# The Role of the State in the Community Participation Program in Health: An Experience from Chile*

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## Ⅰ. Introduction

There has been growing attention in social policy literature on participation from communities/ civil society in specific policy design and implementation. It is not only the academic world that has begun to look at participation as a new element to reform the existing framework of social policy but also various international agencies that strongly emphasize the importance of participation from communities as a key element of development as well as democracy.

In 1998 in the Annual Meeting Speech, James D. Wofensohn, the President of World Bank, said that

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** 박윤주(Keimyung University, Department of Spanish and Latin American Studies, yunjoopark@kmu.ac.kr), "칠레의 사례를 통해서 본 의료정책에서의 시민참여 그리고 국가의 역할".

> participation matters -not only as a means of improving development effectiveness, as we know from our recent studies- but as the key to long-term sustainability and leverage. We must never stop reminding ourselves that it is up to the government and its people to decide what their priorities should be. We must never stop reminding ourselves that we cannot and should not impose development by fiat from above -or from abroad (World Bank 1998).

His strong support for participation as a key for sustainability is a reflection of how participation has grown into an essential element of social policy.

However, what is more interesting about the emergence of participation as a new way of doing social policy is the fact that the strong interest in participation has derived from strong criticisms of the state[1)] as an effective tool to execute social programs. Much of the literature has criticized the role of the state as mere representation of specific interests of state bureaucracy (Freidman 1962), an ineffective institution to respond to continuously changing demands from society (CEPAL 1995) or an obstacle to

1) There are three main perspectives on the state: the pluralistic conception of the state, the instrumentalist conception of the state and finally the structuralist conception. Among them, the pluralistic conception defines the motivation of the state as the consensus among the various social interests groups and the government (Dahl & Roberts 1961). The state is a vector of power from different interests groups in society. The instrumentalist conception sees the state as an instrument of the dominant group of society. Marx states that the state is only “a committee for managing the common affairs of the whole bourgeoisie (Marx 1888)” in *the Manifesto of the Communist Party*, and it would be the best example of instrumentalist approach. The third approach to the state is structuralist approach, which defines the state as a reflection of social relation/class structure in society. It differs from the instrumentalist approach due to its emphasis on the relative autonomy of the state based upon a social structure of domination. Also the structuralist approach to the state is different from the pluralistic definition because the former stresses the conflict between diverse social classes and the domination of capitalist class, while the latter focuses on more consensuses among interest groups. In this paper, I used Gramsi’s (1971) notion of the state as an “unstable equilibria between the interests of the fundamental group and those of the subordinate groups-equilibria in which the interests of the dominant group prevail, but only up to a certain point, i.e. stopping short of narrowly corporate economic interest (p. 182)”.

democracy in the social sector (Graham 1998). Therefore, the strong emphasis on participation became a tool to transform social policy into something more effective as well as an important way of fixing problems of the state.

The importance of community participation is also present in the state's reform efforts in health policy in Latin America. To achieve greater equity, efficiency and effectiveness in the health care sector, Latin American governments are encouraged by international institutions such as CEPAL (Economic Commission for Latin America and the Caribbean) and the World Bank to adapt a public-private mix system to reduce state regulations to "adequate" levels and to promote decentralization and participation (CEPAL 2000; World Bank 1996). Based upon such policy recommendations, Latin American countries have promoted both privatization and community participation programs believing that these programs would solve the problems of excessive state power and the economic burden of social programs. The health sector is not an exception in the tide of reforming efforts. This relatively new way of administering health gives rise to interesting sociological inquiries: how do various actors react in society, especially when the state has been the only provider of the service? Is the relation between the state and communities antagonistic as many critiques of the state have argued? Is the withdrawal of the state "the" condition to make community participation successful and, furthermore, to enhance democracy as predicted by some scholars such as Freidman and Graham?

To answer these questions, I looked at the case of Hospital Makewe in Chile where the indigenous communities mobilized themselves to run a local hospital with active interactions with the state and promote intercultural health programs. First, I analyzed the literature on the role of the state in social policy and community participation. Then, I explored the case of Hospital Makewe in Chile to understand the relationship between the state and participation from the communities involved.

## Ⅱ. The state as interventionist or the state as provider?

Even though there is much literature on the role of the state in social programs, little attention was given directly to the role of the state in the community participation program. Therefore, it is necessary to look at the literature on the role of the state in social programs in general and examine its relevance to research on the role of state in the community participation programs. The existing literature on the role of the state in social programs can be categorized into three approaches: the neoliberal approach, the state-centered approach, and the rights-based approach.

