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Implementation Challenges in Public Policies Towards Indigenous Peoples: The Impact of Health Policies in Urban Contexts

Verónica Figueroa Huencho [a], Cristian Lagos Fernández[b], Mónica Manriquez Hizaut [c] and Jame Rebolledo Sanhueza [c,d]

[a]Institute of Public Affairs, University of Chile, Santiago de Chile, Chile; [b]Department of LinguisticsFaculty of Philosophy and Humanities, University of Chile, Santiago de Chile, Chile; [c]Department of Kinesiology, Faculty of Medicine, University of ChileChile, Santiago de Chile, Chile; [d]Faculty of Medicine, Inclusive Development Nucleus, University of ChileChile, Santiago de Chile, Chile

ABSTRACT

How are indigenous public health policies implemented in contexts of diversity? The rural-urban migration processes that indigenous people have experienced since the mid-1990s in Latin American countries have affected the implementation of public policies, especially in the field of health. These processes have put pressure on ancestral practices of territorial representation, challenging traditional mechanisms that have supported western health policies. Based on a case study in urban Chile, this article examines the implementation processes of indigenous public policies in field of intercultural health. The analysis is informed by data collected from in-depth interviews with 35 key actors (Indigenous health practitioners, managers, health professionals, users, indigenous leaders), who have played a role in different stages in the implementation process of 'Indigenous Peoples Special Health Program (PESPI)'. The data points to some challenges that persist with the implementation and adaption to this policy into a Western Health Model, where indigenous practices do not always find space to develop. The data collected reveals the efforts that indigenous people make in order to maintain their traditions and practices in different territorial contexts. The findings have the potential to enrich discussion and decision-making on intercultural and or indigenous health policies in other countries experiencing similar issues.

Introduction

Reducing health inequity gap between indigenous and non-indigenous people has been one of the main global challenges (Percival et al., 2016). In the World Bank's annual report on the Millennium Development Goals (MDGs)[1] regarding indigenous peoples, Latin America registers the worst results in child mortality, access to water and quality of life. Health has been an area where these rates demonstrate the persistence of gaps between indigenous and non-indigenous people (Robles 1993; Aliaga and Serra 2001; Rojas 2007; Heise et al. 2009; Moloney 2010; Hassen 2012).

Following the Pan American Health Organization's recommendations, many countries in the region began to implement policies and programmes from an intercultural perspective, especially since the 90s when the indigenous people's demands acquired more visibility (OPS 2008; Figueroa Huencho 2014). That is the case of Chile with the public policy 'Indigenous Peoples Special Health Program PESPI', implemented in 1996. As in other Latin American countries, this kind of policy focused on rural areas where there are higher concentrations of indigenous peoples, and where ancestral authorities are in charge of the physical and spiritual wellbeing of inhabitants, and further, where the dimension 'land' constitutes a fundamental criterion for health actions.

However, in the last decades the growing trend of rural to urban indigenous migration has produced new challenges for responding to indigenous health demands in more diverse contexts. In these settings where there is greater interrelation between hegemonic western cultures and indigenous peoples, new challenges arise for formulating and implementing intercultural health policies.

This situation has redefined strategic and administrative concepts and processes of Western health institutions in Chile, which have had to adapt their practices to accommodate intercultural indigenous health in urban areas in such a way as to not damage the systems of ancestral representation or the collective action of indigenous peoples. Therefore, the Chilean case allows us to analyse the process of implementing intercultural health policies in urban contexts, in the light of the growing theoretical and empirical development in this area, where Western approaches to public policy analysis must be enriched with contributions that arise from intercultural contexts.

According to Mazmanian and Sabatier (1989), any analysis of public policy implementation must consider design factors, normative adaptation, management, and the demands of the target groups. In contexts of diversity however, it is necessary to review the implications for indigenous policies, because the target group is not only culturally diverse but also differentiated political subjects. This type of analysis may also lead to the emergence of new analytical frameworks (Collins 2018).

Starting from a Chilean case study, this article analyses the indigenous health policy implementation process that emerges with 'Indigenous Peoples Special Health Program PESPI'[2], which establishes the longest-running political and administrative institutions. The experience from 'The Ruka' (one of the most important intercultural Health Centres in an urban zone) will form the basis of this analysis. Data was collected from in-depth interviews with 35 key actors (see Table 1), who have had been involved in different stages of the implementation process of this policy. The article proceeds with a

Table 1. Interviewees list.

Interviewee	Role	Quantity
Users	People/recipients that receive health care in *The Ruka*	19
Employees	Professionals and/or western health employees working at the primary health care centre related to *The Ruka*	5
Indigenous health practitioners	People who perform the Mapuche health procedures: *machi, lawentuchefe* and *dungumachife*.	3
Directors	People in management positions in institution related to *The Ruka* in the district.	2
Programme supervisors	People in charge of implementation and monitoring the programme at ministerial level	4
Indigenous leaders	People in charge of *The Ruka* management	2

brief theoretical discussion regarding public healthcare policies, followed by a discussion of methods, data, and finally the conclusions and implications for the research agenda.

Public Policy Implementation: Dimensions for its Conceptual and Methodological Understanding in Contexts of Diversity

Approaches to Policy Implementation: Relevant Dimensions in Health Indigenous Policy Process

Interest in the analysis of public policy implementation is long standing (Pressman and Wildavsky 1973), several different studies have been developed. Implementation can be defined as a process of putting into practice a public policy through a variety of mechanisms and procedures that involve different social actors, instruments and resources, among other aspects, in order to achieve the goals established by the State (Mazmanian and Sabatier 1989; Dimitrakopoulos and Richardson 2001; Olavarría 2017).

