therefore, during the meeting they deliver public opinions from communities regarding services of the hospital. The officials are elected by 35 member communities. Also, the officials of the hospital, especially the director, regularly visit communities in the area of Makewe-Pelale to discuss issues regarding the administration of the hospital. While I was conducting the survey in the communities, quite a few people told me that they met the director of the hospital when he visited their community to inform them about the hospital.

Direct participation of the members of communities in the administration is limited to occasions when the hospital needs strong support or input from the community. However, the leaders of each member community are frequently invited in various meetings and often asked to be a member of the governing body of the hospital. José Ladino Cayul, the secretary of the governing body, explained this web of participation.

> To administer this hospital, we need to form an indigenous health organization. And people participate in the association. Those people elected me as a secretary. .. Before I was just a member ….When we (the officials) have meetings in each community, we talk with its leader then later we organize general meetings so that people would come and express their opinions about the hospital.
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> (Interview with Jose Ladino Cayul March 14, 2002)

Several questions in the survey sought to evaluate the participation of communities in the administration of the hospital. One of the questions was

whether they had ever participated in any community meetings that discussed Hospital Makewe. Out of 103 households participating in the survey, 31 households responded that they have participated in the community meetings. In the area close to Makewe, 16 out of 27 households said that they participated in community meetings that discussed the hospital. The communities closer to the hospital show a higher level of participation because the proximity to the hospital meant greater accessibility to information.

The overall participation rate is still high. Thirty one percent of households in the area Makewe-Pelale said they had participated in community meetings that discussed Hospital Makewe, while 59 percent of the households that live close to Hospital Makewe reported that they have participated in the meeting where issues regarding Hospital Makewe were discussed.

The survey results about participation of leaders of the community in the general meetings of Hospital Makewe show the same tendency. Twenty two out of 103 households reported that their leaders participate in the meetings, while 14 out of 27 households declared that their community leaders participate in the meetings with Hospital Makewe.

In the survey, I also asked whether they know who administers Hospital Makewe. The knowledge about the hospital, especially knowledge about the administrator of the hospital reflects the level of active conversation about the hospital within communities. To the question of who administers the hospital, 58 out of 103 households answered that the Indigenous Association administers Makewe. If we just look at the area close to the

hospital, 20 out of 27 households who live close to the hospital correctly identified the Indigenous Association as the entity that administers the hospital.

Another channel to galvanize participation is through donations. During campaigns for donations, the officials of the Indigenous Association visit each community in the area and inform community leaders as well as members about problems of the hospital, which are, in most cases, financial. The first donations occurred in 1992, when the Anglican Corporation admitted its financial difficulties in providing health services. Many people who participated in the interview recalled the donation drive and said,

> Suddenly people realized that Makewe needed some help in order to keep working. So my community donated something. I donated half a sack of potatoes. All the communities around the hospital donated something. The Indigenous Association came to my communities to ask help. (Interview with Avelina February 13, 2002)

The survey results about the donations show strong participation from the communities. I asked the households in the area of Makewe-Pelale if they had ever donated anything for the hospital since 1992, out of 103 households, 30 households said yes. But if we look at the responses from the communities close to the hospital, 15 households out of 27 responded that they had donated something for the hospital. Thus, more than 50% of households in the area close to Makewe donated for the administration of the hospital.

Despite the fact that the hospital initiated several donation drives to help

the hospital financially, the donations work more in terms of generating political support rather than providing feasible financial support for the hospital. The majority of the residents in the area are poor and due to the decline in the price of agricultural products as well as famine in the 1990s, the Mapuche communities in the area had limited economic room for donations. Often patients left potatoes, eggs and wheat for the hospital in order to express their appreciation for the service but donations have never been a regular support for the administration of the hospital.

Another method that Hospital Makewe uses to expand participation from communities is constant monitoring of their service. Even though the members of the communities have limited chances to directly participate in the administration of the hospital, they have various channels to evaluate the services. Each community which receives medical service in their community from the hospital evaluates the service and passes it along to the hospital. This practice works to promote participation from the community. José Ladino Cayul explains,

> The evaluation from the communities that receive our service in their communities is important. If there is not input from the communities, there is no use to bring all the medical team to the communities. Obviously if the service is good, people would not like to tell us anything. However, this evaluation is a way to encourage more participation from the communities and to let them know we care about their opinions. (Interview with Jose Ladino Cayul, secretary of the Indigenous Association March 14, 2002)

Since the managing board of the hospital consists of community leaders,

people also feel free to contact Hospital Makewe directly. In the interviews with the patients, various people stated that they would meet the president of the hospital or the members of the managing board of the hospital if they have any complaint or suggestions about the service. The staff members of the hospital also know that if a patient has any complaint they would talk to the officials directly.

