

Dealing with ‘*Mapuche Permitido*’: Faces of Neoliberal Multiculturalism in the Chilean Health Sector

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ABSTRACT

Inclusion of indigenous workers in the public sector under neoliberal multiculturalism creates different locations within the state where indigenous workers enter: (1) governmental nonindigenous sector, (2) governmental indigenous sector, and (3) nongovernmental indigenous sector. The impact of including Mapuche workers in the Chilean health sector is explored via differing effects in diverse state locations. After detailed examination of Mapuche workers in various areas, I argue that the state in an era of neoliberalism evolves into a multilayered entity, whose impact on Mapuche workers varies depending on location.

Key Words: Chile, neoliberal multiculturalism, Mapuche, public health, racism

INTRODUCTION

Inclusion of indigenous peoples became a keyword for development programmes that attempt to address demands from indigenous peoples in Latin America. As a result, many indigenous professionals are included in the state or become a part of state actions. Some enter the state via indigenous programmes while others become state employees in nonindigenous programmes under affirmative-action types of considerations. More important, large numbers of indigenous workers are hired in various social organizations or nongovernmental organizations

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(NGO) which become a part of the state's indigenous policies. Existing evaluations of these workers in the state have not paid enough attention to different locations in the state where indigenous workers are employed as a part of the state or state actions. Most analyses of the impact of inclusion have focused on generalised assessments of whether such inclusions benefit or harm the overall indigenous movements without considering the specific changes experienced by indigenous workers in the state and the strategy of the state to control indigenous workers. Instead of reopening different locations of the state produced by inclusion of indigenous workers in the state or state actions, many scholars portray the state acts as a single entity with centralized power (Lucic 2005; Millaman 2000; Bengoa 1983; Aylwin 1998).

This dominant view of the state as a monolithic entity is understandable when the history of indigenous peoples' struggle against the ethnocentric state is considered. Indeed, there was nothing 'inclusive' about the state in its brutal invasion of indigenous territories. However, it is also true that, with the emergence of civilian governments and the wave of institutional democratisation in Latin America, the states there seem gradually to cede more power to the local governments and open up spaces for indigenous peoples. Hale defined such changes in indigenous policy in Latin America as neoliberal multiculturalism (Hale 2002). Based on a case study of Guatemalan neoliberal multiculturalism, Hale wrote that such inclusion of indigenous workers in the state is not to open spaces for generalised empowerment of indigenous peoples but to create a dichotomy between 'Good' or 'Authorised' *Indios* and 'Bad' or 'Unauthorised' *Indios* (Hale 2004). Not completely discarding the possibility of some productive attempts from *Indios Permitidos*, he warned that working within the state under neoliberal multiculturalism would be risky.

While Hale correctly elucidates the danger of a growing division among indigenous workers/activists along the lines of *Indio Permitido* vs. Others, Park and Richards point out limitations of homogenous understanding of *Indio Permitido*, showing examples of Mapuche workers within the state who challenge the state from within (Park and Richards 2007). They argue that there are differences in actions taken by indigenous workers within the state and such differences need to be considered seriously to develop more nuanced understanding of a complex and ambiguous nature of neoliberal multiculturalism in action. While Hale and Park and Richards offer valuable points in analysing a growing number of *Indio Permitido* in many Latin American countries, one question remains: What makes the differences in actions taken by *Indio Permitido*? Hale never denies

the possibility that some indigenous workers in the state could provide productive efforts to enhance general indigenous peoples' empowerment. Park and Richards further the case and showed that there is a difference in the degree of co-optation by the state or challenges of indigenous workers against the state. However, the question of what actually causes such differences in state actions still remains.

In this article, I attempt to answer the question, explaining that the different locations within the state could make a difference in indigenous workers' consciousness as well as actions. I do not deny the fact that individual indigenous workers' class and educational backgrounds would generate great differences in terms of their actions within the state. However, after looking at various Mapuche workers in the Chilean health sector who share relatively similar class and educational backgrounds, I came to realize that location within the state, more specifically distance from the centre of the state, is also a very important element to consider in exploring the variation of actions taken by indigenous workers. And such analysis based on location within the state will lead to better understanding of neoliberal multiculturalism as a new technology to govern *at a distance*.

To explore the impact of different locations within the state on indigenous workers, I focus on the case of the Chilean health sector and the Mapuche, who make up about 80 per cent of the indigenous population. The Chilean health sector is an ideal case to use for examining different locations within the state. The Chilean state, with a generally strong centralising structure, has expressed reluctance to decentralise social services such as health care (Angell, Lowden and Thorp 2001; Scarpaci 1991). Contrary to its reluctance to decentralise other state functions, the Chilean state has actively invited local governments and NGOs to replace the state in indigenous programs. As a result, the Chilean health sector developed significantly distinct locations within its structure where the Mapuche work: (1) governmental nonindigenous sector, (2) governmental indigenous sector, and (3) nongovernmental indigenous sector. And these different locations not only represent different levels of state intervention but also induce different actions from Mapuche workers.

BACKGROUND

Chile has followed neoliberal economic policies since the Pinochet regime and the basic principles have not been altered by civilian governments.

The health sector reflects this continuity of economic policy.

The central problems of the Chilean health system are the inequalities. The introduction of a private health insurance system (ISAPRES: Health Institutes) constituted a regressive form of targeting because health care was being financed by a payroll tax. And it helped to deepen the crisis in the public health system (FONASA: National Health Fund) due to transfer of funds from the public system to the private. Most people in the four lower quintiles are covered by the public health system, and only in the richest quintile does ISAPRES cover a higher proportion of people than FONASA (French-Davis 2002). According to FONASA, 73.49 per cent of the total population is covered by FONASA and only 15.90 per cent is covered by ISAPRES (Fondo Nacional de Salud 2010).