Therefore, an important dimension of implementation will be the complications that are taken in the formulation stage, where the gaps, biases or challenges can create conditions for a lesser or greater discretion of the bureaucrats. In this context, the degree of coherence or incoherence between the policy design, implementation structure, and the needs of the recipients is important (Hill and Hupe 2009).

From an administrative point of view, some authors highlight management and strategic dimensions. For Vancoppenolle et al. (2015), organizational and inter-organizational behaviours, skills level, and the bureaucrats' level interests and target groups' expectations will be relevant. Given this, a model of implementation must consider (a) values and interests; (b) policies tools; (c) structure or organizational design, and; (d) the target group. Therefore, the implementation of public policies is influenced by the design and its biases, including: the chosen policy tools, the organizations that manage them, the resource availability, the type of intervening actors, the recipients, among other aspects (May, 2012). Further, implementation must consider the roles assumed by different actors, the interaction between the public policy and the administrative-organizational design, the resources implied, and communications channels (Mazmanian and Sabatier 1989).

Yet, it is important to identify whether these dimensions are enough in culturally diverse contexts, and in our case, when it involves health policies and indigenous peoples. Multiple studies have shown the limitations of health policies when they are implemented in contexts of diversity, where priority has been given to the imposition of the values of one culture over another, deliberately trying to change cultural norms or practices that are considered negative for non-indigenous stakeholders (Alkire 2005; Fondo Indígena 2007; Banco Mundial 2014).

Latin America is characterized by its diversity expressed in the existence of more than 522 indigenous peoples (10 per cent of total population), each one with their own unique manner of establishing relations with the States where they reside. Most of the indigenous people in Latin America are poor, where its human development indicators such as education and health care conditions, systematically have stayed behind compared to the rest of the population (Figueroa Huencho 2014). Aside from discrimination and racism, the primary causes of this situation are attributed to the liberal reforms of the nineteenth century; the introduction of the idea of private property caused a progressive loss land

and a breakdown of existing communitarian economies. Furthermore, globalization, modernization, economic adjustments, etc., have produced technological, political and socio-cultural restructuring, that have aggravated the precarious situation of most of the indigenous peoples (Hernandez and Calcagno 2003).

Worsening the situation is the migratory trend of rural to urban movement, which has historically also involved an 'assimilation' process to dominant culture (Van Hear et al. 2018). In the specific case of indigenous policies, the absence of institutional adaptation, the weak integration of cultural, historical, and social elements in programmes and projects, lack of knowledge from political or bureaucratic actors, as well as the diversity of visions of these peoples, have been dismissed (Parvin 2009). In this problematic scenario, the promotion of higher health care standards for indigenous people became a relevant goal for promoting equity and social justice (World Health Organization 1986). Currently however, indigenous peoples continue to face inequality in their access to health services, whether due to lack of resources, poor adequacy of infrastructure, lack of training of medical personnel, poor valuation of traditional indigenous medicine, what has increased the distrust between indigenous and non-indigenous people who participate in the health system, as well as in the State and its policies (ELLA 2013). In that sense, the context in which public policies are implemented is also relevant to the issue of indigenous health.

But there is a cultural dimension that is also important to consider. Some scholars have found that failures in the implementation of health policies for indigenous peoples occurs when policymakers do not consider the importance of local cultures, the development of their capacities, the empowerment of the community or the local appropriation of knowledge (Demaio et al. 2012). In Latin America, as in Chile, States have privileged a paternalistic approach that has ignored the exercise of autonomy and the right to self-determination of indigenous peoples, supported by a 'sanitary guardianship' (Cuyul 2013a). In this way, health is treated as disconnected from the rest of the problems that indigenous people may face. It is not linked to the social and economic structure as a whole or to matters of a political conflict (Boccara 2007).

Given these deficiencies in the formulation, the interculturality of these policies remains an aspiration. Here interculturality signals that policy administrators have pushed for limited actions such as 'meetings' or 'dialogues' between Western and indigenous medical models, or sought management spaces for the 'harmonization' of both medical systems with integrationist goals, especially because indigenous health authorities, and indigenous people and their health practices more broadly are considered subordinate (Cuyul 2013a).

A study of the implementation of indigenous health policies in Australia (Percival et al., 2016) revealed the need to consider three important processes:

- *Active participation of indigenous agents:* to promote the intercultural adaptation of policy instruments, where these agents can be empowered in the intercultural health system, acquire and adapt knowledge, interact with Western health professionals and reduce the appearance of prejudices
- *Reciprocity of health systems:* where values and principles are defined and shared between indigenous and western health agents, considering the participation of professional teams and users of the system, highlighting attitudes of respect and

appreciation of diversity, dialogue and shared learning reciprocity was necessary to recognize and value these multiple perspectives.

- *Organizational governance:* where there are sufficient resources for the financial sustainability of the policy along with formal mechanisms of interaction between health systems. This governance must be flexible to the needs of indigenous peoples, promoting their autonomy and empowerment. This promotes better communication, the definition of responsibilities and the incorporation of new learning (Percival et al. 2016).