> If the patients have any complaint, they would go and talk directly with Don Francisco (the director of Hospital Makewe). Everybody comes here (the administration office) because they know that they could find Don Francisco here. ••• Whoever needs to talk, they look for Don Francisco. (Interview with Rut Hidalgo, administrative secretary of the Makewe February 15, 2002)

To identify the channels of evaluating the service, the survey questionnaire asked the users of the service how they would make their complaints or suggestions. Out of 50 households who use Hospital Makewe, 15 households said that they would talk directly to the director of the hospital; 6 households declared that they would talk to the managing board; 9 households said that they would talk to the representative of their community; 7 households responded that they would use the book of suggestions. Ten households responded that they would not complain or make any suggestions. One household said that they would talk to Dr. Ibaxache, who is the technical director of the hospital. And two households did not reply. In sum, 76 percent (38 households) said that they would express their concern through one of the channels that Hospital Makewe offers. The channels to address concerns and opinions of patients and their

proper functioning are crucial to furthering participation and to improve the accountability of the service, especially when institutionalized racism within health institutions have prevented indigenous peoples in the past from using available channels to express their grievances about the quality of the service.

2. Nueva Imperial: Selected Participation and Division of Communities

The debate among Mapuche communities regarding the proposal to build an intercultural hospital made by the Coordinadora mirrors the conflicts between the state and the Coordinadora. Serious questions arose about the lack of professionalism of the Coordinadora and the content of the organization's proposal. Mapuche communities which do not support the Coordinadora were not shy in questioning the Coordinadora's ability to execute the proposal as a "professional" organization as well as the "authenticity" of the proposal in representing true Mapuche culture. Criticism regarding the Coordinadora's professional ability to build an intercultural hospital intensified when Mapuche communities in the region realized at two community meetings organized by the SSAS that the Coordinadora had not finished the proposal. Several community leaders expressed their frustration.

> We have to deliver our own new ideas about how to construct an intercultural hospital••• These days the state wants some documents and we need to give the documents to the government.

> Then they will think we have our own ideas. We do not want intervention from the state then we need to show the State our own proposal. Talking about an intercultural hospital is not enough. I am frustrated by the fact that the Coordinadora did not come here with their own proposal. (Interview with Julio, a Mapuche community leader, March 29, 2002)

The interviews show that, for some community leaders, the failure of the Coordinadora in submitting their proposal on time meant not only the incompetence of the Coordinadora but also that of the Mapuche communities. They feared the possibility that the state would impose its own vision of an intercultural hospital ignoring Mapuche perspectives on interculturality because the Coordinadora did not offer any proposal. Several participants of the community meetings expressed this fear.

Therefore, the Coordinadora had to face a double pressure regarding deadlines; one from the state and the other from communities. The Coordinadora defended its position explaining its difficulty in dealing with such a mega project without receiving any solid funding from the government and accused the government of not being supportive of their activities during these community meetings. However, the fear of communities that the project is being dominated by the state has grown when community leaders realize that the Coordinadora plans to put a *machi* in the hospital because many interpreted the efforts to place a *machi* in the hospital as a typical showcase policy of the state on the indigenous policies.

According to Mapuche tradition, a *machi*, a spiritual leader of community who is in charge of healing community members, sees and cures patients in

her/his own community. She or he is not supposed to leave one's community since Mapuche believe that the spiritual power of a *machi* comes from the land where he or she lives.

> If a *machi* leaves her territory, she loses her spiritual power. Even though she performs some spiritual healing away from her territory, you cannot know if it works or not. In worst case, she can harm patients because the land does not allow her to heal them. We call them *calco-machi* (pseudo *machi* or bad *machi*), who loses her power and possibly harms patients. (Interview with Francisco Chureo March 11, 2002)

Unlike Western medical doctors, Mapuche believe that each *machi* can do her work in her own territory based on the power of the land. Each community has its own *machi* and its own spirit. It does not make sense for the traditional Mapuche culture that a *machi* of certain community could cure people of the other communities since that *machi* cannot know specific spiritual circumstances of patients who are from different lands. Most community leaders expressed concerns about having a *machi* in the hospital settings.