The inequalities become even more remarkable when we look at the health situation of indigenous peoples. Many available but incomplete epidemiological data show that municipalities with the largest concentrations of indigenous populations have more serious health indicators than the rest of the country.¹ For example, the infant mortality rate during the period 1988-1992 40 per 1,000 live births among the Aymara the rate was; 57 among the Atacameños; 32 among the Rapa Nui; 34 among the Mapuche, while the average infant mortality rate in Chile is 11.1. Health conditions among the indigenous population appear to have worsened even more in urban areas than in rural ones.²

To address health inequality in general, the Chilean health reform has introduced decentralisation in ministerial policies. Chile Decree N 1/3063, ratified in 1980, transferred the responsibility for the administration of primary-care facilities to the municipal level. By 1988, most of the establishments of primary health care in Chile came under the control of municipal governments (Scarpaci 1991, 115). Municipalisation of primary-care in Chile is an attempt to decentralise the administration as well as improve accessibility of the service, tailoring it to the needs of each community.³ Regional Offices of the Health Ministry were established throughout the country, with oversight for particular programmes as well as secondary and tertiary levels of care. Control of

1 PAHO, *Chile: Profile of the Health Services System*.

2 From the national census of 2002, the main indigenous ethnic groups in Chile are listed as the Mapuche, Aymara, Rapa Nui or Pascuense, Atacameño, Quechua, Colla, Kawashkar or Alacaluf, and Yámana or Yagán. Mapuche is the largest ethnic group in Chile, which represents 87% of the indigenous population. The second largest group is Aymara (7%) followed by Atacameño (3%). Quechua, Rapanui, Colla, Alacalufe, and Yámana correspond to 0.9%, 0.7%, 0.5%, 0.4%, and 0.2% respectively (INE 2005).

3 PAHO, *Chile - Basic Health Indicator*.

the Regional Offices and their budgets remained firmly under the Ministry of Health in Santiago, however.

Contrary to health reform in general, which does not reduce the power of the centralised state, health reform for the indigenous peoples in Chile invited more participation from both local/regional governments as well as nongovernmental sectors. First, the Regional Health Services of the IX Region introduced the Bilingual Information Services to serve the Mapuche population and the Patient Care Services to greet and accompany patients and their families from admission to discharge at the hospital. From the perspective of the state, a bilingual office within hospitals, hiring indigenous health workers, and allowing some input from indigenous communities in hospital administration was expected to improve the accessibility of the service and reduce the inequality between indigenous and nonindigenous populations. Second, in addition to the Bilingual Information Services, the Chilean civilian government created the Health Programme with Mapuche (Programa de Salud de Mapuche: PROMAP) in IX region in 1992 and soon launched the national Health Programme with Indigenous Peoples (Programa de Salud con Pueblos Indígena) within the Ministry of Health in 1997. Both the building of the Bilingual Information Services in the southern states in Chile and the inauguration of health programmes for indigenous peoples were a part of the civilian government's reaction to the demands from Mapuche communities to promote intercultural health by incorporating their medical knowledge into the Chilean medical system. The steps represented the restoration of their culture as well as an improvement in the health situation among Mapuche communities (Cañulef and Díaz 2000; Ibxache).

The different dynamics of health care reform in Chile created different types of new governmentality in distinct locations within the state. The most notable distinction exists between the nonindigenous governmental sector and the indigenous governmental sector. While the nonindigenous governmental sectors continue to be tightly monitored as well as controlled by the central state in every decision, the indigenous governmental sector enjoys relative freedom from such regulation. Important indigenous health programmes emerged from local government initiatives and stayed as successful regional health programmes until the Ministry of Health decided to join the cause, installing the national indigenous health programme. However, the relation between the national Health Programme with Indigenous Peoples and other regional indigenous health programmes did not grow into a hierarchy between the central and the regional governments.⁴ The difference between the governmental and the

nongovernmental indigenous sectors in health is also clear. Even though the governmental indigenous health programmes receive less monitoring from the Ministry of Health, they require following basic governmental guidelines as state programmes, while the nongovernmental indigenous sector is much less controlled by the state and even has an option of terminating its relation with the state.⁵

The different types of state control in various locations within the state create different dynamics between the state and Mapuche health workers in each site. And such diversity is one of the reasons why the patterns of actions taken by Mapuche health workers vary greatly. I argue in this article that diverse dynamics within the state illustrate neoliberal multiculturalism as a new governmentality to govern indigenous peoples *at a distance*, and the analysis of different dynamics in various locations within the state clarifies the fact that in the case of the Chilean health sector, distance from the central government actually matters in the practice of *governing at a distance*. In the following section, I turn to the theoretical tools that will shed light on the importance of location within the state to analyse Mapuche workers within the Chilean health sector.

NEOLIBERAL MULTICULTURALISM AS A NEW GOVERNMENTALITY

Many have considered the state to be equated with a particular political economic discipline –capitalism or communism– and the action of the state has been identified with the political economy of the state. Marxist understanding of the state is an example of identifying the state with state action. In *Manifesto of the Communist Party*, Marx argued that the state is only a committee for managing the common affairs of the whole bourgeoisie (Marx 1967[1888], 221). Although in *The German Ideology*, he acknowledged the possible autonomy of the state from the bourgeoisie when there are various competing classes in the society without a dominant class (Marx 1960[1845]), Marx expected that the state would act on behalf of the bourgeoisie once a solid capitalist system emerged. In the modern capitalist society, the state represents capitalism, the dominant political economy, and acts against the will of the proletariat.