### *Neoliberal Approach to the State in Social Policy Reform*

The neoliberal approach sees the state as interventionist or a clientalistic entity that has its own interests and acts on behalf of its own political goal. The neoliberal approach believes the private sector is more effective in delivering social goods than the public sector/ the state. Friedman argued in his book, *Freedom and Market* (1962), that the scope of government must be limited to the functions of preserving law and order, enforcing private contract and fostering competitive markets (2). If the state functions beyond these basic limits, it would be a threat to freedom and democracy because the state often reacts against the individual citizens' interests by imposing "social" good. He highly doubted, first, if there are so-called "collective" interests and, secondly, whether these can be pursued through the state. For him, adding functions to the state such as social service provisions always ends up creating a concentration of power, which is a serious threat to individual freedom.

Graham's book *Private Markets for Public Goods* (1998) also fit in the neoliberal approach. In this book, she argues that more participation from the grassroots is possible by reducing the role of the state in the social sector and, if possible, by privatizing it. By doing so, she believes that the power of the state will be spread down to the grassroots, and people as

stakeholders can actively participate in decision-making procedures. In examining capitalization and popular participation programs in Bolivia, she shows how capitalization contributes to maintain the stability of Bolivian economy and, at the same time, to increase participation of citizens in the policy making process.

The neoliberal approach seems to be gaining a strong hold of international institutions such as the World Bank and CEPAL. In *Modelos de desarrollo, papel del estado y politicas sociales: Nuevas tendencias en América Latina* (1995), CEPAL shows the “new” model of social development, which is based upon withdrawal of the state in social programs to increase efficiency and participation from the grassroots. This new model of social policy from CEPAL is strongly based upon reducing the role of the state and sharing responsibility of social provisions with civil society. The state-centered approach to social policy was seen as a “high cost with low effect” measure, which deepens inequality in society rather than reducing it.

The neoliberal approach to the role of the state in social provision is useful in criticizing the clientalistic state, which failed to address the inequality problem in Latin America and, rather, deepened the problem and impeded the democratization process. Therefore, often the neoliberal approach received support from those who fought for the democratization of the region, because the market is believed to have a “democratizing effect” by reducing the power of authoritarian state and opening space for popular participation (Reis 1996).

### *State-Centered Approach to Social Policy Reform*

However, the withdrawal of the state from social provision has been criticized by many who see the drastic reduction of the state as eliminating minimum social protection for the poor and deepening inequality in society. The critics of neoliberal approach often find their theoretical support from the state-centered approach.

Vergara (1997) argues in her study of the Chilean social policy reform, including privatization, the reduction of the state has seriously undermined the efficacy and scope of the state's social policy as a redistributive tool in Chile. In effect, she sees that the "new" paradigm of social programs has created a dual welfare system in which a private system with high-quality services for the rich coexists with an incredibly underfinanced public system for the poor. She argues that decentralization and community participation programs caused problems rather than cured them. In her book, she states that the absence of well-trained public employees in local communities has worked against effective decentralization and has reduced the efficacy of local initiatives. The reduced power of the state in social programs created a serious lack of regulation over the private sector.

Birn's article (1999) *Federalist Flirtations: The Politics and Execution of Health Services Decentralization for the Uninsured Population in Mexico, 1985-1995* is another example of the state-centered approach to social programs. Here, she shows how the reduced role of the state through decentralization in Mexican health care system worsened the situation by putting the health care system for the uninsured population in the hands of local governments, which have less financial and political ability. She believes that the reduction of the role of the state is not necessarily followed by a transfer of the power to the grassroots. Rather, she argues that the neoliberal way of reducing the state only means transferring responsibilities to local communities without providing adequate financial and political power.

Despite the fact that the state-centered approach correctly points out the problems of reducing the role of the state in social policy, the problem with this approach is that the state has not been an equalizer in Latin American countries. Rather, the state has been clientelistic abusing its power in social policy provisions in many cases. Furthermore, the state-centered approach seldom offers how to reach a "good" state without overestimating or underestimating the importance of the state.

### *The Rights-Based Approach to Social Policy Reform*

The third approach -the rights-based approach- to the role of the state in the social program/public administration overcomes shortcomings of the first two approaches. In other words, the third approach accepts the importance of the state as a regulator of the market, at the same time, trying to find a way to reform the state from the grassroots to make it a "good" regulator or provider of social services. For this approach, a good social program should guarantee not only better social services to citizens but also channels to continuous struggle for expansion of their rights.