> a *machi* cannot be in hospital. She needs support from her land, her people and her spirit. A *machi* is not a person who can write prescription as she wishes. Furthermore, a *machi* has one's own territory. We need to be very sensitive and respect each *machi's* territory••• (Maria Porma, a Mapuche community leader, at the community meeting in May 8, 2002)

Even though some Mapuche leaders expressed their concerns about showing the state the image of a divided Mapuche, most leaders did not hesitate to express their concerns. They think that a *machi* cannot be in the hospital and it is not Mapuche culture to move *machis* around for convenience.

At the meeting of May 8, 2002, in the absence of the Coordinadora, some leaders even proposed organizing an alternative committee to write the proposal. The attempts to organize an alternative committee did not succeed; but, it shows the intensity of opposition to the Coordinadora's plan to place a *machi* within the hospital. However, we need understand the reason why Mapuche leaders feel so strongly about having a *machi* in the hospital not only in terms of which measure is more "authentic" Mapuche. The more important question here is why the issue of "authenticity" turned out to dominate the relations among Mapuche communities and ultimately produced a severe division among communities.

The Coordinadora consulted with several *machis* in the region and apparently the Coordinadora got permission from *machis* in the area to submit their project (La Coordinadora Comunal de Salud 2002). Also, the situation that the Mapuche population faces these days is different to what it was in the past and some of the leaders who are strongly against the Coordinadora's project admitted in private that the transformation of their culture cannot be avoided. Even some leaders at the meeting discussed a possible way of having *a machi* in the hospital should the hospital provide enough open space for the *machi* with a proper structure based on Mapuche culture. However, the overwhelming discontent with the

Coordinadora's proposal did not yield any space for these types of opinions.

Division among Mapuche communities over this issue is understandable since Mapuche tradition has not allowed a *machi* to travel to do rituals even though that tradition is under serious challenge. However, the intensity of the resistance to the Coordinadora's proposal should be understood from a more socio-political perspective. The reason why the Coordinadora had such a hard time to convince Mapuche leaders to accept their proposal was not only their proposal's "new" interpretation of Mapuche culture but the fear that the project could be planned and imposed by the state. The strong criticisms of several leaders show this fear clearly.

> For the SSAS, it is easy to say "look! We put a *machi* in the hospital. It is intercultural." They would do it without any problem. I feel it is disrespectful that they think they could locate *machi* or a *Rewe* without consulting us. This project does not reflect our culture. (Rosendo, a Mapuche community leader, at the general community meeting in May 8, 2002)

> At a meeting, we have tried to analyze what the *machi* told us in our community, but we were not taken into account at the meeting. Then we stopped going to more meetings because we felt offended. We did not see any meetings organized by the Coordinadora that analyzed things profoundly as Mapuche··· However, we cannot let things happen like this. We should consult a *machi* and, as a good Mapuche, follow what they would tell you. (Isabel, a Mapuche community leader, at the general community meeting in May8, 2002)

In these comments, it is clear that these leaders see the Coordinadora's proposal as a part of the state's intervention and question its "authenticity" as a true Mapuche project. As Isabel's remark shows, even if there are *machis* who agreed to come to the hospital, those *machis* could be "bad" *machis*. The discontent of some Mapuche leaders was intense enough to challenge the authority of some *machis* in their own area. And this intense discontent, I argue, stems from the fear that this state driven project exploits their culture without changing the system itself. In other words, the strong presence of the state in the project made some Mapuche leaders immediately oppose any radical or new interpretation of their culture and see it as a part of the state's attempt to distort the project. And they did not hesitate to accuse the Coordinadora of not being Mapuche enough or not being authentic Mapuche.

The strong presence of the state in multicultural social programs has often been criticized for dividing communities and diminishing genuine participation from the communities. Often the state has been portrayed as an active divider with the agenda of destroying indigenous activism. The "divide and conquer" strategy has been seen to persist and be "unchanged" since colonization. However, the case of Hospital Nueva Imperial shows that the division and conquer strategy, if any, needs to be examined in a much more complex context. In the case of Hospital Nueva Imperial, the state did not actively engage in dividing the communities but the strong presence of the state itself triggered enough worries and fears from communities about state intervention. Due to the long history of state intervention and oppression, both the Coordinadora and Mapuche

communities desperately sought a measure to prove that they were not a part of the state. The distrust between the state and communities ironically worked to deepen the division among communities rather than to unify the communities against the state.