Unanswered in Marxist theory is the question of how the state actually

4 Interviews with Margarita Saez, Jaime Iboxache, and Ricardo Celis.

5 Field observations; Interviews with Mapuche activists.

perpetuates the spirit of capitalism to the masses, who often oppose the bourgeoisie. More important, the question of how politically to transform the state, if possible, grew into a crucial part of inquiry for many scholars. The call to answer these questions became urgent with the emergence of formal/institutional democracy and the formal separation between politics and the economy in Western societies.

Foucault addresses the questions with the notion of governmentality and understanding the nature of state action. Governmentality or rationality of government for Foucault means “a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it was practiced” (Gordon 1991, 3). Contrary to many who identify the state with its action, Foucault distinguished the state from its governmental action. Foucault pointed out that “political economy is a form of scientific knowledge of which the government needs and realizes, but what political economy can not do for the state is to generate a detailed, deductive programme for state action” (Ibid, 16). The state pursues its political economic principles (capitalism, communism, or socialism) but political economy of the state does not always explain the actual actions of the state with respect to its political economy. Defining a state as capitalist or socialist does not translate directly into actions to promote its political economic ideology in society. For Foucault, it is governmentality that actually makes the political economy of the state penetrate into, manipulate, and, in some sense, persuade society. In doing so, he explained what neoliberalism actually means: Neoliberalism is not a new mode of political economy or philosophy but a new way of governmentality.

According to Foucault, one of the primary challenges to Western societies became how to rationalise the role of government as it became less reliant upon political institutions of the state and “to develop techniques for *governing at a distance*, relying increasingly upon a pluralisation of forms of governing and of technical, organizational, and administrative knowledge” (Hay 2003) based on the principle of individual freedom to self-govern. Modern societies not only develop dominant hegemony to create consensus within the society but also perpetuate the principle of self-government through technology of the self, which encourages citizens to govern themselves based upon morality or an “ethic” of self-reliance. Neoliberalism encourages ever greater reliance upon self – self-expertise and self-governing as essential components of a new form of governmentality affecting every

aspect of life. Because neoliberal governmentality emphasises that citizens should not be subject to direct forms of state control, “it relies upon mechanisms for governing ‘through society’, through programmes that shape, guide, channel – and upon *responsible*, self-disciplining social subjects” (Ibid., 166).

The governmental indigenous and the nongovernmental indigenous programmes in the Chilean health sector fit Foucault’s notion of technology of the self from neoliberal governmentality. The health programmes for Mapuche people emphasize participation by them to be responsible partners in the social policy. Not just the state but also Mapuche people are expected to participate in the process. More important, this approach aims to reform the health sector by reducing direct control by the state as well. Rather than direct coercion and repression of Mapuche people, the state can instead adopt self-relying and participatory methods to govern them. Through these programmes, the state can govern indigenous communities *at a distance*.

One aspect that Foucault’s new governmentality does not address, however, is the hybrid reality of Latin America, where diverse political rationalities coexist rather than evolve. Foucault’s notion of transformation of governmentality in Western societies may explain European experiences of political development, but in Latin America the introduction of a new governmentality (in this case, neoliberal multiculturalism) does not mean a rupture from the previous form of political rationality. The insertion rather tends to add one more dimension to the existing melting pot of political rationalities, and I argue that different locations within the state often reveal different rationalities that influence greatly the actions by Mapuche workers within the state. By analysing Mapuche workers’ training experiences as well as their attitudes toward Mapuche issues, I show that old governmentality and new governmentality coexist in Chile. The coexistence of governmentalities ultimately produces varied actions from Mapuche workers within the state.

METHOD

The focus of this paper is Mapuche health workers who are employed within or with the state in Chile. More specifically, I will analyse the training that Mapuche workers receive as ones who work within or with the state as well as their attitudes/perceptions regarding Mapuche issues in general and specifically the health situation of the Mapuche population.

By doing so, I will consider how different locations with disparate governmentalities within the state elicit diverse actions and attitudes of Mapuche workers toward Mapuche issues. During the fieldwork for this research in 2001 (June to July) and in 2002 (January to August), I conducted more than 100 interviews with Mapuche health workers, patients, and governmental officials both in IX Region (Temuco, Nueva Imperial, Padres las Casas) and Santiago (la Pintana and la Florida). In 2010, I visited Chile again and conducted fieldwork on indigenous health workers. Three more in-depth interviews with indigenous public employees who work in the health sector and three non-indigenous health workers were conducted. Here I focus on 38 interviews with Mapuche workers employed in public hospitals and with the regional governments through nongovernmental programmes. All the workers self-identified as Mapuche and share relatively similar socioeconomic backgrounds as low-level health workers or low level administrative staff. Their ages range from 21 to 52, with the majority of the interviewees in at their 20s.

FINDINGS

With neoliberal multiculturalism, the entities where Mapuche workers have started to work within or with the state are in the following types of programmes: (1) governmental nonindigenous sector, (2) governmental indigenous sector, and (3) nongovernmental indigenous sector. The emergence of indigenous nongovernmental programmes is a direct result of neoliberal multiculturalism, which led to a growing transference from the state to local governments or to NGOs key state indigenous programmes. Although those spaces are meant to be independent from the state, they continue to be controlled by state regulations and are under supervision by the state, which means nongovernmental indigenous programs form a part of the state. With neoliberal multiculturalism, the state is not reduced but rather diffuses its power by establishing different locations where we find different governmentalities.

This article focuses on the Mapuche who work in the three locations within the state. The fourth possible location –nonindigenous nongovernmental programs– is omitted because of lack of cases.