As Spink (2000) argues in his article *the Rights Based Approach to Local Public Management: Experiences from Brazil,* the true transformation of the state is possible only when it is aimed at broadening citizens' participation and rights in the public administration. The elimination or reduction of the state in the name of economic efficiency, which is main theme of a neoliberal approach to state reform, only resulted in growing social inequality and exclusion, because the neoliberal approach made the relation between the state and civil society thin and reduced democracy to be a purely electoral one. He argues that "it is vital to consider ways in which empowerment is stimulated and above all turn public service organization outwards towards citizens and increase their sensitivity to the many small elements of service provision that create subtle and not so subtle barriers to the poor, to women, to indigenous peoples and afro-descendants (Spink 2000, 8)." Therefore, the issue is not how to reduce the state but how to make it more sensitive to citizens' rights in order to correct problems such as clientelism and authoritarianism.

The third approach is successful in overcoming the disadvantages of the first two approaches without loosing their advantages. Contrary to the other two approaches that see the state as static, this approach defines the state as transforming and ambivalent. According to this approach, the state can be a "bad" interventionist or a "good" regulator depending on the degree of participation from the grassroots. Therefore, this approach makes it possible

to look at a dynamic interaction between the state and communities in the process of policy formation and implementation.

However, some questions remain unanswered: how does the state and community interact in community participation programs and when does this interaction actually turn out to expand citizens' rights toward social services? The rights-based approach argues that the state, which can be authoritarian or democratic, should reform itself to expand citizens' rights. And it asserts that the only "real" reform is the reform that guarantees a channel for more participation and rights. However, this theory does not tell us what makes the state reform itself and act toward the expansion of rights. To answer these questions, now I turn to the case study of a community participation program in Hospital Makewe.

## Ⅲ. Methods

I conducted the fieldwork in Chile in summer 2001 and between January 2002 and August 2002. First, I conducted semi-structured, open-ended interviews. These were conducted with Mapuche patients, doctors, nurses, paramedics in three hospitals, health officials from national, regional and municipal governments with which the three hospitals interact and negotiate, Mapuche leaders in Makewe. Respondents were selectively sampled based on their representativeness and willingness to participate. Secondly, I did in-depth interviews with the main actors of each intercultural health programs; members of the Asociación Indígena in Makewe. Thirty six interviews, both in-depth and semi-structured interviews, are my main method because I was interested in how different actors interpret the meaning of intercultural health programs. In addition, I collected documents from the organizations, PROMAP, MINSAL as well as written state and media representations of Mapuche and intercultural health programs. I conducted extensive archive analysis of newspapers to record the historical process of the formation of these programs and to double check the information I collected from

interviews from different actors. The detailed list of interviews is provided in the end of this paper.

## Ⅳ. The Experience of Hospital Makewe

### *Formation of Community Participation Program*

Hospital Makewe is a legally private type 4[2] hospital with 35 beds. It also has a policlinic in addition to dental and kinesiology services. The population that the hospital covers is approximately 20,000. There are thirty staff members in the hospital including two doctors, one dentist, three midwives, one kinesiologist, six paramedical health workers, four custodial workers, three secretaries, three chefs, three drivers and one assistant for dental service (PHO 2001). In addition, this hospital developed special links with traditional healers, Machi, who are religious, spiritual and medical authority in Mapuche[3] culture. These traditional Mapuche healers participate in various events of the hospital to recuperate Mapuche culture and give advice about the administration of the hospital. Also the hospital transfers patients who doctors believe need care from traditional Mapuche healers (PHO 2001). Therefore, in terms of intercultural health, this hospital could be the most advanced in Chile with the longest history.

However, the most notable characteristic of this hospital is neither its intercultural health program nor its socioeconomic background. It is its strong participation from Mapuche communities in the administration of the hospital through *the Asociación Indígena para la Salud Makewe-Pelale*

2) Hospital type 4 means an establishment with low complexity. In Chilean health care system, there are nine categories: Hospital type 1 and Hospital type 2, which are and establishment of high complexity. Hospital type 3 is an establishment of middle range of complexity. Then there are resting home for elderly, delegated hospitals, attached out patient facilities, rural and urban general primary health care centers and medical rural stations and health posts (Ministerio de Salud(1996), *Visiting Card: Health Situation in Chile 1996*).

3) The largest indigenous people in Chile.