If the strong presence of the state places structural conditions for possible division and antagonism among communities, the Coordinadora could not overcome this problem because of its preference for selective participation. The Coordinadora could not avoid being suspected as of not being "Mapuche enough" because it failed to galvanize broader support and communication among indigenous communities. Most leaders who participated in community meetings and were interviewed by me said that the Coordinadora did not fully devote itself to organizing and mobilizing the base for its cause. Several leaders raised the possibility that the Coordinadora intentionally excluded some community leaders who questioned the Coordinadora's proposal. The survey results also show that there was not a massive participation from communities in the project.

Only 20% (19 out of 97) of respondents replied correctly to the questions of who administered the project of construction of the intercultural hospital of Nueva Imperial. If we look at the actual rate of participation in any meetings called by the Coordinadora, the number is small, too. Only 21% (20 out of 97) of respondents said they participated in any meetings to do with the project. To the question of whether they had ever donated anything for the project, even smaller number of (6 out of 97) households said yes.

The Coordinadora itself acknowledges the fact that they were not

effective in getting participation from a broad range of communities in the area. They also admit that they know about the complaints against them over lack of participation. However, as the Coordinadora repeatedly pointed out, the number of communities that they have to cover is huge considering the fact that none of the working members of the organization has the resources to visit all these communities and talk to them. Despite the lack of communication between the Coordinadora and communities in the area, the Coordinadora argued that a relatively large number of community leaders have been participating in meetings. One of the members of the Coordinadora criticized those leaders who did not participate in the meetings and then expressed concerns later in the meetings organized by the state. The problem for the Coordinadora is that only those who can travel easily to the meetings could participate in the meetings and it strongly limited the range of participation that the Coordinadora could organize. That's why most leaders who expressed their concerns about the Coordinadora see the participation as not authentic.

The debate regarding the authenticity of the Coordinadora's proposal is more than a mere debate about interpretation of Mapuche culture. The issue of who was correct in the interpretation of their own culture became a litmus test of the authenticity of the project. In the end, the Coordinadora did not have adequate support either from the state or from the communities to pass the test. The difficult relations between the state, the massive scale of the project, and the strong presence of the state in the project limits the Coordinadora's ability to mobilize the base. However, it is also true that the selective participation in the activities of the Coordinadora

failed to persuade either the state or communities that they are "authentic" representatives of the communities in the area.

Ⅵ. Program Evaluation

1. Hospital Makewe

In my interviews concerning their satisfaction with Makewe, patients showed a high level of positive opinions about the hospital. The first question of the survey was why people used the service from Makewe. Since the hospital had been a private hospital up until 2004, the residents of the community can choose one of various health institutions available in the area. For example, a resident of the municipality of Padre las Casas can choose between the Municipal Clinic of Padre las Casas and Makewe. The majority, 34 out of 50 households who use Hospital Makewe answered that they chose the hospital because of the high quality of its service. Twelve households said that they chose the hospital due to proximity. Four households responded that they chose Makewe because of lower cost.

I asked how long they normally had to wait to see a doctor or nurse in Makewe. This question is important since the major complaint about the public health system is its very long waiting time. The IX Region is not an exception to this trend. In February 8th of 1998, *Austral* published a special report on the quality of service in public hospitals in the region and the title was "Cuando la Salud Depende de un Número: Humillante Espera (When health depends on a number: Humiliating Wait)".

The majority, 29 out of 50 households who used the hospital service at Makewe said that they waited less than one hour. Eighteen households said that they waited more than 1 hour but less than 2 hours. Two households stated that they waited more than 3 hours. Even though many patients stated that the waiting time in Hospital Makewe was short and was strictly based on first come first serve, I found in my observations over a week in the reception area of the hospital that people usually waited about two hours on average except for those who arrived before the opening of the hospital.