Governmental Nonindigenous Sector

In this sector, the strongest co-optation or perpetuation of hegemonic

discourse about the Mapuche population was found. Mapuche workers in this sector identify themselves as Mapuche and clearly indicate that discrimination against Mapuche is a general occurrence. Regarding their own work, however, they repeat the discourse of the state. Rodolfo⁶ is a Mapuche paramedic in the biggest public hospital in the city of Nueva Imperial. The hospital is run by the regional government with 100 per cent of its funding from the state.

During the interview on the health situation of the Mapuche population and the attitude of the Mapuche on being patients, he clearly stated that he personally had experienced discrimination; but he separated his own experience from the institutional discrimination in any public hospital.

More than anything, because of the lack of communication and information about diabetes or high blood pressure, the Mapuche have those problems. A lot of Mapuche patients have diabetes and high blood pressure, but they do not even know what diabetes or high blood pressure is [...] Then the problem became very difficult to fix. A lot of Mapuche patients come to the hospital because of these diseases. *But the diseases affect the Mapuche population because they do not know what to eat.* In the past, they eat healthy food but not now. They eat a lot of bad food which causes those diseases.⁷

He asserted that the health problems of Mapuche patients are caused by the individual Mapuche's ignorance or bad habits. When he talked about Mapuche patients, Rodolfo repeated the hegemonic discourse about the health situation of Mapuche, that the ignorance and bad habits of the Mapuche population cause health problems. Furthermore, when he engaged in hegemonic discourse to answer the question, he switched from the pronoun 'we' to 'they' to describe the Mapuche population. This change suggests that he sees himself as somewhat separated from the Mapuche as a group.

This tendency was even clearer when I asked about the transformation of the hospital into an intercultural one, where traditional Mapuche healers could see patients. He said,

Well... *People in the rural area* in general do not know about the management of the hospital. But if you work here in the health sector, you can understand a little bit more. *Those Mapuche who live in the rural area* would say that this

6 I use pseudonyms to protect the interviewees unless an interviewee gave me permission to use one's full name or the interviewee is a public official whose information is public. The interviews are translated by the author from Spanish.

7 Interview with Rodolfo. Emphasis added by the author.

hospital is Mapuche now. Mapuche will demand more and more. Because it is *their nature*. Mapuche always demand more and more. *They* never stop.⁸

When Rodolfo identified Mapuche as those people who live in the rural area and those who always demand and never stop, he was repeating prejudicial stereotypes perpetuated by the dominant Chilean society. And when he engaged in hegemonic discourse, he continuously separated himself from 'those Mapuche'. His perception of Mapuche influences his attitude toward the indigenous health programmes in general but particularly toward the transformation of his hospital into the first intercultural public hospital in Chile. Rodolfo was sceptical about the transformation and doubted that Mapuche could manage a part of a modern hospital, due to 'their nature', which is 'to demand more and more'. When he referred to this 'Mapuche' attitude, he separated himself from the whole Mapuche community – 'those Mapuches' who live in the rural area. The administration of the hospital, which is not indigenous, has tried to implement this new form of health care for years. Rodolfo, who only works on nonindigenous issues, does not believe in the possibility of successful management by Mapuche communities of an intercultural hospital, reiterating the dominant point of view toward the Mapuche.

Another public employee of the hospital, Javier, shared the same attitude. He worked in the reception area of the hospital. He is Mapuche, but his work was not related to indigenous issues. He rejected the assertion that non-Mapuche doctors do not respect Mapuche health workers at the hospital and that there is racial discrimination against the Mapuche population there. He thinks there is racial discrimination in the society in general, but not in the hospital where he works.

YP: *Some Mapuche told me that it takes more time for Mapuche to see a doctor. They told me that they had to wait more than 'winkas' (Non-Mapuche Chileans) at the hospital. What do you think about this?*

Javier: It is a lie.

YP: *Lie?*

Javier: It is a lie. Maybe the Mapuche do not have good transportation so it takes more time for them to come. But it is not true that a Mapuche needs to wait more than a winka because she/he is a Mapuche. There are many Mapuche who have bad Mapuche temper and say that everything wrong is because of winkas. But we need to be very objective and impartial here. [...] There is no discrimination against the Mapuche patients in the hospital. People, no matter who they are, Mapuche or not, have to wait

8 Ibid.

more because of the market. Doctors want to work in private clinics, and the state does not have enough money to hire more doctors. So everybody waits. It is not true that the Mapuche need to wait more than the *winka*.⁹

Before the interview began, however, he expressed strong opinions critical of the Chilean state, when he described the Chilean state as exploiting and repressing the Mapuche throughout history. He stated that a strong and unified Mapuche movement in the area is urgent. In the cafeteria, where I conducted the interview, he kept looking around to see if there was a police officer nearby. He tried to whisper while he talked about repression by the Chilean state, saying that if anybody could hear the conversation, it would be bad. This attitude seems in stark contrast to his denial of the possibility that there is any discrimination against Mapuche patients in the hospital.

Even though Javier denied any existence of discrimination against the Mapuche, there is institutional racism in the hospital according to my observation. For example, the hospital started a system of making appointments by phone, which are not available to many in Mapuche communities. If patients do not make appointments, they obviously need to wait longer at the hospital. Furthermore, the process to obtain a number to go to a doctor's office and to get a prescription is very complicated depending on insurance type. Mapuche patients have insurance for the extreme poor (SOME), which requires additional paperwork. If patients are not familiar with the language and culture of the procedure, they are likely to be confused by the process. Furthermore, several patients stated in the interviews that they or their relatives were embarrassed by health professionals who made fun of their Mapuche last name or became condescending immediately after they realized that the patient was Mapuche.

