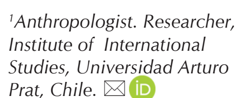
SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

Illegitimate patients: Undocumented immigrants' access to health care in Chile

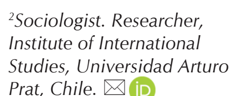
Pacientes ilegítimos: Acceso a la salud de los inmigrantes indocumentados en Chile

Nanette Liberona Concha[1], *Miguel Ángel Mansilla*[2]

[1]*Anthropologist. Researcher, Institute of International Studies, Universidad Arturo Prat, Chile.*



[2]*Sociologist. Researcher, Institute of International Studies, Universidad Arturo Prat, Chile.*



ABSTRACT In recent decades, Chile has become a destination for immigrants from other South American countries, which has significantly impacted public services – particularly the public health system – at the economic, social, and cultural levels. The aim of this paper is to provide substantiated information on issues concerning undocumented immigrants' access to health care in Chile. A qualitative methodology, fundamentally an ethnography of the clinical setting, was used. Results were then analyzed in relation to theories of power asymmetries and interethnic relations. The research results highlight the lack of compliance with existing regulations and the exercise of discretionary personal judgment as barriers to access. It is concluded that in Chile immigrants in general, and undocumented immigrants in particular, are considered to be illegitimate patients.
KEY WORDS Health Services Accessibility; Immigration; Patient Rights; Socioeconomics Factors; Chile.

RESUMEN Chile se ha ido convirtiendo en un país de destino para las migraciones sudamericanas, las cuales generan un impacto en los servicios públicos, en particular en salud, a nivel económico, social y cultural. El objetivo de este artículo es aportar información documentada sobre los problemas de acceso a la salud de los inmigrantes indocumentados. Trabajamos desde una metodología cualitativa, basada principalmente en una etnografía del espacio clínico. Para el análisis de los resultados nos hemos basado en las teorías de las relaciones asimétricas de poder, así como en las de las relaciones interétnicas. En los resultados de la investigación, se destaca el incumplimiento de la normativa y el ejercicio del criterio personal discrecional como barreras en el acceso. Concluimos que, en Chile, los inmigrantes en general e indocumentados, en particular, son considerados pacientes ilegítimos.
PALABRAS CLAVES Acceso a la Salud; Inmigración; Derechos del Paciente; Factores Socioeconómicos; Chile.

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

INTRODUCTION

This study was conducted upon the need to respond to a series of alerts regarding the violation of the right of the immigrant population to access health care in Chile, a right contained in Chile's legal framework. Moreover, according to the last National Socio-Economic Characterization Survey, of the total number of individuals born abroad and currently residing in Chile, 8.9% are not eligible for Social Security benefits, while this percentage reaches 2.5% in the Chilean population.[1] This shows the existing inequality regarding access to Social Security between the national and foreign population.

Chile has been the destination of South American migrations for the last two decades.[2] The increase in this population has posed a greater challenge to public policies, particularly in terms of health care. The figures reported by the Aliens and Migration Department in 2016 show that, in the last 13 years, the number of foreign citizens has increased by 123%. By 2014, the foreign population residing in Chile had increased to 410,988 people, most of whom came from neighboring countries: 37.8% of the total number of foreigners are Peruvian, followed by 16.3% of Argentinians and 8.8% of Bolivians.[3]

Regarding the distribution of immigrants, the Chilean regions that have experienced the largest immigrant population growth rate are mainly the northern part of the country, especially Antofagasta, Tarapacá and Atacama (Table 1). The bi-border region of Arica and Parinacota has experienced an average growth rate similar to that of the Santiago Metropolitan Region, which is home to the

Table 1. Estimated number of foreign residents by region. Chile, 2009 and 2014.

Region	Residents 2009	Residents 2014	Average growth rate per period (%)
XV Arica and Parinacota	10,383	14,577	7.03
I of Tarapacá	17,517	27,565	9.56
II of Antofagasta	18,200	30,829	11.19
III of Atacama	2,191	3,782	11.57
IV of Coquimbo	4,814	6,468	6.11
V of Valparaíso	20,781	24,934	3.71
VI of O'Higgins	4,358	5,704	5.54
VII of Maule	4,164	5,106	4.16
VIII of Bio-Bio	9,461	11,576	4.12
IX of Araucanía	8,488	9,353	1.96
X of Lagos	7,190	8,344	3.02
XIV of Ríos	2,840	3,206	2.45
XI Aysén	1,636	1,825	2.21
XII of Magallanes	2,349	2,986	4.92
XIII Santiago Metropolitan Region	202,685	285,274	7.11
Total	317,057	441,529	6.87

Source: Aliens and Migration Department, 2014.