Thus, the implementation of indigenous health public policies must consider subjective and objective issues, such as the valuing of ancestral authorities, the knowledge and concepts used in communication processes, the place of traditional practices in strategies, the existence of indicators and monitoring activities, among others. Given that, any analysis of implementation, must recognize these substantive aspects culturally diverse contexts, such as those that characterize indigenous peoples in urban areas. In this way, not only are analytical frameworks enriched but these are able to generate adaptations targeted at promoting an equitable relationship with the indigenous peoples and improving their living conditions. In addition, can serve as a guide to explain causes and consequences of implementation process of intercultural indigenous health in specific cases, contributing to the theoretical development in this field (Bovens and 't Hart 2016).

An analytical model for the implementation of indigenous health policies is shown in Figure 1:

The Case of Chile: Implementation of Indigenous Health Policy Process in 'The Ruka'

In Chile, the 12.8% of the population of the country is considered to belong to an indigenous people, of which one: (a) 79.8% was recognized as Mapuche, (b) 7.2% Aymara, (c) a
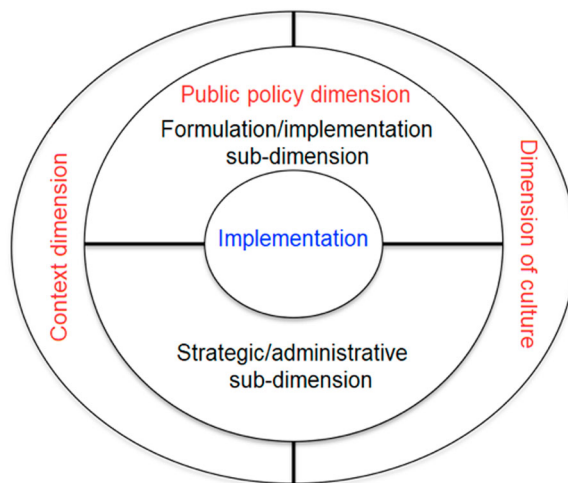

Figure 1. Implementation analysis model of indigenous health policy. Source: Prepared by the authors.

4.1 Diaguita, (d) a 1.5 Quechua, (e), a 1.4 Lican Antai, (f) a 0.9% Colla, (g) a 0.4 Rapa Nui, (h) a 0.1% Kawesqar and (i) a 0.1% Yagan. According to Government Census 2017, 74% of indigenous population are in urban zones or cities. In case of poverty, the 2015 CASEN Survey[3] shows that 18.3% of the indigenous population is poor versus 11% of the non-indigenous population.

According to the Ministry of Health, there are greater inequalities in access to care in territories where indigenous peoples reside. In urban areas, indigenous people have a complex epidemiological profile associated with a position of marginality in the social structure. Therefore, a challenge for public policies is to develop intervention strategies that focus actions on the communities with indicators of greater vulnerability (Minsal 2017). From 1996, The Ministry of Health has been implementing the 'Indigenous Peoples Special Health Program PESPI', which establishes the longest-running political and administrative institutions. Its objective is to contribute to the reduction of inequality gaps between the health of indigenous and non-indigenous peoples, through the participatory construction of health plans that recognize cultural diversity, promote complementarity between medical systems and provide adequate health services that respond to specific epidemiological needs, rights and profiles.

Important criticisms have been made of this approach, where interculturality has been understood in a biased or limited way, that does not account for the socio-historical condition of indigenous people (Boccara 2012; Bolados García 2012). Yet, some indigenous communities have made efforts to advance their health needs within this intercultural institutional framework created by PESPI. One of the most important experiences in this area is 'The Ruka', which in 2006 was authorized by the Chilean Ministry of Health to deliver Mapuche intercultural healthcare in association with the CESFAM (acronym for family health care centre) 'Los Castaños' in La Florida district (city of Santiago), administered by the Mapuche indigenous community 'Kallfulikan' (in Mapuche language this means kalfu: blue; and likan: powerful and spiritual mystic rock).

The Ruka, (this name was chosen because it denotes a traditional Mapuche house), sets up a pioneering inclusive health model, which provides healthcare services to anyone who requires it, regardless of their indigenous or non-indigenous condition, their health system, the district where they live or their nationality. According to data of 2017, La Florida has a population of 365.000, of which 10% identify themselves as indigenous. Of these, 9.27% are Mapuche, followed by 0.23% Aymara.

The Ruka as focused on recovering and rescuing Mapuche indigenous health, practicing an intercultural approach to health that respects Mapuche values and worldview, based on indigenous social participation in the formulation, execution, evaluation and monitoring of public programmes and health plans. Initially, patient care was carried out in coordination with CESFAM, privileging those people with Mapuche surname in their records, since the intention was to exclusively target Mapuche people. However, from the beginning they had to respond to a significant demand for healthcare from non-indigenous people.

Currently, they have a registry of more than 1035 patients, where 63.2% declare themselves Chilean, and 34.8% indigenous. The majority of users have come to know The Ruka through non-formal channels (known or familiar). Regarding the reasons for consultation,

people are treated for a previously diagnosed disease in the western system (59.9%). On the other hand, 27.3% consult for their general health, both physical, mental and spiritual, and 5.7% consult for mental health issues, such as depression, general mood disorders, addictions, among other things.