These observations could be interpreted as instances of institutional discrimination against the poor as an entire class and not specifically against the Mapuche population. Certainly, Javier did think that any difficulties experienced by a Mapuche patient in the hospital are related more to economic status than to race/ethnicity. This notion is a part of a hegemonic discourse of the Chilean state, but Javier based his claim that institutional racism is a lie on what he described as the bad Mapuche temper. His strong denial of any institutional racism in his workplace is at odds with his seeing institutional racism everywhere. Javier works only in the reception office, and may not be able to see the whole picture. It is revealing to hear the exact mainstream discourse of the state, however,

9 Interview with Javier.

from a person who has such a strong antagonistic view of it.

Other Mapuche workers in this sector show similar attitudes toward discrimination in their workplace, despite whether they see discrimination in Chilean society in general or not. Furthermore, they were sceptical about the success of intercultural health programmes because they doubt the ability of Mapuche people to run modern health services, as well as the validity of *machi* (the traditional Mapuche healer). These attitudes are related to training they received from the state.

Despite the growing number of governmental indigenous programmes, the Chilean state has not officially recognised indigenous peoples in the Constitution and has not ratified the International Labour Organization (ILO)'s Convention 169 which recognises: 'the aspirations of (indigenous peoples) to exercise control over their own institutions, ways of life and economic development and to maintain and develop their identities, languages and religions, within the framework of the States in which they live'¹⁰. In terms of health, the state does not recognise the Mapuche healer or any indigenous medical knowledge as 'legitimate' medicine. Under the current Chilean health code, practicing Mapuche medicine (or any indigenous medicine) in public health centres is illegal. It is possible under the Indigenous Law but not under the Chilean Health Code. The nonindigenous governmental health sector is ruled by the Chilean Health Code, not by the Indigenous Law. The training and education offered to health professionals in the sector as well as the training require for hire in this sector were strongly controlled and monitored by the Chilean Health Code and the existing Chilean bylaws, which often do not even recognise the existence of indigenous peoples and refuse to acknowledge Chile as a multiethnic society. In addition, Western medical knowledge has ignored and dismissed non-Western medical knowledge as unscientific and 'bad' for years, if not for centuries. Mainstream Chilean medical society is based on Western medicine, and the combination of Western medical knowledge and the hegemonic discourse of monoethnicity in Chile results in little or no training of Mapuche workers in cultural rights or indigenous issues in health service. Rather, Mapuche workers internalised prejudice against Mapuche patients and their cultural heritage.

Governmental Indigenous Sector

Most Mapuche workers I interviewed fell into this category. Mapuche

10 International Labour Organization.

workers could get a job within the state with the emergence of various state indigenous health programmes but jobs for Mapuche workers within the state are still limited to ‘indigenous programmes’. Many Mapuche professionals were hired by the state, but highly concentrated in programmes related to Mapuche issues such as CONADI, the Orígenes, and the Intercultural Health Programmes. Mapuche workers in this sector showed ambiguity in their discourse. Some workers reiterated the hegemonic discourse regarding Mapuche patients and their health problems while others succeeded in co-opting the state. Often a Mapuche worker expressed ambivalence.

Within the governmental indigenous health sector, there are two different types of work: Working in a hospital as a bilingual facilitator or working in an particular indigenous health programmes within regional or national government. Both positions require Mapuche workers to accept regular supervision from the state, but the degree of control from the state as well as the challenges vary. And these differences result in Mapuche workers’ different perceptions of health problems of the Mapuche population and which actions to follow in solving the problems.

Mapuche employed in various public hospitals or clinics as bilingual assistants/facilitators were hired by each hospital. José was a bilingual assistant at a public hospital in Nueva Imperial. He facilitated communication between non-Mapuche doctors and Mapuche patients. He also assisted Mapuche patients with documentation procedures that enabled them to be qualified for various social programmes. At the same time, he worked for the intercultural hospital project and was one of the key activists who connected Mapuche communities to the project. I had conversations with him on a number of occasions. He was very involved in communities and worked really hard to make the construction of the first public intercultural hospital happen in the area.

I am a translator in this hospital. My work is to help communication between Mapuche and non-Mapuche people. It is very nice to have somebody like me to help Mapuche patients in the hospital. However, my existence proves that there is a problem. Doctors or nurses here have worked in this hospital dealing with the majority of Mapuche patients. But they do not want to learn *Mapudungun* [the language of the Mapuche]. They are not interested. [...] Some non-Mapuche workers are very nice to Mapuche patients but others are not. They have prejudice against the Mapuche population, and it is not the hospital but those individuals who discriminate against Mapuche patients. They do not have any knowledge about Mapuche culture. They are just ignorant.¹¹

Unlike Mapuche workers at the nonindigenous governmental sector, José clearly mentioned that there was discrimination against Mapuche people even though the problem was always reconcilable. He blamed discrimination not on the institution (hospital) but on individuals. This belief was a probable explanation for his becoming the mediator between Mapuche patients and doctors, who think Mapuche patients do not understand their instructions. As an educator for Mapuche patients and non-Mapuche health workers at the hospital, his strong emphasis on education regarding another culture seemed to be understandable.

Regarding causes of health problems of the Mapuche population, he thought that so many Mapuche patients were at the hospital because they did not follow a 'healthy' lifestyle. When I asked what the main health problem of the Mapuche population was, he said,

If they have abdominal pain, they come to the hospital. If they have headache they come to the hospital. One of my colleague found out that various people who had health problems, abdominal pain, or headache just did not drink enough water. [...] Then I asked people whether they drink enough water. They told me that they drink tea or mate. But it is not same because tea and mate get water dirty.¹²

Drinking a lot of clean water as a healthy habit is not a strange idea. However, José expressed the idea that Mapuche people acquire so much medical information that they come to the hospital even without a serious illness. Furthermore, he related this phenomenon to a lack of knowledge (not knowing that drinking water is different from drinking tea). He continued,

Well, the problem that I see is too much information. Science and technology give them (the Mapuche population) much information of Western medicine. Then the Mapuche feel that they should use, for example aspirin, or *Tapsin*¹³ and they think that they should come to hospital. A lot of Mapuche already forgot their own medical knowledge. Now they have to come to hospital.¹⁴

This type of reasoning concerning the deteriorating health situation of the Mapuche population seems to be common among health workers in many public hospitals and clinics whether they are Mapuche or not.