The discrepancy between my observation and the patients' feeling on waiting time are possibly explained by strong patients' satisfaction with the hospital's efforts to minimize waiting time. Furthermore, patients stated in the interview that "unlike the other public hospitals" they were confident that Hospital Makewe would serve patients on the basis of "first come, first serve" without any discrimination based on their ethnicity or income level. And the absence of favoritism and discrimination is an important issue in influencing a patient's feeling about waiting time. Many interviewees stated,

> If I have to wait, it is something normal because there are people who arrived earlier than I did. Obviously they should be attended first because I arrived late. And they (doctors and nurses) will attend me later. I do not have any problem with that. (Interview with Silvia February 19, 2002)

> Sometimes I have to spend all day to be attended by doctors or nurses because I live very far from the hospital and there is no good transportation to come here. But if I arrive early, they will treat me early. It is not like city (Regional Hospital of Temuco),

> where you need to know somebody to be treated early. (Interview with Celestino February 19, 2002)

The discrepancy between actual waiting time and the perceived waiting time reveals an important element with health care reform. The impact of health care reform does not entirely rely on the effectiveness of health services per se. It also relies on the "cultural' aspect of the service. When the cultural problems that specific patient groups face such as discrimination or inequality dissolve, the users of the service respond quite positively to the reform as a whole. I do not argue here that the cultural aspects of such a policy define its entire results. Rather I maintain that the success of health care reform depends on both sides of the reform: the expansion of cultural rights and the improvement of social rights.

One of the reasons why people positively react to the service provided by Hospital Makewe is because the hospital tackles not only the problem with social service delivery but also the cultural problems inside the service delivery system. This point becomes clear with the issue of the clarity of doctors' explanation of the illness. When asked how clear the explanation was provided by doctors about their health problems, forty seven out of 50 households, users of Hospital Makewe, answered that the explanation the doctors gave to them was clear. Only two households answered that it was so-so and one household answered that it was not clear. The perception that doctors' explanation are clear stems from the fact that doctors try understand better the cultural aspects of the Mapuche. One of doctors, Jaime Ibaxache, the director of technical team of Makewe, could speak fluent *Mapudungun*. Also there is a paramedical health worker, who is

Mapuche and a native speaker of *Mapudungun*. Overall, many patients stated that they feel "known" in this hospital since nurses and doctors "know" them. This familiarity also facilitates communication between the doctors and patients.

When I asked about the general quality of attention given by health workers in the hospital, thirty one out of 50 households reported that it was very good and 16 households said that it was good. And there was not a single household that expressed dissatisfaction with the service. We could see that the high level of satisfaction is closely related to the feelings of the patients about the service. Hospital Makewe is an old hospital with limited resources as well as staff. It is not by any means the best hospital in the area. However, the patients give the highest marks to the service of the hospital due to the fact that they feel comfortable and safe in the hospital.

The next question was how the patients feel about the treatment. I asked how they evaluate the doctor's treatment of their illness. Forty three out of 50 households answered that the doctor's treatment was adequate. The adequacy of the treatment is also closely related to the effectiveness of communication between doctors and patients. If a patient feels that she/he had communicated well with the doctor about her/his illness, the probability that the patient would agree with the treatment becomes higher. Also the adequacy of the treatment is closely related to the attitudes of doctors toward Mapuche culture. Since the hospital seriously pursues an intercultural health program, the attempts to combine the two medical knowledge increases the perceived adequacy of the treatment. Many

patients stated their concern that Western doctors could not find the true cause of their disease because Western doctors do not know about their culture and "Mapuche illnesses". If a Mapuche patient sees that doctors acquire knowledge about both cultures, she/he felt more confidence about the doctor's treatment.

Finally, I asked how they evaluated the service of the hospital in general. Again the majority indicated that they evaluate the service as very good or good. It is clear that Hospital Makewe has a distinct working environment and rules that make health workers more effective and accessible to the patients. Hospital Makewe also incorporated many innovative policies in the administration of the hospital. For example, unlike the other hospitals in Chile that strictly restricts time for family to visit hospitalized patients, Hospital Makewe encourages family members to come and stay with their ill relatives. Some health workers expressed concern because letting family members in the hospital at all times often impedes their work. But these workers did not deny that it had been good for the patients.