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

largest population of immigrants.[4] This situation has a significant impact on the public services of the regions with the largest number of immigrants, especially in the Public Health System (SPS) [*Sistema Público de Salud*]. Moreover, it should be considered that a certain percentage – which is hard to quantify – of the immigrant population, known as "undocumented" or "irregular" immigrants, resides in the country illegally. On an international level, "Estimates suggest that only between 10% and 15% of the migrant populations are in "irregular" status."[5]

In view of this situation, and in accordance with the new migration policy (which was implemented in 2008 by the President of the Republic[6] through Executive Order No. 9, in which Chile was declared "host country"), the Ministry of Health of Chile (MINSAL) [*Ministerio de Salud*] and the National Health Fund of Chile (FONASA) [*Fondo Nacional de Salud*] adopted the United Nations' International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families[7] as their ethical framework. Part III, article 28 of the convention establishes that migrants:

> ...have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.[7]

In addition to urgent care, the government of Chile decided to tackle the issue of "irregular" immigrants by executing inter-institutional agreements between the Ministry of Interior and the Ministry of Health. Those agreements were materialized in MINSAL Exempt Resolution No. 512, Exempt Resolution No. 1914 of the Ministry of Interior, and MINSAL Ordinary Resolution A-14 No. 3229. Hence, the right to Social Security (FONASA) was granted to specific types of "irregular" or undocumented immigrants as follows:

- Refugees and asylum seekers are granted the right to access Social Security.
- Foreign minors with an irregular migratory status are entitled to receive health care attention and allowed to apply for a temporary visa.
- Pregnant women with an irregular migratory status are entitled to access prenatal care and allowed to apply for a temporary visa.

The enforcement of these agreements will be analyzed in this article, which is based on the ethnographic work conducted in the clinical setting and that, on this occasion, we will analyze by using institutional sources, perceptions of health care providers in the health care sector and a review of written media articles. The point of view of users or immigrant patients is not taken into consideration in this article due to lack of space and because they have already been analyzed in other publications.[8,9]

Revision of bibliography

The relationship between migration and health has been a topic of interest on an international level, especially for organizations such as the United Nations (UN), the International Organization for Migration (IOM) and the World Health Organization (WHO). The latter focuses on, among other things, how international migration has impacted the health of those who are left behind and those who are on the move.[10] AIDS, sexual and reproductive health and tuberculosis[12] have been topics of special interest for studies about migration and public health.[11] The report titled *AIDS and mobility* states that HIV-positive individuals migrate in order to have access to treatments and also reveals a controversial measure taken in some countries: the requirement of a mandatory test that determines whether or not a person is authorized to enter the host country.[13] The main focus of these studies is placed on the fact that both the people and the diseases cross the national borders despite political and

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

administrative boundaries, thus establishing epidemiological comparisons between local and migrant populations. Risk behaviors of migrants are one of the main variables to be analyzed. There are notorious cases in border areas such as Central America-Mexico and Mexico-United States, as well as Spain, where the migrant population is especially vulnerable and affected by infectious diseases due to the health status in their countries of origin and to overcrowding and poverty conditions in the host country. Therefore, studies are being conducted about social protection in health care, in which the financial issue is shown as an obstacle to overcome in cases of migration from Mexico to the United States.[14]

In South America, the main focus has been placed on the access and use of health care services. In Argentina, a team led by Jelin states: "How to distribute the scarce resources as well as whether or not those residing in the country or specific areas should be prioritized were the central issues in the debate."[15] Thus, the rights of foreigners are questioned in relation to the rights of access to health care of local or native citizens. On the one hand, in the Argentine study it is observed that the policies regarding access to health care depend on the orientation and attitude of the directors of the institutions or of the physicians and health workers,[16] even when access to public health care is guaranteed by the State. On the other hand, Bolivian immigration to Brazil has been subject of multiple studies, among which the topic of the right to health care is included, which shows discrimination and abuse against this community. However, it is concluded that the causes actually stem from a structural deficiency of the system, as there would be marginal Brazilian patients who would also receive a similar treatment.[17] Moreover, Brazil has experienced a strong demand in health care in theborders with Argentina, Paraguay and Uruguay due to free movement agreements between the member states of the Southern Common Market (MERCOSUR) [Mercado Común del Sur], which have allowed the free movement of people, facilitating their residence and enabling them to exercise their right to health in this host country. Thus, the migratory flows in the borders reveal the asymmetries in health care systems in different countries, while questioning the decision to prioritize the economic dimension over the social integration process promoted by MERCOSUR.[18]

In Chile, some studies have been conducted by the health care sector that show how this problem has become a subject of national interest. It is important to highlight the reports on immigrants' health and mental health in the northern area of the Santiago Metropolitan Region.[19] These diagnoses approach the problem based on the local experience and establish the characterization of this new health care situation that resulted from immigration. Similarly, Vásquez-De Kartzow[20] reflects on this issue from a pediatric perspective, and suggests that migration in Chile entails challenges for which the Chilean society is not prepared. He also mentions the impacts that migration has caused on an international level, particularly at a demographic and epidemiological level, and how the health care systems have adapted to them.