*(Indigenous Health Asociación Makewe-Pelale: The Asociación Indígena).* The Asociación Indígena formed in 1997 based upon the mobilization of the communities around Makewe-Pelale area[4] from 1993, when the *Corporación Anglicana (Anglican Corporation)*[5], which built the hospital and administrated until the Asociación Indígena took control in 1999, decided to close the hospital. With constant negotiation with both the state and the Corporación Anglicana and mobilization of communities from 1997 to 1999 through the Asociación Indígena, communities in the area finally succeeded in taking control of the hospital from 1999 and has administrated the hospital ever since. In the sense that the Asociación Indígena took the administration of the hospital through constant participation from the communities and negotiation with the state, the hospital Makewe provides a rich case to explore the relation between the state and communities in a social program in action.

The hospital Makewe is located in the Padres Las Casas municipality, which is categorized by the Ministry of Health as a poor *urban* municipality because it is geographically close to Temuco, the capital of IX Region. However, Padres Las Casas includes large number of Mapuche communities and rural areas. Even though the Hospital Makewe is located in the municipality of Padre Las Casas, it covers the population beyond this administrative (governmental) division. Makewe-Pelale area covers part of Municipality of Padre Las Casas as well as Nueva Imperial, Freire and Temuco.

The hospital Makewe started its service in 1895 as a community clinic administrated by the Corporación Anglicana with financial and technical support from British Anglican Corporation. Later, due to increasing needs,

4) The area is based upon geographical division from Rio Quepe to Temuco.

5) The presence of Anglican church in Chile go back to 1830s with the arrival of British captain Allen Gardiner, who had the vision of evangelize the indigenous people in the south of Chile. Also at that time, small but influential British communities obtained official permit to celebrate the discrete cult in British consulates and flagships. The first British church constructed is the St. Paul's church in Valparaíso, which inaugurated its services in 1869 (http://www.iglesia anglicana.cl/notas_iach.htm).

it became a hospital with thirty five beds for tuberculosis patients and general pathology in 1925 in addition to its policlinic service. In 1962, this hospital made an agreement with *el Servicio National de Salud (The National Health Service)*, which is currently *el Servicio Salud Araucania Sur (The Health Service Araucania Sur: SSAS)*[6]. With this agreement, the hospital began to receive a subsidy from the state to finance its services under the condition that the hospital would administrate basic public health programs such as vaccination, health control of the elderly population and health education about epidemic disease (PHO 2001).

According to the interview with Bishop Apeleo Abelino[7] of the Asociación Anglicana of IX Region (2002), the hospital had to face serious economic problems from 1963[8] due to transformation of the Asociación Anglicana of Chile. With growth of its capability and scale, the Corporación Anglicana de Inglaterra en Chile (British Anglican Association in Chile) became independent from British Corporation and transformed into the Corporación Anglicana de Chile (the Chilean Anglican Corporation). He explained that, due to this transformation, all the financial supports from abroad declined drastically. Despite the success in making an agreement with the National Health Service to receive a subsidy, the size of the subsidy was not even enough to cover basic services. In addition to limited regular financial support from the government, he pointed out that, due to its religious nature, the Corporación Anglicana could not be competitive in applying for any government projects or additional funding.

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6) Under the Ministry of Health, there are 19 regional health offices called Servicios de Salud. Those regional offices of the Ministry of Health supervise the public system in each region and at the same time those offices are directly under the central government (Ministry of Health) not under the regional government. Each regional government has their own regional ministry of health (SEREMI de Salud). With strong emphasis of health reform in decentralization of the service, Servicio de Salud becomes central part of the Chilean public health system.

7) I will use pseudo name for the interviewees whose identity is not public. However I will use the real name for those whose identity is public.

8) http://www.iglesiaanglicana.cl/cronograma.htm

In 1993, the Corporación Anglicana in IX Region finally decided to close the hospital due to accumulated deficits. The Corporación Anglicana already had closed a hospital in the municipality of Chol-Chol without major problems. However, the communities in the area of Makewe-Pelale were not as quiet as the communities in Chol-Chol.

According to the interview with Rosalino Catrilaf (2002), vice president of the Asociación Indígena, the communities had already mobilized and formed the Comité de Apoyo al Hospital Makewe (Support Committee for the Hospital Makewe) before they realized that the hospital planed to be closed in 1993. He explained that the Corporación Anglicana had to sell major part of its land around the hospital to finance the hospital but it was not enough to save the hospital. Soon the communities found out the critical status of the hospital and mobilized themselves to help the hospital. The Support Committee for the Hospital Makewe was the result of it.