This experience is highly relevant because it is the most long-standing indigenous intercultural health case in an urban context, working with Indigenous health practitioners such as a *machi*,[4] *lawentuchefe*[5] y *dungumachife*,[6] and an intercultural facilitator. In addition, it is an experience where the initiatives of urban indigenous Mapuche social base has been the central component, rather than being the result of the application of a public intercultural health policy designed from a central or services level. For that reason, the analytical model proposed in the previous section will be applied to the case of '*The Ruka*' and its experience in implementation of PESPI.

Methodology and Data

This article analyses the implementation of indigenous policy in Chile 'PESPI' in '*The Ruka*', using the analytical model shown in Figure 1, being a case study. The word *case* refers to 'experiences in which events involve interventions that may lead to changes in a policy' (Barzelay et al. 2003: 23). As Gerring (2007) suggests, a case study is 'the intensive study of a single case for the purpose of understanding a larger class of cases' (95). For that reason, it does not intend to confirm hypotheses but rather build knowledge from a model that becomes the main guide for inquiries in an attempt to understand broader cases (Gerring 2007). Yin (1994) states that this strategy is appropriate when the research question asks 'how' or 'why' a certain phenomenon occurs to find the best explanation (among others) (Yin 1994: 5).

The principle data collection technique used here is in-depth interviews. These were conducted between 2018 and 2019 with 35 key actors (directors, programme supervisor and indigenous leaders), and to Indigenous health practitioners. Additionally, a group interview was applied to primary health workers, and ethnographic interviews to '*The Ruka*' users (see Table 1). The identification of the interviewees was made following the criteria of theoretical sampling (oriented to collect information necessary to establish comparisons of actors, events, relevant activities and analytical categories) and theoretical saturation (which avoids collecting information that does not add value to the examination of any category analytical) (Valles 2007: 356).

The interview analysis was conducted using QSR International's NVivo 11 qualitative data analysis software. Interviews were conducted as conversations covering different topics, including policy design and implementation strategies, concepts from indigenous and non-indigenous points of view, facilitating factors, challenges, principal actors and their roles, main decisions made, etc. The data triangulation method was used to guarantee internal validity. This method seeks to obtain information from various sources in order to determine whether the results obtained during the research process converge with the information gathered from different perspectives (Martínez Carazo 2006). Therefore, the results of these interviews have been complemented with other sources of information, such as non-participant observation, content review of documentary sources and others in newspapers.

Analysis of the Implementation of Indigenous Health Policy in Urban Migration Contexts

Context Dimension: The Role of Intercultural Health in the Public Policy Agenda

In the case of Chile, Law No. 19.253, promulgated in 1993, marked an important milestone in establishing specific rules on the protection, promotion, and development of indigenous peoples, but did not create any specific institutional framework for formulating indigenous health policies, an area that remained in the purview of the Ministry of Health. The Health Authority Law No. 19.937 of 2004 establishes that this Ministry will have the function of '*formulating policies that allow incorporating an intercultural health approach in health programs in those communities with high indigenous concentration*' (Art. 4).

Therefore, intercultural health policy has had little development within the formulation of global health strategies as it is integrated into a sectoral Ministry. In this way, PESPI has not had political or programmatic relevance, being rather '*a focused strategy that has not undergone significant growth since its creation in 1996*' (Interview with programme manager). An exception was the 'Origins Program' implemented by the Chilean government in alliance with the Inter-American Development Bank in 2000, which had an intercultural health funding scheme, which did not remain in effect post-completion.

The PESPI has three areas of action: (a) the promotion of the principle of equity in health care (aiming to reduce access gaps for ethnic reasons); (b) the promotion and establishment of an intercultural approach to health both in the actions of professionals and technicians of the health team; and (c) the promotion of indigenous social participation in the formulation, execution, evaluation and monitoring of local plans through which the programme is executed in each territory.

Like similar Latin American policies, its focus was mainly in rural areas with high indigenous populations. In Chile, the inaugural experiences were concentrated in two health centres: the *Makewe Hospital* and the *CESFAM Boroa Filulawen Family Health Centre*, both focused on the Mapuche people, and then extended to other indigenous peoples. However, these experiences were described as complex, heterogeneous and with multiple tensions, especially due to the subjectivity, different interpretations and undervaluation of ancestral knowledge by western health teams (Cuyul 2008; Piñones et al. 2017).

The increase of indigenous people in urban areas (currently 75.3%), as well as the increase in their demands for greater recognition of health rights, have led to the implementation of adjustments to the provision of health in normative centres of western medicine to accommodate the wishes of indigenous peoples, leading to the emergence of intercultural health centres. However, beyond the legitimate implementation of actions such as these, tensions have also arisen among indigenous peoples themselves who have had to move their health authorities from ancestral lands to different areas. '*Being the link with the land a fundamental aspect for well-being and health, this was also a political decision that sought to maintain the survival of a people*' (interview with indigenous leader). This is how Indigenous health practitioners, such as *machis* and *lawentuchefes*, had to adapt to respond to a demand outside their ancestral territories.

The Ruka was one of the pioneering centres in this, as it was the first to have a *machi* who provided health permanently in La Florida district. With this, they hoped to improve and maintain the spiritual and physical balance of indigenous people in the cities (interview with Indigenous leader). In that sense, the interviews highlight that this adaptation

was initiated by indigenous actors linked to *the Ruka*, which led them to provide health informally in the beginnings: '*it was we who proposed the idea, we were what we resorted to the authorities, not the authorities or politics to us … the State did not intervene here, a Service did not intervene, a political class did not intervene*' (Interview with Indigenous health practitioners).