As for the social sciences in Chile, there is interest in connecting health and migration in several studies. For instance, Cortez's research work highlights the delicate situation of immigrants in an irregular administrative situation, warning that one of the aspects of greatest impact to accessing medical care is a person's migratory status.[21] Moreover, in other research, Cortez *et al.* point out that, "Even if the migratory status of people is regularized, there is still a high percentage of unregistered migrants in the medical centers..."[22] Some studies conducted in Chile have addressed more specific aspects related to sexual health, as shown in the study focused on young immigrants conducted by Cortez, which mentions the risks and vulnerabilities that this group presents against HIV/AIDS.[23] Along these lines, the study of Núñez shows the hardships that Peruvian women encounter to access and receive sexual and reproductive health care, which evidences the discriminations they suffer.[24]

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

These researchs usually highlight and address problems in the form of characterization or denouncement. However, this work is focused on analyzing the criteria for the access to health care of undocumented immigrants, aiming to address the source of the difficulties that they encounter in Chile. Furthermore, the studies mentioned above help identify the lack of information about the conflictive situations experienced by immigrant patients. Therefore, this work will address the relationship established among administrative officers, health care providers (hereinafter, officers), and immigrant patients, as well as the relation between the latter and the Public Health System. The perceptions of officers about immigrant users in general will be shown for the purpose of proving our hypothesis that there is a power relationship between officers and immigrant users based on social inequality (asymmetry), political inequality (nationalism), and cultural inequality (alterity). This work is supported by studies that show that the clinical setting is relational and, above all, complex in a pluralist context, as the meaning of life, death, and suffering is not universal.[25] Cognet points out that the cultural differentiation established by therapists regarding foreign patients arises from the confrontation with such alterity: "Culture is no longer that of a distant Other but rather of an Other that lives in our house."[26] On the other hand, Fassin[27] explains that "immigrant's health" is a long-standing concern because it carries the heavy stigma of introducing new diseases, which represents a risk to society as a whole, both bacteriologically and economically. However, Fassin also remarks that the relationship between public health and immigration policies places body- and life-related matters on the foundations of our political moral principles, as disparities are not limited to socio-economic differences; on the contrary, the gaps remain when it comes to minorities such as foreigners.[28] This is how social inequality becomes apparent in what Caizzi calls a "relationship of avoidance and unilateral domination," and remarks that it is difficult for a public service agent not to create his or her own system of representations, which may hinder the main purpose of such service: access to social rights.[29] The result of this inequality may be an act of discrimination which, according to Fassin, "is the unequal treatment based on the enforcement of an illegitimate criterium."[30]

This article aims to fill the gaps in relation to this matter and provide substantiated and updated information on issues concerning undocumented immigrants' access to health care in Chile, although this may affect the immigrant population in general.

METHODOLOGY

This text is mainly based on the results of a doctoral research[8] and on the follow-up conducted on our current projects. Within an etnography of the clinical setting, a qualitative research methodology was used. In other words, the researcher delves into the field of study to better describe it and interpret it. To achieve this purpose, in 2009, a four-month fieldwork was conducted in Health Care Centers No. 1, No. 5 and Los Nogales, as well as in the Hospital San Borja Arriarán, wichi reports to the Central Santiago Metropolitan Region Health Service [*Servicio de Salud Metropolitano Central*]. 19 officers, who represented each of the work areas of the health centers (Table 2), were interviewed. The directors of the centers decided who to interview based on their positions and requested their collaboration. Each interviewee signed an informed consent form and authorized the audio recording of the interviews. The number of interviews was determined by the saturation of the collected data; that is to say, until no new data could be found. Participant observation was used as a supplementary method. It consists of being part of the studied group by assuming a specific role in order to understand how the group functions from within. In this case, we joined a work team for the elaboration and testing of a pilot project on training and sensitization about care to immigrants aimed at

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

Table 2. Number and age range of interviewed health officers, according to their position/occupation and sex. Santiago Metropolitan Region, Chile, 2009.

Position/Occupation	n	Sex		Age range
		M	F	
Directors of (medical) centers	3	2	1	25-35
Social workers	3	1	2	25-45
Psychologists	2	-	2	25-35
Nurses (4 Area Supervisors and 1 clinical support)	5	-	5	35-55
Nutritionist	1	-	1	45-55
Physician (Deputy Director)	1	1	-	45-55
Administrative coordinator	1	1	-	25-35
Officer at the information, claims and recommendations Unit	1	-	1	35-45
Paramedical Technician	1	1	-	45-55
Officer at the medical orientation service	1	-	1	45-55

Source: Own elaboration.

officers of the Central Santiago Metropolitan Health Service. There were two intervention activities: a three-hour workshop in which all the officers of Health Care Center No. 1 participated (approximately 90 officers) and a 16 hour-training course, divided into two sessions, in which 60 officers participated.