In 1993, when the Corporación Anglicana officially announced its intention to close the hospital, about ninety two communities joined the protest against the closure of the hospital (PHO 2001) and they also organized a protest in front of the municipal building of Temuco -Padre las Casas was at that time was a part of Temuco- to show the governmental authority that communities in the area opposed to the church's decision. Aníbal Inglés Cayul, a leader of community Inglés Ñancumil, remembered the protest:

> "A few leaders of communities who knew the situation of the hospital informed the leaders of the other communities. There was not a specific organization that mobilized people. People in the community passed the news to their neighbors and then we started to protest. We did protests not only in front of the hospital but also we traveled to Temuco to protest. Also we used all the organizations that we had such as Junta de Vecinos. […] So many people arrived from everywhere. Then the authority understood immediately that it (the closure of the hospital) would be a difficult task (Interview with Aníbal Inglés Cayul translated by the author 2002)[9]" .

9) All the interviews have been translated by author.

The scale and importance of the protest is shown in various interviews with members of communities. Most interviewees remembered the protest.

> "The church administrated this hospital before but things went bad and they wanted to close the hospital. So we, Mapuche, organized some protests. Then Mapuche organization started to administrate the hospital (Interview with Antonio 2002)".

> "The hospital was bankrupt because there was no resource from abroad. Then the church wanted to close the hospital. They did not want to work here any more. Then indigenous people took the hospital after some protests (Interview with Eugenia 2002)".

It was not only the local authorities that realized the resistance from the communities against the closure of the hospital. The Corporación Anglicana also felt the pressure from communities. Bishop Abelino remembered the pressure from the communities,

> "We had two options to deal with the economic crisis of the hospital. The first one is obviously to close the hospital. We realized that we could not meet the demands from the communities. Closing the hospital was an easier solution for us because we reached at a point that we did not want to work with the hospital any more. However, we had to face with tremendous pressure from the rural communities (Interview with Bishop Abelino 2002)".

Due to the resistance from communities, the Corporación Anglicana, instead of closing the hospital, started to search for an institution that would administrate the hospital. Meanwhile, Mapuche communities strengthened the Support Committee for the Hospital Makewe and initiated a campaign for donations to help the hospital. There is no information about the amount of donation that the hospital received through the Support Committee. However, again, various interviewees remembered the campaign and told that they participated in the campaign.

> "I do not remember exactly when [...] it was when the church wanted to close the hospital. I came to leave some donations here in the hospital. Our community also made some donations. A lot of communities donated (Interview with José 2002)".

> "It seems that there was a campaign. My community donated agricultural products such as wheat, potatoes, chickens and some money to make the hospital keep working (Interview with Manuela 2002)".

In this process, the state did not play any significant role. The SSAS neither significantly increased its subsidy for the hospital nor maintained minimum level of increase to match inflation rates. Due to aggravated financial hardship in 1993, the church began more active search for an institution to administrate the hospital. According to interview with Abelino and Chureo[10], there were several institutions that had shown interests in administrating the hospital including a major private health service provider in Santiago. At the same time, the Support Committee for the Hospital Makewe started to have meetings and organize themselvs to take control of the hospital. Finally in 1997, the Support Committee transformed itself into the Asociación Indígena para la Salud Makewe-Pelale (the Asociación Indígena) with thirty two member communities.

> "We called a general meeting of the communities in the area and told people that the only way we could save the hospital is to form an association because a committee does not have a legal status to administrate a hospital. There were 35 communities out of 92[11] communities in the area Makewe-Pelale that agreed to join the association (Interview with Catrilaf 2002)".

10) Francisco Chureo is the president of the Asociación Indígena and the director of Hospital Makewe.

11) Even though the map provided by CONADI of IX Region shows there are 103 communities in the area Makewe-Pelale, often community leaders told me that there are 92 communities in the area. This discrepancy is due to the fact that there are

There were several reasons that only 35 communities out of more than 100 communities participated in forming the Asociación Indígena. Fist of all, there was a communication problem. It was hard for the members of the Support Committee to reach all the communities. Some leaders of the community said that they would have participated in the association if they had known on time. Therefore, even though only 35 communities participated in the Asociación Indígena, it does not mean only 35 communities supported the idea. Following remarks from a community leader proves this.

> "Our community did not participate in the Asociación from the beginning. It is not because we did not like the idea but because we simply did not know about it […]. They (Support Committee for the Hospital Makewe) had to form an Asociación as soon as possible to summit a proposal to the SSAS and they did not have time to call and visit everybody. 35 is the minimum number you need to form an Asociación. So if you have 35, why do you need to ask more? (Interview with Inglés 2002)".