11 Interview with José.

12 Ibid.

13 A popular brand of cold medicine.

14 Interview with José.

Accusations of abusive use of health services and ignorance about healthy habits are not structural or institutional approaches to health problems. Instead, the problem is located in special behavioural patterns of each Mapuche individual. Many bilingual facilitators also stated that the Mapuche population suffers worse health problems than the non-Mapuche population in Chile, but again, they said that it is due to the individual Mapuche's unhealthy habits or ignorance and not because of persistent discrimination against Mapuche people in Chile.

The individualistic understanding of health problems of the Mapuche population seems to be related to the training process of bilingual facilitators. Most facilitators I interviewed were recruited from existing low-level health workers in the hospital or clinic, which means that their initial training was the same as that of the nonindigenous governmental health sector. The requirement to be hired by bilingual services was not set up formally, but the informal requirements were some knowledge of *Mapudungun* (Mapuche language) and a willingness to work with Mapuche communities. Once they become bilingual facilitators, they are occasionally invited to information and training sessions organised by the state and other indigenous groups. However, they are not required to participate in these sessions.¹⁵ Some Mapuche facilitators told me that they had a hard time persuading the directors of their hospitals to let them participate because non-Mapuche doctors expressed their doubt of the need for 'cultural' training for 'health' workers.

Ironically, a strong emphasis on grassroots initiatives in indigenous health programmes resulted in a lack of nationally or regionally organised efforts in training health workers in the indigenous programs. The national health officials and regional officials are cautious in developing a standardised understanding of intercultural health. In addition, already underfunded indigenous health programmes often could not afford to monitor or train Mapuche bilingual facilitators.¹⁶

Many Mapuche bilingual facilitators are a symbol of multiculturalism in the Chilean health sector, but other than symbolic significance they do not have any power to monitor or control the institutions. They work in health institutions where the biomedical model of health is predominant.

15 Fieldwork observations; interviews with Mapuche facilitators.

16 Fieldwork observations; and interviews with governmental personnel of the National Health Program with Indigenous Peoples and the Health Program of Mapuche People. For detailed discussion of lack of funding for indigenous health programs in Chile, see *Best Practices in Intercultural Health Report* (The Centre for Aboriginal Health Research 2005).

They are constantly monitored by nonindigenous health workers. Their symbolic presence does not alter the power relation between Western medicine and Mapuche medicine in the workplaces. Rather, their presence reinforces the hierarchy – that is, indigenous issues are subordinate to 'general' health issues.

Without strong support, training, or power, bilingual facilitators tend to show ambivalence in their perception on Mapuche health situation as well as in their actions regarding health problems. For them, contrary to Mapuche workers in the nonindigenous governmental health sector, the discrimination against Mapuche patients and racial inequality in health between the Mapuche population and the non-Mapuche population are real. As previously discussed, however, many attempt to use an individualistic explanation to digest the reality of racial discrimination against the Mapuche population in the Chilean health sector. In terms of blaming individuals for obvious structural problems, many facilitators hardly deviate from hegemonic understanding of health problems of the Mapuche population.

While bilingual facilitators have become a popular position for Mapuche workers in the public health sector, working in an indigenous health programmes in the Ministry of Health, Regional Health Services, or in CONADI, is another option for many Mapuche professionals. Those who work exclusively in national or regional indigenous health programmes tend to develop a more critical view of the state. For example, Mapuche workers in PROMAP have developed various programmes to advocate for cultural rights as a part of efforts to reduce inequality in health. One Mapuche worker noted,

Mapuche suffer from such terrible health conditions because they have lost their culture. Health is related to social conditions. Health is related to their rights. Therefore, recuperating Mapuche territory and autonomy is necessary to address health inequality.

Mapuche workers in PROMAP not only relate health issues with structural conditions but they also become a part of various programmes often directly challenging state health policies as well as indigenous policies emphasising environmental justice, territorial autonomy, and cultural rights.¹⁷

Relatively strong challenges against the state from within the state in these programmes seemed to derive from the fact that the workers in them had experience in being activists in indigenous movements. Also

17 Field observations; Interviews with Mapuche workers of PROMAP: Also see Guillaume Boccara (2004).

Mapuche workers in the indigenous health programmes such as PROMAP and the National Health Program with Indigenous Peoples work with other Mapuche workers who share similar notions on indigenous issues. Contrary to bilingual facilitators who usually work alone under the supervision of nonindigenous workers, workers in indigenous health programmes tend to develop better organizational powers as a group in front of nonindigenous workers and within state bureaucratic structure.¹⁸ As a result, workers in these programmes succeeded in some cases to use resources of the state to challenge state indigenous health policies and to grow awareness of racial inequality in health.¹⁹

The different types of jobs in the indigenous governmental health sector, though, create tensions among Mapuche workers in the sector. One of the bilingual facilitators argued that he saw serious inequality among Mapuche workers in the indigenous health programmes. He expressed the feeling that Mapuche workers in the national or regional indigenous health programmes enjoyed better pay and working conditions than bilingual facilitators yet Mapuche workers in the indigenous health programmes were not terribly helpful to the bilingual facilitators. He said,

I receive 200,000 pesos (c. US\$308) per month. Only 200,000 pesos per month! Ask Dr. Iboxache (the director of PROMAP) about how much their workers receive. I am here receiving all those patients and working on the project to build the first intercultural hospital in Chile at the same time. What do they do? They just criticize us. They do not trust us. But they receive much more money than we do.²⁰

Antagonism among Mapuche workers became evident in public meetings to discuss how to construct an intercultural hospital in Nueva Imperial. Mapuche workers in various governmental and nongovernmental indigenous health programmes questioned each other's position over interculturality in health –such as if the office for Mapuche healers could be inside the hospital building or not– and blamed each other for not being Mapuche enough.