Another difficulty in advancing institutionalization has been that the western health system is not adapted to the ancestral health certification processes. The *machi* obtains its quality of ancestral authority through a 'dream' (*pewma*) and they are accompanied in their learning process by another *machi*, with no need for formal learning centres. As Indigenous health practitioners indicates, his knowledge is born from the connection with nature

> … I learned everywhere, where I went, in the forest, on the hills, with people, with animals, with little birds. I was learning things, because there is the whole story, all the wisdom, in nature, you don't learn in a university.

Intercultural health policy has had slow progress and recognition. In fact, in relation to other policies, it has been somewhat delayed, experiencing structural difficulties to long-term institutionalisation, mainly due to the restrictions generated by Western health institutions. In the case of *the Ruka*, the political relevance has depended on the indigenous leaders linked to the community that have promoted intercultural health among the community, rather than by national-level political decisions. Further, there have been no significant incentives to generate an institutional policy. '*The indigenous issue exists because the indigenous world has pressed for it to exist. The State has never implemented it on its own initiative*' (Interview with programme manager). In the opinion of other interviewees, this affects long-term planning as it has depended on the good will of the CESFAM director. However, an indigenous leader interviewed suggests that a possible change of address places the longevity of the benefit in question.

The aforementioned also relates to the undervaluation of indigenous knowledge and the low importance that western health has had to give to so-called '*unscientific and verifiable knowledge*' (Interview with Indigenous health practitioners). However, for indigenous leaders, progress in the recognition of rights is fundamental, since health rights are tied to the delivery of political rights. Indigenous peoples must be recognized by the State of Chile as subjects with differentiated rights (Interview with programme manager). A Indigenous health practitioners points out that

> there has to be a constitutional recognition of Mapuche medicine, which regulates the practice and exercise of Mapuche medicine, if that does not happen we are at a latent risk because it is going to start exercising and putting into practice what is called bad health practices, usurpation of functions, of roles.

In short, the lack of an advanced rights framework to recognizes indigenous people at the Constitutional level has limited the possibility of advancing in the recognition of intercultural health, showing in this case that intercultural health cannot be understood just a sectorial policy. For indigenous people, health depends on a broader legal framework than those recognized as culturally and differentiated actors. However, *Ruka's* experience shows that an appropriate strategy to drive important adjustments is of a bottom-up type, especially because of the confrontation between two knowledge systems that seem to

have found no meeting points. For the western system, the recognition of intercultural health means not only generating administrative adjustments but also political and legal ones, an issue that, in the opinion of the majority of the interviewees here, will not occur in the short term.

Cultural Dimension: Understanding and Assignment of Roles in Intercultural Health

The recognition, understanding and assessment of intercultural health has been a complex area in the implementation of PESPI in urban areas. That is why, for indigenous users, 'The Ruka' has been a fundamental experience to advance in the construction of intercultural spaces, where different actors can demonstrate their contribution to the improvement of the health and wellbeing of the indigenous population and not indigenous, enriching urban spaces (Interview with indigenous user).

However, there is still a lack of knowledge on the part of CESFAM staff regarding the meaning of intercultural health, the roles of Indigenous health practitioners and interaction spaces. For some interviewees it is an ancestral knowledge that only has validity for indigenous peoples, where what corresponds is the derivation from a western system to an indigenous one (Interview to employee). This makes the different expectations that exist among the people who participate in its implementation more evident.

For the indigenous leadership, these differences are maintained because the PESPI has not developed specific protocols or processes for long-term capacity-development; such as training or teaching intercultural competencies that strengthen the standing and practice of indigenous health in institutions tasked with health pedagogy. In fact, it is difficult for indigenous leaders to speak formally of an intercultural experience, even though in political settings they prefer to use that concept. They point out that

> we do not consider it as intercultural health. We work Mapuche health. When both traditional and Mapuche cultures can complement each other, talk, establish a framework to share the experience, share the work, and work for a common cause that is to improve people, then it will be intercultural. (Interview with indigenous leader)

As it stands, intercultural health is unidirectional, and steps are needed to transition it to a bi-directional cultural exchange.

Another relevant dimension is the lack of knowledge of the roles of the different actors of the indigenous health system, and the difficulties in assimilating the horizontality that characterizes it. For example, Mapuche health approaches patients not as mere recipients of a health intervention or benefit, but fundamental actors in the process, where their lineage, their territorial origin or the behaviour of their ancestors will influence their current wellbeing. There is, therefore, no clear hierarchical relationship to the *machi*, but collective, health is community. Thus, the concept of 'patient' does not exist, but that of 'person' is relieved (Indigenous health practitioners Interview).

In another sense, it has not been possible to match the legitimacy of the western physician with the *machi*, who is considered rather an 'informal healer.' This has influenced an asymmetry and undervaluation from western medicine that discourages the possibility of working in teams or jointly between doctors and *machis*. For the indigenous leaders, it has not been easy to highlight the role of their health practitioners, but they point out that the

experience of *the Ruka* has helped their '*best identification as legitimated authorities also to dialogue with the State and its representatives*' (Interview indigenous leader). Among the elements that have supported this legitimacy are the leadership role of *machi*, who participates and take decisions in meetings with political authorities and the support of users (indigenous and non-indigenous), reflected in the increase of intercultural attention.

In that sense, the continuous and long-term work that Kallfullikan association has conducted is also important. As one director points out

> we are recognized today as a reference centre in Mapuche health and medicine, unique in the commune and with the legitimacy to point out our demands to high political levels. We dialogue with the political authorities more than with CESFAM (Primary Care Centre), because our ancestral authority, our machi, is at that level.