While the church was contacting several health institutions to confer the administration of the hospital, the Asociación Indígena contacted the government to pressure the Corporación Anglicana. The Asociación Indígena had a project to administrate the hospital with emphasis on intercultural health. The emphasis on intercultural health was a decision from several general meetings among community members. With an alternative way of administrating the hospital, the Asociación Indígena actively negotiated with the SSAS from 1997. From 1997, intense negotiation process began between Asociación Indígena and the Corporación Anglicana and between the Asociación Indígena and the SSAS. The closure of the hospital became out of discussion since the resistance to

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several communities that split the area and form a new community when they registered to CONADI in 1987.

the idea based upon strong mobilization of local communities was evident (Austral 1999).

After two years of intense negotiation and mobilization process between the Asociación Indígena and the state (SSAS) and between the Asociación Indígena and the Corporación Anglicana, in 1999 the three parties finally reached to an agreement (Austral 1999). The Corporación Anglicana agreed to let the Asociación Indígena use all the hospital facilities and administrate the hospital for 5 years without any payment under the condition that the Asociación Indígena kept health workers who were hired by the Corporación as far as they wanted to keep working at the hospital. Also the Corporación Anglicana did not transfer any debt to the Asociación Indígena. So the Asociación Indígena could start fresh. However, the Corporación Anglicana did not transfer the ownership of the hospital building and facilities to the Asociación Indígena.

With strong support from the SSAS and local communities, the Asociación Indígena could have better position to negotiate with the Corporación Anglicana. At the same time, the Corporación Anglicana did not want to cause more trouble in the area so they tried to hand over the hospital to any reliable institution. The Corporación Anglicana believed that transferring the hospital to the Asociación Indígena would be more easily accepted by the communities than closing it. In addition, since the hospital suffered from lack of funding, the Corporación Anglicana preferred an institution that showed fund-raising ability. The Asociación Indígena met both conditions. Since it is an organization of Mapuche communities of the area, obviously it would be accepted by the communities better than any other institutions. Also, it proved to have negotiation capability with the state inducing its strong support.

> "We thought that the Committee of indigenous sectors (the Indigenous Health Association) would have much better acceptance. Their projects and demands would be more accepted than those of the church. So we chose them and handed over the

> administration of the hospital in order that the communities could maintain their hospital (Abelino 2002)".

The SSAS agreed with the Asociación Indígena to keep subsidizing the service of Hospital Makewe. Furthermore, once the Asociación Indígena took the administration of the hospital in 1999, it succeeded in increasing subsidy from the state from 5 million pesos (about US$ 7,000) to 8 million pesos (US$ 12,300). The association also received a new ambulance from the Health Ministry. At the same time, the Asociación Indígena received funding from the Programa de Salud con Pueblo Mapuche (Health Program with Mapuche People: PROMAP) to hire one registered nurse, one paramedical health worker and one kinesiologist. Achieving all these financial and technical supports from the state, the Asociación Indígena obtained considerable autonomy in administration of the hospital. The SSAS required the Association Indígena to continue several governmental health programs and to maintain certain level of health indicators. Besides these basic responsibilities, the hospital could enjoy considerable autonomy to pursue its own health model.

### *Complementarity between Communities and the State*

As we saw from the history of Hospital Makewe, communities around the hospital were very successful in achieving administration of the hospital and administrating it with considerable autonomy. The administration of the hospital has been so far successful. According to survey that I conducted during my fieldwork from January 2002 to August 2002, almost 90% of hospital users expressed high satisfaction with the service. They reported that there was no discrimination against Mapuche people in the hospital and that the intercultural health service improved Hospital Makewe by offering more options for patients. The hospital became famous as a successful story of the intercultural program and community participation nationally as well as internationally. Even Hilary Clinton visited the hospital in 1998 to learn

about community participation and intercultural program of the hospital, while she visited Chile with her husband, ex-president Bill Clinton.

Hospital Makewe shows us an interesting relation between the state and communities. The Asociación Indígena turned out to be successful in negotiating with the Corporación Anglicana due to strong supports from the state (SSAS). In the case of Hospital Makewe, the state seemed to function as a "good" reformer. It opened space in social policy allowing communities of the area to pursue their own model of health service -intercultural health program- as well as providing financial and technical support to communities, which were essential to a success of the new administration. How could it be possible? Why did the Chilean state, which is known in Latin America as one of most centralistic and bureaucratic states, reach out to the communities to open space for their participation without "overly" intervening or controlling the administration?

Ironically, this complementarity between the state and the Asociación Indígena derives partly from the fact that this hospital is legally a "private" hospital even though almost 90% of the budget comes from the state. Because the infrastructure is owned by the Corporación Anglicana, it maintains its legal status as a "private" hospital. Since the hospital is legally outside of the governmental health service system, the state as well as the Asociación Indígena can be more flexible in administration allowing less control by strict governmental regulations.