Antagonism among Mapuche workers within the state was evident in the interview with María, who worked in both the intercultural hospital project and the Orígenes. She expressed discontent with PROMAP.

18 Field observations; Interviews with Mapuche workers of PROMAP and the National Health Program with Indigenous Peoples.

19 Park and Richards, “Negotiating Neoliberal Multiculturalism”; Boccara, “Del Buen Gobierno en Territorio Mapuche”.

20 Interview with José.

Actually we were not worried about the administration of PROMAP or why they [workers in PROMAP] did not support us. On the contrary, we see obstacles in PROMAP. The accountant of PROMAP told me that we needed to give her every detail of our expenses. [...] We understood that PROMAP is in the governmental structure and that's why they had to follow rules and regulations of the government. However, after all our efforts to follow their regulation, they did not support us at all. They [workers of PROMAP] always treat us like crazy people who keep trying to make projects. They think they are the only people working on the issue.²¹

As evident in the interview, María was frustrated with PROMAP. Even though PROMAP was supposed to be her closest ally, she focused on competition between Mapuche workers in PROMAP and Mapuche workers in various governmental projects in hospitals and clinics. She did not indicate frustration with the central government, however, which she considered as the state. Instead, she expressed trust in the state – central government and authorities in the regional government, who happened to be non-Mapuche.

President Lagos could have very good ideas, and his advisors –like ministers– also have very good intentions. When I visited Santiago, the minister (of Health) received us immediately, despite the fact that we did not even ask for an appointment. However, here, to meet a governor, you should make an appointment before. Now we have a new governor, and I guess things will change [...] With the government, I personally do not blame them too much. The problem is the intermediaries. I prefer to talk to the maximum authority, like ministers or president. But not the intermediaries.²²

By 'intermediaries', she meant workers who were in charge of governmental indigenous programmes. And the role of Mapuche workers in governmental indigenous health programs turned out to be dealing with Mapuche communities. When Mapuche leaders or workers in small projects apply for any funding from the state, they usually need to deal with these 'intermediaries' of the state. The level of frustration is typically higher toward these people with whom there is direct contact than toward those who are truly at the centre of power in such issues. Therefore, not only is there tension among Mapuche workers who compete with governmental funding for similar projects but also there is growing distrust between Mapuche workers in these indigenous programmes and Mapuche workers who need to write reports and submit proposals to them. The

21 Interview with María.

22 Ibid.

'intermediate' Mapuche workers in indigenous health programmes became a buffer between the state and many frustrated bilingual facilitators and indigenous activists.

The governmental indigenous health sector in Chile demonstrates the complexity of neoliberal multiculturalism in many ways. While Mapuche workers in this sector tend to be more conscious about discrimination and racial inequality in health than the nonindigenous governmental health sector, the division between bilingual facilitators and workers in indigenous health programmes created tension among Mapuche workers. Furthermore, the distinct perception of and attitudes toward health problems faced by the Mapuche population among bilingual facilitators and workers in indigenous health programmes reveal that state control and supervision in this sector is as persistent as in the nonindigenous governmental sector despite differing types of control and supervision. As a result, without strong organizational efforts within the state to maintain autonomy from it, many Mapuche workers in this sector ended up being merely a symbolic presence in the health sector, reinforcing the existing hierarchy between Western mainstream health discourses and Mapuche medical knowledge.

Nongovernmental Indigenous Sector

Mapuche workers in this sector are included as workers of the state because they are also under state supervision and have constant interactions with the state which provides most of the funding for their activities. Being a nongovernmental sector allows more room for Mapuche workers to negotiate with the state, which enables Mapuche workers to maintain their critical view of the state.

Francisco Chureo, the director of Makewe Hospital, clearly realized that there is racism in Chilean society and stated that it is his main goal to challenge the hegemonic prejudice against the Mapuche in the health sector. Makewe Hospital is a legally private hospital with 35 beds and a policlinic. This hospital had developed special links with traditional health specialists such as *machi*, who are religious, spiritual, and medical authorities in Mapuche culture. In terms of intercultural health, this hospital is considered the most advanced in Chile. Even though it is legally private, almost 97 per cent of its budget consists of governmental funding through both the Regional Health Service and PROMAP. Therefore, it needs to follow governmental regulations.

In the interview, Francisco recognised that there was constant conversation and negotiation between the state and the hospital because

the hospital did not share some of the state's point of view on health.

When the government talks about intercultural health, it talks only about hiring bilingual facilitators in hospitals. Then it would say that hospitals in IX Region are intercultural, because they all have bilingual assistants. But for us it is not intercultural health. [...] For us Mapuche, intercultural health happens when there is change of attitude toward the Mapuche population. [...] If the government does not want to change its attitude, we cannot discuss intercultural health together.²³

The difference between the government and Makewe hospital on how to form and manage an intercultural health programme did not become a primary source of conflict between the state and the hospital. The main problem with the state was about budget increases because Makewe Hospital relies heavily on state funding. Even though there was no direct conflict between the state and Hospital Makewe, Chureo expressed distrust of many state programmes and this distrust also influenced his attitude toward other Mapuche workers in the governmental programmes.