The satisfaction level with Hospital Makewe is very high both in the answers to the survey questions and in my in-depth interviews. It is surprising since Hospital Makewe is an old and insufficiently funded hospital with a limited number of workers as well as services. Despite the efforts to deliver the service as efficiently as possible, the hospital does not differ much from any public clinics in the area. Then why does it make such a "satisfactory" hospital for Mapuche patients in the area?

The importance of achieving complex set of goals in multicultural social policy gives us answers to this question. Mapuche patients who used the

hospital perceived the service is good not only because the hospital offers effective service but also because the hospital tackles specific issues that Mapuche communities face in the health care system such as discrimination, poverty and need for an intercultural approach to health and illness. In other words, the intercultural health program in Hospital Makewe attempts to expand both social rights and cultural rights.

2. Hospital Nueva Imperial

The satisfaction of Mapuche patients in Hospital Nueva Imperial varies largely depending on which health workers they happened to meet in the hospital. And it is closely related to the fact that non-Mapuche's perception of Mapuche patients depends on individual preferences. Some Mapuche patients claimed that they experienced severe discrimination against Mapuche patients while others were very happy with the service.

> Doctors and nurses at least treated me very well. I did not have any problem. (Interview with Raul, a patient visiting the emergency room, April 22, 2002)

> There are not many Mapuche working here. So, if a Chilean (non-Mapuche) or a more or less "Westernized" person came with a good look and talked to the window (of office), that person would receive preferential treatment. A Mapuche, if badly dressed and cannot express oneself clearly, does not receive any favor. Actually a Mapuche has hard time understanding all the procedures. They said to a Mapuche to wait a minute but she/he ended up waiting hours. I have bad experiences··· The service here is bad. There is discrimination against the Mapuche as well as against poor peasants.

(Interview with Orlando, a patient waiting at the pediatric, May 9, 2002)

The nurses and doctors who treated me are nice. I did not have any problem personally. It depends on your luck•••ha ha.. If you happened to be treated by a bad nurse, you will feel bad. If you meet a nice nurse, you are okay. (Interview with Melissa, a patient, May 9, 2002)

The survey results reflect the same pattern. Thirty eight percent of the respondents said the service of the hospital in general is very good or good while 35% thinks the service is bad or very bad. Twenty seven percent said it is neither good nor bad. Regarding health workers of the hospital, the same pattern appears. Thirty one percent of patients think health workers treated them well while the other 31% said that they were not treated well by health workers. Most of patients said that doctors' explanations are clear. Note that the level of satisfaction of Makewe Hospital was much higher.

The bilingual worker of the hospital, Antonio, also told me that how a Mapuche patient is treated is largely based on who would treat the patient. If a Mapuche patient is lucky enough to meet a health worker who is not prejudiced against the Mapuche population, she/he will be treated well. If not, she/he will be in trouble. Due to the absence of a systematic channel to control the quality of service, the quality of service largely depends on each individual worker's conscience. The lack of a mechanism to control the quality of the health service is directly related to the lack of channels to address complaints or suggestions about the administration of the hospital.

Even though some of the leading members of the Coordinadora

acknowledged the unpredictable and often low level of satisfaction of the service provided by the hospital and the presence of discrimination at the hospital, they said that they do not see the channels or the power to change the whole system since they do not participate in the administration of the hospital. Even though they can receive complaints from Mapuche communities regarding the health service, how to address those complaints again depends on how each leader of the Coordinadora decides to resolve the issue. Some of them told me that they would talk to the director while some of them told me that they do not have a definite way of handling the issues yet.

The lack of channels for participation from the communities in the administration of the hospital is also reflected in the survey results. Sixty five percent (63 out of 97 households) of respondents replied that they would address their issues with the hospital administration, while 35% (34 out of 97) of respondents said that they either do not know how to address the issue or they will not say anything about the issue. The majority of the respondents showed willingness to express their opinions and concerns about the hospital. The issue is whether there is a proper channel to direct participation of communities to improve the administration of the hospital.

Since there is no feasible way to direct their opinions, a near majority (27 out of 63 cases) of the respondents who said that they would address their grievances to the administration replied that they would use the opinion box. However, according to my observation in the lobby from March to May of 2002, the opinion box was used as a small trash can. To

submit complaints through the opinion box, you need to write your name, social security numbers and home addresses in Spanish. Considering patients' concern about retaliation from the hospital and the status of Nueva Imperial Hospital as the only public hospital in the area, this is not the best way of encouraging participation from patients. Actually one of the paramedics said that the system protects the "higher" level of the health workers such as doctors and nurses.