The other reason for this complementarity is democratization and decentralization of the health service sector in Chile. The impact of democratization is evident in the interview with Dr. Ricardo Celis, the director of the SSAS.

> "I believe that the role of the state is not to allow or to prohibit but to facilitate. Then the role of state is rather guarantor or supervisor not actor. If the State has its goal to promote intercultural health and places the task to the local institutions, the state should only regulate and supervise the institutions. Especially regarding intercultural health, they are those who

> have better knowledge than ours. The state should learn from them (Interview with Ricardo Celis 2002)".

As the interview with Dr. Celis shows, strong emphases on democratization and decentralization of the state made by civilian governments in Chile transformed the concept of the role of the state for many public employees. Many public employees expressed that the state under the civilian government should be completely different from the state under military dictatorship. Many of them were part of the democratization movements against the authoritarian state. One example could be the technical director of Hospital Makewe, Jaime Ibacache Burgos, who also was the director of PROMAP. While working in the state, he has been active in indigenous movements in the region and in promotion of interculturality in health. Since he was the technical director of Hospital Makewe, it was quite natural to see constant conversation between the Asociación Indígena and the SSAS. The SSAS receives influences from him since he offers more direct and open channel to communicate with communities in the area.

However, the most important reason behind the success of Hospital Makewe is massive participation from communities from the beginning of the process. The participation made the Asociación's demand more acceptable as well as powerful in the negotiation with both the state and the Corporación Anglicana. As I pointed out before, due to strong participation from communities, the Asociación Indígena was able to create suitable and compelling demand, the intercultural health program. The intercultural health program was the results from several general meetings among communities' members in the area. At the same time, the massive participation itself pressured the state not to ignore the demand from communities especially when the state pursued democratization as one of its main goals.

Furthermore, on the contrary to neoliberalist scholars' prediction, strong community participation did not make the state withdrawn. Rather it hastens

action of the state offering reason and legitimacy to act on the issue. What happened in Hospital Makewe with strong community participation was not a cut of subsidy but an increase of financial and technical support from the state.

## Ⅴ. Conclusion

Community participation is one of the favorite themes of state reform yet it is one of the most contested issues. The advocates of neoliberalism welcome community participation because they believe it could induce the withdrawal of the state, while the believers of democratization are excited about community participation programs because of the space that it would open for the grassroots. However the state-centered approach expresses some concerns about community participation programs since it could be used as one more political machine to transfer responsibilities of the state to civil society while maintaining clientalistic relation between the state and civil society.

All these perspectives have some advantages and limitations. There are evidences that the community participation programs open new possibility for the democratization of the social sector, meanwhile some cases show that community participation programs became one more political machine that defends clientalistic regimes. This ambivalent nature of community participation programs indicates, as the rights-based approach points out, the relation between the state and communities is not static. The state can be either “good” or “bad”. To illustrate the dynamic nature of the state in community participation programs, I analyzed a “success” story of Hospital Makewe.

As we saw in the case of Hospital Makewe, to make the state “good”, strong community participation is indispensable. Only when strong community initiatives exist, a community participation program works in opening space for people in social policy designing and implementation. At

the same time, to make a successful community participation program, the state should play a crucial role in providing resources. In Hospital Makewe, the state increased the subsidy rather than cut it. The state sent a crucial member of public health sector to provide technical support to the hospital. Based upon stable funding and technical knowledge, the community organization succeeded in promoting more participation from the communities and in building valid channel to evaluate their services for the communities.

The case of Hospital Makewe elucidates clues to answer important questions about community participation programs in social policy and the role of state in the program. It shows us that community participation is neither an excuse to reduce role of the state nor a political machine to defend the state. Rather community participation makes the state to be more effective and democratic. In addition, more importantly, community participation makes the state more involved in social policy not withdrawn from it. In Hospital Makewe, the state and community participation form a complementary alliance not an ultimate battle field.

## Abstract

최근 라틴아메리카 각국은 효과적인 사회정책의 운용을 위하여 과도한 국가의 규제 및 참여를 축소하고 시민사회의 참여를 확대하려고 노력해왔다. 신자유주의적 경제정책의 기조 속에서 추진된 사회정책에서의 국가 축소는 시장의 확대뿐 아니라 사회 정책에서의 민주화 또한 이룰 것으로 기대되었다.