In February 2002, Francisco Chureo and Antonio (a Mapuche social worker at Makewe Hospital) were invited by Dr. Iboxache, director of PROMAP to present a model of Makewe Hospital in front of Mapuche workers of the Orígenes so that intercultural health programmes of the Orígenes would follow the Makewe Hospital model. According to Antonio and Dr. Iboxache the meeting was not successful. Antonio told me that the Mapuche workers of the Orígenes 'were (sell-outs)'. He believed that they had betrayed his people and that the Orígenes was nothing but another state strategy to co-opt Mapuche organisations. Agreeing with Antonio, Francisco Chureo left in the middle of the meeting, saying that it was not useful.

Antonio does not trust the state. He told me he does not feel like a Chilean citizen. His citizenship is imposed by the state. He regards himself only as a Mapuche. Antonio also told me that because of the long history of the Mapuche repression, Mapuche people have strong feelings against the state. He explained that the Mapuche do not want absolute independence from Chile but rather to be recognised as a people in Chile and obtain autonomy for the Mapuche nation within the Chilean state.

Later in a series of conversation with Antonio regarding the role of the state in Makewe Hospital, he told me that he refused to work in

23 Interview with Francisco Chureo, director of Makewe Hospital.

CONADI when he graduated from the university because CONADI is 'another co-optation machine'. He felt better working with Makewe Hospital as a social worker. He said 'I see my work as recuperation of Mapuche territory, demanding better rights and services for my people. And I do not receive any money from the state. I receive money just from Makewe Hospital'. Most of his work in Makewe Hospital, however, is also regulated by various governmental programmes and involves writing reports and projects to get more funding from the state. Furthermore, in Mapuche communities, he was seen as a social worker who could connect them with various governmental social programmes.

While collecting data in and around Makewe Hospital, I witnessed many Mapuche come to him and treat him very formally to ask his help in getting information about governmental programmes. People in the community did not recognise the differences between public employees and nongovernmental workers who just deliver governmental programmes. This difference seems to be huge, however, both to Francisco Chureo and Antonio. Both of them expressed confidence regarding their negotiating power with the state and their autonomy from state intervention. Overall, Francisco and Antonio could avoid co-optation by the state by maintaining their autonomous views.

Mapuche workers in the nongovernmental indigenous sector showed strong negotiation power with the state. Francisco Chureo's successful negotiation with the state shows that many Mapuche workers learned how to deal with the state in this sector. Even though there is more negotiation and co-optation of the state possible in this sector, however, we also see that there is severe competition in this sector, which ultimately weakens the overall negotiating power of Mapuche people.

Despite being 'nongovernmental', most of their projects relied on governmental funding and were distributed through project competitions. The project selection ostensibly minimised corruption in the process and maximised the quality of those selected. The process led to competition among Mapuche workers, though, which undermined cooperation, especially when competition was severe. Therefore, even though this sector showed a possibility of transforming or co-opting the state by the Mapuche, there are obstacles that diminished indigenous mobilisation and negotiation power. Direct co-optation seemed to be reduced in this sector but was in fact replaced by indirect co-optation by the state, due to growing competition and antagonism among Mapuche workers.

CONCLUSION

Using changes in the Chilean health sector caused by neoliberal multiculturalism, this article reveals that, as a new type of governmentality, neoliberal multiculturalism does not reduce the state but rather creates different locations within it that contain varying levels and tactics for controlling indigenous peoples *at a distance*. In this article, I looked at three locations within the Chilean health sector: (1) governmental nonindigenous sector, (2) governmental indigenous sector, and (3) nongovernmental indigenous sector.

This study reveals that each location represents different tasks for Mapuche workers to challenge the state from within. Among the three locations of the state discussed in this article, Mapuche workers in the indigenous nongovernmental programmes seem to obtain more power to challenge the state than do those who work in the other two locations. They suffer the most severe competitions among themselves, however, which ultimately weakens cooperation of Mapuche organisations. Mapuche workers in governmental sectors show that state control and co-optation happen in complex ways. Mapuche workers within the governmental non-indigenous health sector tend to be part of reproduction of hegemonic discourse against the Mapuche people. Some workers in this sector recognise persistent discrimination and racism against Mapuche people in society in general, but then fail to see discrimination in their own workplaces. This study shed light on the power of cooptation in the state.

Those who work within the governmental indigenous sector, though, tend to experience ambivalence between co-optation and resistance, due to the complex techniques used by the state to govern Mapuche workers. Contrary to assumptions on '*Indio Permitido*' as a homogenous group, the analysis of the governmental indigenous health sector in Chile reveals that there are distinct types of work within the sector and different types of work create disparate conditions for Mapuche workers. Bilingual facilitators, the most common position created by the Chilean state to address indigenous demands in the public health sector, suffer from lack of systematic training and organisational support. Working alone in a public hospital/clinic where the dominant discourse regarding Mapuche people is still vivid, many bilingual facilitators opted to choose an individualistic approach to reconcile the discriminatory reality and their training from mainstream Chilean medical community. Contrary to bilingual facilitators, Mapuche workers in national or regional indigenous health programmes enjoy better support and organisational power largely because

they work together as a group and tend to have strong indigenous activism as personal background. Yet, they also have to follow state regulations and, more important, they end up being the intermediaries between the state and indigenous communities taking the blame for state bureaucracy and control. Furthermore, the tension between bilingual facilitators and indigenous health programmes signals a new division among Mapuche workers within the state.

Growing antagonism among Mapuche workers throughout different locations shows us that the neoliberal governmentality does not mean a reduction of the state, but instead the diversification of its technique, which utilizes competition and division among workers as a central component. Still, this article also indicates that diversification of the technique opens a possibility that Mapuche workers can actively engage in challenging the state from within.

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