Furthermore, according to Sonia, the secretary to the director's office, the total number of complaints submitted through the opinion box is 2-3 per month. She said that the director's office directly responds to the complaints and there was not a serious problem in handling them. The small number of complaints about the hospital may represent good performance on the part of the hospital. However, taking account of the low satisfaction levels with the hospital and many concerns regarding the hospital's service, too few complaints are more likely to represent the lack of a systematic channel to address patients' concerns.

The lack of a channel to address concerns and recommendations from communities to the administration of the hospital became one of issues for the project. Through community meetings on the project, several Mapuche leaders pointed out that co-administration is crucial to make the hospital truly intercultural. The Coordinadora, in its final version of the project, also stated that they would be interested in negotiating how to co-administrate the hospital. Thus, it never became the central issue of the whole project. Most health workers and the Coordinadora itself focused on how to build the intercultural 'annex' to the hospital and administer the "intercultural"

space. Since there was a major dispute regarding how to administer the intercultural part of the hospital - about presence of a *machi* inside of the hospital or putting a *rewe* in front of the hospital - the issue of increasing the community's participation and presence in the new intercultural hospital did not receive serious attention. Only 3 out of 97 respondents see the Coordinadora as their voice in the hospital.

It is quite ironic to evaluate the impact of the intercultural project on the satisfaction of the patients or the possible future impact of the project on the satisfaction of the patients. The goal of the project is to improve Mapuche patients' satisfaction level with the service of the hospital as well as increasing the accessibility of the hospital. However, this project has not addressed the key issue of how to listen to communities' opinion about the service nor to induce communities' to participate in the administration of the hospital in an organized way. While most discussion was centered on the issue of what is the culturally "authentic" intercultural project, one of essential issues of the project - to make the hospital more accessible and satisfactory to Mapuche patients - was constantly ignored. Furthermore, limiting the Coordinadora's function to planning - not administering- the annex to the hospital, the Coordinadora did not have much to say about the quality of the service in general, which the majority of Mapuche patients see as poor.

Ⅶ. Conclusion

The different types of participation and the dynamics between actors

affect the level of satisfaction differently. In Makewe Hospital, where wide participation from communities in administration of intercultural health program existed, the participation contributed to increased levels of satisfaction. The participation of communities allowed a higher accountability within the system which led to a health program sensitive to the demands of patients.

More importantly, for the administrators of the hospital, the high satisfaction level is a key to maintain its power in Mapuche communities as well as in the negotiation with the state. It made every effort to eliminate any discrimination against the Mapuche in the hospital and those efforts influence the level of satisfaction.

This illustrates a very important issue about community participation program in health and how to evaluate such a program. As the case of Hospital Makewe shows, the satisfaction level of health services depends greatly upon both the goals of increasing the efficiency of the health service and of expanding patient's rights within the health service system. Focusing solely on the efficiency of health service delivery system cannot guarantee the improvement of satisfaction level. Only when both goals were pursued and achieved with significant participation from communities, could the satisfaction level of an intercultural health program be improved. Since Hospital Makewe succeeded in achieving both goals more than did Hospital Nueva Imperial, patients in Hospital Makewe expressed higher satisfaction levels.

Therefore, comparing the level of satisfaction of two cases, we can conclude that the participation from communities could have a positive

impact on the level of satisfaction only when it could truly relate to the overall transformation of the system aiming at achieving both goals: improvement of health service delivery system and the expansion of patient's rights. If not, as we could see in the case of Hospital Nueva Imperial, it is hard to expect that selective participation, which does not have much impact on both the improvement of health services and the expansion of patient's rights in the hospital, would improve the level of satisfaction of the service.

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Appendix: List of Interviews

Francisco Chureo March 11, 2002

Jose Ladino Cayul March 14, 2002

Rut Hidalgo, February 15, 2002

Maria Porma, May 8, 2002

Avelina*, February 13, 2002

Julio*, March 29, 2002

Rosendo*, May 8, 2002

Isabel*, May8, 2002

Silvia*, February 19, 2002

Celestino*, February 19, 2002

Raul*, April 22, 2002

Orlando*, May 9, 2002

Melissa*, May 9, 2002

(* a pseudonym was used due to the interviewee's request.)

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