Another important element is that the above is related to the dispute between spaces of power that exist between CESFAM and *The Ruka*, since so far it has been a question of separate healthcare spaces. That is why the indigenous leadership has developed a role to dialogue with, and sensitize the authorities of CESFAM: '*It is a space that the organization has earned for its work, and that the Municipality or the State what it has done is to recognize the space they have earned. But as public policy there is not much*' (Interview with programme manager). For the leadership, the community strategy has been very important to generate added value: '*Not everyone is going to talk about health on behalf of the organization, we are based on indigenous thinking and the importance of the community. Not everyone can talk to the State, take over the political dialogue*'.

This could affect the fact that, although there are asymmetries, none of the actors involved question indigenous health, but instead emphasize the need to deepen actions that allow it to be positioned more seriously and permanently in the public policy space. For some interviewees, this is a legitimate aspiration of the indigenous people, where the experience of *The Ruka* must be considered as a source of learning and adjustment in the PESPI, because it demonstrates that a broad health benefit is possible for both indigenous and non-indigenous members of the community (Interview with programme manager).

In this way, the cultural dimension is important to understand the need to adjust health policy in urban contexts, where is necessary to generate strategies to promote an intercultural dialogue that enables to western policymakers and implementors comprehend the real nature of indigenous health practices. Indigenous health has adapted to western health frameworks, where traditional health agents have adjusted their performance and their care processes to act in different contexts (Interview with manager). In this way, cultural roles have been relaxed mainly by indigenous health, being necessary to implement adjustments to Western institutions. Here it is very important to collect and systematize *the Ruka* experience as a good practice that motivates the generation of structural adaptations to the PESPI.

Public Policy Dimension

The Interrelationship between Formulation and Implementation

In this case, the biases in the way the PESPI has been formulated affect its implementation. One, PESPI adopts a very limited understanding of indigenous peoples as subjects of law,

rather than as ancestral cultures that seek ways to maintain their existence. This is tied to the way that the concept of 'ethnicity' is applied to indigenous peoples in Chilean law, limiting the full exercise of their rights, especially those recognized in international laws that the Chilean State has ratified. In another way, these biases are related to the denial of indigenous peoples as political actors, instead they are only recognized as ethnic groups with different cultures, excluding them from political decision-making processes.

Our interviews with indigenous health users indicate that these biases also affect the move towards an equal treatment of indigenous health with the western health, and this is an 'issue of power'; because if indigenous demands in health were to be seen to have more relevance, it could start a path towards other demands in political, social or economic dimensions (Users interviews). For some political actors, moving forward in this area could '*open the door to the demand for other rights, and they [State Officials] don't want to enter into that discussion*' (Interview with programme manager).

According to the indigenous leadership, another flaw in the formulation is that the PESPI was designed with a top-down logic, in a social, political and economic context very different to the current one, where the rural and subsidiary visions regarding Western health have not been modified (Interview with Indigenous health practitioners). In that sense, health agents are key to the improvement and redefinition of these biases (User interview). Yet in order for this to happen, policymakers and practitioners must consider the demands that come from indigenous peoples and their representative organizations, these often draw on territorial parameters; worldviews; communities; and the transformations that occur in the city, all of which implies a that a dynamic approach to these politics are needed (Interview with indigenous leader).

Regarding the implementation, a concrete limitation is the physical and spatial needs that indigenous health requires to be effective: such as, the presence of animals, contact with the land and objects of territorial connection, which contradict the aseptic vision of the western health (Interview with Indigenous health practitioners). Moving towards intercultural health requires adjustments to the Chilean health regulatory framework and this, once again, is related to political will: '*talk about intercultural health without having land, territories, without having appropriate places to go looking for herbs for remedies, it is complex [...]. It is another way of understanding well-being*' (Interview with Indigenous health practitioners).

In the opinion of the interviewees, the gaps that PESPI poses in its formulation have also served to find spaces for adaptation in its implementation, where the organizational capacity of indigenous leaderships has been fundamental. The spaces for dialogue between *The Ruka* and CESFAM have allowed them to do some joint training, strategic coordination meetings and infrastructure improvements. However, the challenge is that this can be recognized in a redesign of the PESPI itself. In that sense, the lessons from the implementation of *The Ruka* have not been used to improve PESPI or to generate new intercultural health policies. Therefore, it is necessary to create information systems from this experience for political decision making, to not lose the findings on management or intercultural dialogue that emerges from this experience.

In short, the link between implementation and formulation is relevant but not decisive in the success of an intercultural health experience, as evidenced by *the Ruka* case, which again reinforces bottom-up strategies of policy design. However, given the multidimensional nature of intercultural health, especially in urban areas, it is necessary to advance

inter-sectoral strategies that link to different levels of government: local, regional, central, thus enrolling a greater proportion of public administration.

The Necessary Coherence between Strategy and Administrative Process

The commitment and support from the strategic levels of CESFAM has been relevant for the strengthening of *the Ruka*, so it has been a permanent strategy of dialogue and awareness promoted by the indigenous leadership. However, it is necessary to identify and develop intercultural competences at all levels of the organization, not only at the managerial level, in order to reduce resistance at the operational levels responsible for implementing the PESPI (Manager Interview). If an organization has intercultural competences, it can negotiate, communicate and work in diverse teams and respond to the emerging health demands of the urban indigenous (and non-indigenous) population. This is because there is a growing interest among the Chilean population to accessing an indigenous health system (User interview).