본 논문은 사회정책 특히 의료정책의 개혁에서 논의되는 국가의 역할 축소에 대한 이론적인 입장들을 정리하고 칠레 의료 개혁의 사례를 통해 이러한 이론적인 접근들이 현실 속에서 갖는 의미를 조망, 의료 정책을 개혁함에 있어서 국가가 갖는 역할을 살펴보았다. 칠레의 시민참여 프로그램을 분석한 결과 본 논문은 국가와 시민사회의 관계를 적대적으로 상정하는 신자유주의의 관점이 갖는 한계를 지적하며 오히려 국가와 시민사회의 관계는 상호보완적이며 국가의 기능은 시민사회의 참여 정도에 따라 규정된다고 주장한다.

Key Words: Community Participation, Social Policy, Health Policy Reform, State Reform, Neoliberalism, Chile / 참여, 사회정책, 의료정책개혁, 국가개혁, 신자유주의, 칠레

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## List of Interviews

| No. | Date | Informant/Event | Agency/ Sector |
|---|---|---|---|
| 1 | 13 Feb. 2002 | Patient 1 | Makewe Hospital |
| 2 | 13 Feb. 2002 | Patient 2 | Makewe Hospital |
| 3 | 13 Feb. 2002 | Patient 3 | Makewe Hospital |
| **4** | **13 Feb. 2002** | **Patient 4** | **Makewe Hospital** |
| 5 | 15 Feb. 2002 | Nurse 1 (1) | Makewe Hospital |
| 6 | 19 Feb. 2002 | Patient 5 | Makewe Hospital |
| 7 | 19 Feb. 2002 | Patient 6 | Makewe Hospital |
| 8 | 19 Feb. 2002 | Patient 7 | Makewe Hospital |
| **9** | **19 Feb. 2002** | **Patient 8** | **Makewe Hospital** |
| 10 | 19 Feb. 2002 | Midwife | Makewe Hospital |
| 11 | 20 Feb. 2002 | Patient 9 | Makewe Hospital |
| 12 | 20 Feb. 2002 | Patient 10 | Makewe Hospital |
| **13** | **20 Feb. 2002** | **Patient 11** | **Makewe Hospital** |
| 14 | 24 Feb. 2002 | Paramedic 1 | Makewe Hospital |
| 15 | 24 Feb. 2002 | Paramedic 2 | Makewe Hospital |
| 16 | 24 Feb. 2002 | Paramedic 3 | Makewe Hospital |
| 17 | 26 Feb. 2002 | Patient 12 | Makewe Hospital |
| **18** | **26 Feb. 2002** | **Patient 13** | **Makewe Hospital** |
| 19 | 26 Feb. 2002 | Patient 14 | Makewe Hospital |
| 20 | 26 Feb. 2002 | Patient 15 | Makewe Hospital |
| 21 | 26 Feb. 2002 | Patient 16 | Makewe Hospital |
| 22 | 28 Feb. 2002 | Office Manager | Makewe Hospital |
| **23** | **4 Mar. 2002** | **Community Leader 1** | **Indigenous Health Association Makewe-Pelale** |

| | | | |
|---|---|---|---|
| 24 | 6 Mar. 2002 | Doctor | Makewe Hospital |
| 25 | 6 Mar. 2002 | Social Worker | Makewe Hospital |
| 26 | 11 Mar. 2002 | Nurse 1 (2) | Makewe Hospital |
| 27 | 11 Mar. 2002 | President/Director | Makewe Hospital/ The Indigenous Health Association Makewe-Pelale |
| 28 | 12 Mar. 2002 | Paramedic 4 | Makewe Hospital |
| **29** | **12 Mar. 2002** | **Community Leader 2** | **Colpanao, Makewe Hospital** |
| 30 | 13 Mar. 2002 | Community Leader 3 | Indigenous Health Association Makewe-Pelale |
| 31 | 13 Mar. 2002 | Community Leader 4 | Indigenous Health Association Makewe-Pelale |
| 32 | 14 Mar. 2002 | Community Leader 5 | Indigenous Health Association Makewe-Pelale |
| 33 | 15 Mar. 2002 | Local Scholar 1 | Universidad de Frontera |
| **34** | **20 Mar. 2002** | **Bishop** | **Anglican Corporation of SSAS** |
| **35** | **19 Apr. 2002** | **Director** | **SSAS** |
| 36 | 2 Aug. 2002 | Presentation & Discussion on Intercultural Health | MINSAL |

* For this study, thirty six interviews were conducted from 2002. 02 to 2002. 08. Out of thirty six interviews, only eight of them were directly quoted in this paper.