The Ruka has become an interesting case of governance, because not only have links with CESFAM been generated, but a linkage strategy was promoted that placed political actors in the community, where emerging challenges were resolved by negotiating with the different actors involved, such as the Municipality, the Health Service, in addition to *the Ruka*, the CESFAM and the *Kallfulikan* Community. An example of the above are the strategic planning meetings that *Kallfulikan* has once a year, where goals are set not only in terms of management but also regarding the positioning of indigenous health at the national level. This is achieved through dialogue, negotiation and persuasion of different actors. As a director of CESFAM points out '*Kallfulikan has been very efficient in this articulation agenda, where it is shown that intercultural health requires a political strategy, it is not just a technical issue*' (Interview to manager).

Another important issue on the relationship between strategy and administration is how to identify the operational areas where it is necessary to generate new adaptations, especially in administrative processes and procedures. Although agreements are reached between the CESFAM leaders and *the Ruka*, one difficulty is the ability to transform those decisions into specific operations. Progress in the formalization of these processes is also important to ensure that the practices are not at the discretion of public officials because that does not ensure their long-term sustainability. As one interviewee points out

> There have been the will of the authorities, we have created spaces of trust, transparency … it is difficult because in health doctors can believe they are the owners of truth … strategic meetings are important, and employee training processes. That is a point that has allowed us to generate more networks. (Interview with manager)

The capacity of articulation between organizations is also influenced by subjective aspects, since the adequacy of practices will not only depend on the generation of protocols but also on the sensitization of the personnel to understand the usefulness of the adjustments, so that they do not question the validity of the methods and approaches that exist in indigenous peoples (Interview with Indigenous health practitioners). It is also necessary to generate incentives for the adaptation of processes, together with competencies that ensure and sustain the new practices. '*This must be accompanied by a commitment from*

senior management, a citizen assessment, recognition of indigenous users, for example' (Interview with manager).

However, the progress in the formalization of joint processes of care or management are very limited, despite the years since this experience. Rather, both *The Ruka* and CESFAM have their own admission, attention, and referral processes. As an interviewee claimed,

> There is a referral commitment, designed by the Ruka … I do not know the specific instrument, they designed and validated it … it has the name of the patients and where they are derived … that is presents the facilitator who registers it and enters it. Then that person has access to machi care, delivery of remedy and then controls, I understand that your benefit ends there. (Interview with manager)

The need for more information sharing is also important, especially to monitor relevant indicators for both health systems (western and indigenous). As one interviewee points out,

> we have generated some statistics, about 3 years ago, in the records of us, how many attentions Kallfulikan delivered … but we need to develop this, define what type of patients we are attending, their characteristics … I understand that 40% of those who attend the Ruka have mental health problems … we need more feedback. (Interview with manager).

In that sense, it seems that interculturality remains an aspiration.

It should be noted that the experience of *the Ruka* has had national and international notoriety especially in media coverage[7] in recent years, which has increased the expectations of the indigenous and non-indigenous population. Effectively, more attentions are demanded and, with that, is necessary to increase the financial and material resources to respond to that demand. As one interviewee points out '*At this moment, attention is very precarious in terms of quotas, because finally people do not have so much intercultural health coverage … but here in the city there are people*' (Interview with indigenous leader).

In short, the revised formulation and implementation aspects give an account of the need to update the definitions of the PESPI and to move towards greater formalization that allows the participating actors to have more certainty over their long-term sustainability. If there are changes in the leadership of *the Ruka* or CESFAM, the experience and its insights might be weakened, so it is necessary to move towards a political dimension, not just a managerial solution. Likewise, interculturality cannot only be a declaration, but must also be accompanied by indicators that allow for an adequate evaluation of progress and a better adaptation of existing institutions.

Discussion and Main Conclusions

The analysis of the indigenous health policy of PESPI health from the Chilean case has allowed us to enrich the general analytical framework around the processes of implementation of indigenous public policies in urban contexts, realizing the limitations that persist in the approaches and intercultural implementation processes.

In that sense, the experience of *the Ruka* allows us to understand the relevance of political strategies to find accommodation spaces for the provision of intercultural health, where the role of indigenous leaders has been fundamental in creating spaces of governance. However, the transfer of learning, the generation of new leadership or the move

towards institutionalized decision making become challenges that must be solved in the short term Boccara (2007), Percival et al. 2016).

This experience also shows that health for indigenous peoples constitutes a substantive scope of political demand, not only of a specific benefit as in Western health, since it expresses the material and immaterial balance necessary to protect the survival of these peoples. *The Ruka* has contributed to an identity-strengthening that is also demonstrated in the increase in the demand for access to health by the indigenous and non-indigenous population, which results in a relevant and distinctive variable from that highlighted in the analysed literature.

The aforementioned also correlates with the need to advance in aspects of implementation, especially in the generation of information and monitoring systems that not only support a better evaluation of the PESPI in *the Ruka* but also to allow greater independence in decision-making. Communication between the participating organizations is a dimension in which progress has been made, but processes, protocols and procedures need to be formalized, as well as generating intercultural skills training strategies.

The experience of *the Ruka* has also allowed to demonstrate some structural aspects of the PESPI model, where there is still asymmetry between the valuation of western health towards indigenous health, which can negatively affect the intercultural relationship because the roles of the *machis, lawentuchefes* and others similar. Indeed, the lack of joint work with the medical teams of the Chilean health system is a major failure, since different reception and care systems are generated, which do not dialogue or complement each other. As Cuyul points out, it is necessary and configure models from a collective and sociocultural perspective, considering indigenous health systems in all their complexity (Cuyul 2013b).

In that sense, although it is a valued and known experience, the case of *the Ruka* demonstrates that advances in indigenous health in urban areas is the result of a political and strategic management that arises from the indigenous peoples themselves, where the political actors act in a reactive manner, which is evidenced in the emergence of adjustments to the PESPI at the local rather than structural level. Health has failed to be truly intercultural. Interculturality does not appear to speak to the problem of power relations between the Chilean State and indigenous peoples. Although in this case the indigenous authorities of *The Ruka* have pointed out the need to recognize the Mapuche as political subjects, not only as recipients of a health system, what Boccara indicates: The State limits itself to recognizing the indigenous culture as 'worthy of respect' (Boccara 2007).

The analysis model used has not only allowed us to demonstrate the key dimensions that allow us to characterize a particular process of public policy implementation, but also to highlight those cultural, political or other dimensions that should be considered to promote a better understanding of these processes when they involve to indigenous peoples. The urban variable is, for this case, a fundamental aspect because it has involved processes of adaptation of indigenous peoples to continue existing in territories other than those of an ancestral nature.

Finally, following what was stated by Ostrom (2007), the value of this article lies in the application of general models to specific cases to support a better understanding of the variables that affect diverse realities, such as those that characterize indigenous currently. The model used in the case of *the Ruka* can be used in other Latin American contexts. With this, progress is being made in the search for new explanations about these processes

and learning spaces are generated, both for academics and practitioners, thus strengthening coexistence in multicultural contexts.

Notes

1. https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf
2. This Program depends of Ministry of Health. Seeks to improve indigenous health promoting a greater interaction between indigenous and western health systems.
3. This is a Nationwide survey conducted by Chilean government to measure socioeconomic conditions of households in the country, in terms of access to health, education, work, and housing conditions.
4. Ancestral authority responsible for the community wellbeing, western equivalent for physician. It is important to mention that in the *Mapuche* culture health is understood in a holistic way, what is known as *Küme Mongen* (or good life) is the result of the balance between the individual, the environment and the supernatural, including this perspective in the harmony-disharmony model, where health is maintained in an interdependence between the elements previously mentioned (Hassen 2012). The *machi* is who carries out the medical attention, diagnosis, and prescribes the herbs for treatment.
5. Person responsible for preparing the medical herbs the *machi* will prescribe.
6. Person responsible for translating the *machi* speech in Mapudungun during the trance when treating a patient.
7. https://www.nytimes.com/2015/08/20/universal/es/chile-health-care-indigenous-practices-seep-in.html (02/09/2020). https://youtu.be/d016FAmq8Mw (02/09/2020).

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Notes on contributors

Verónica Figueroa Huencho Associate professor at the Institute of Public Affairs. Public administrator of the University of Chile (2001). Ph.D. in Management Sciences (ESADE-Universidad Ramón Lull) (2007). Postdoctoral candidate at the Center for Latin American Studies at Stanford University (2013). His main line of research is the process of formulation and implementation of indigenous public policies in contexts of diversity, where he has publications in ISI-indexed journals, as well as books and book chapters in national and international publishers. She has led and participated as a principal researcher and co-researcher in different FONDECYT projects as well as in others of the Inter-American Development Bank.

Cristian Lagos Fernández Social anthropologist and Kinesiologist, Associate Professor of the Department of Linguistics of the University of Chile. Doctor in Hispanic Philology from the University of Valladolid, Spain (2011), Postdoctorate of the Center for Language, Interaction and

Culture (CLIC), Department of Anthropology at the University of California, Los Angeles (2014). His main line of research is the language and culture of indigenous communities in Chile, including traditional systems around health and disease, with publications in ISI-indexed journals, as well as books and book chapters, both national and international. He has led and participated as a principal investigator and co-researcher in different internal projects of the University of Chile, FONDECYT projects, of the Ministry of Social Development and has been a consultant of the Inter-American Development Bank.

Mónica Manriquez Hizaut Kinesiologist, Assistant Professor of the Department of Kinesiology at the University of Chile. Master in Public Health at the University of Chile (2016). His main line of research is studies in Intercultural Health and Disability. She has participated as an alternate researcher and co-researcher in Health Research projects (FONIS) funded by the State of Chile, through CONICYT and in another experience systematization project funded by the Ministry of Social Development.

Jame Rebolledo Sanhueza Kinesiologist. Assistant Professor of the Department of Kinesiology at the University of Chile. Master in Community Psychology at the University of Chile (2019). Her main line of research is qualitative studies in Public Health, and studies in disability and rights. She has participated as a co-researcher in Health Research projects (FONIS) funded by the State of Chile, through CONICYT and in another experience systematization project funded by the Ministry of Social Development, as well as internal funds of the Faculty of Medicine of the University of Chile.

ORCID

Verónica Figueroa Huencho http://orcid.org/0000-0002-5422-6043
Mónica Manriquez Hizaut http://orcid.org/0000-0002-5325-1749
Jame Rebolledo Sanhueza http://orcid.org/0000-0003-3245-1431

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