The analysis of the transcribed interviews and the annotations from conversations and observations is based on an analysis of the perceptions of the subjects studied, in this case, the officers. As expressed by Witker Barra,[31] perception is understood as:

> ...the cognitive activity related to the storage and processing of information and that consists of the following abilities: to classify, select, simplify, abstract, analyze and summarize the information received.[31] [Own translation]

The perceptions were separated into "appreciations" (understood as personal considerations and comments) and "verifications" (understood as affirmations and certainties). Then, a subcategory was established to mark the subjective nature conveyed by a "positive," "negative," "ambiguous," or "neutral" value judgment of the statements referring to immigrant patients or their practices.

In order to conduct this analysis, the interviews and field notes were read, and the phrases and concepts of greater occurrence and frequency were selected. Then we interpreted the narratives, looking for relations and hierarchization of perceptions. By doing so, we realized that sometimes, a perception was an appreciation (that is, an opinion based on personal perceptions) and, other times, a verification (that is, an assertion they defended).

Moreover, Chile's legal framework regarding immigration was studied, as well as the evolution of health regulations and policies focused on the undocumented population. In addition, the national press and the local newspaper "*La Estrella de Iquique*" – from the Tarapacá region – were monitored in order to select pieces of news that included the following keywords: immigration, immigrants, Peruvians, Bolivians. This information was used to illustrate the relationship among public policies, the officers' actions and the implications for the immigrants.

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

This research was endorsed by the Ministry of Health of Chile, the National Health Fund of Chile and the Central Santiago Metropolitan Region Health Service. These institutions authorized the fieldwork, the guidelines for the interviews, and participated in the elaboration and implementation of the intervention project.

ETHNOGRAPHY OF THE CLINICAL SPACE

This section presents the results of the cross-checking of data, which were collected from the analysis of interviews, participant observation, and the reviewing of articles published by different written media.

Officers-immigrant patients relation

Health Care Centers No. 1 and No. 5 of Central Santiago (Chile) are old buildings, with a sturdy architecture, thick walls and high ceilings that produce a microclimate several grades below the outside temperature and generate a low intensity lighting. These ancient buildings are not quite immigrant-friendly, and the immigrants do not feel welcomed, especially early in the morning, when users of the center ("the community") rush to book a medical appointment. Health workers only consider national users as members of "the community"; immigrants are not considered as a part of the community and are categorized as "new users." It is at this time of the day when most of the conflicts between national and foreigner users are unveiled and hostile situations towards the "new users" can be readily observed.

Figure 1 shows the most frequently mentioned perceptions in the interviews, informal conversations, and observations about immigrant patients in general. No trends associated with the social position of the officers – such as job position or educational level –, or with the age group or sex of the interviewees have been observed. However, a transversal predisposition on the officers' part to perceive immigrant patients negatively has been found (16 negative appreciations of a total of 32 and 10 negative verifications of a total of 21), expressing, for instance: "they are insistent," "they are very demanding," "they consult a lot." These three perceptions are associated with immigrants pressing the Public Health System and can be interpreted as follows: "they come for any reason, they demand proper treatment and they are defensive." This has been analyzed in other publications in a more detailed manner.[8,9]

On the other hand, some positive characteristics are mentioned, such as: "they are well informed, and they know their rights," "they meet all the requirements needed," "they are well spoken." These three perceptions show that officers recognize that these patients create their own strategies (either personal or collective) to access health care, despite the barriers imposed on them.

Ambiguous perceptions were also found to a lesser extent. That is to say, these perceptions are neither explicitly negative nor positive, for instance, "They have a particular way of being." There are also neutral perceptions which are non-judgmental, such as, "More women seek care, specifically pregnant women." Despite these perceptions being ambiguous or neutral, they suggest that, on one hand, this is a "different" population and that, on the other hand, this population exerts pressure on the system from the maternity area. Finally, it has been found that there are two negative perceptions that stand out and which are stated as verifications: those that say that immigrants "are an epidemiological public health problem," and those that point out that immigrants "are an economic burden to the system." These perceptions impact the access to health care and medical assistance, especially when there are other pre-existing barriers such as lack of documentation. This condition of undocumented immigrants implies that, for instance, a female user cannot be registered in the system because she does not have a national identification number. At the same time, this implies that the system does not receive a subsidy from FONASA for

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

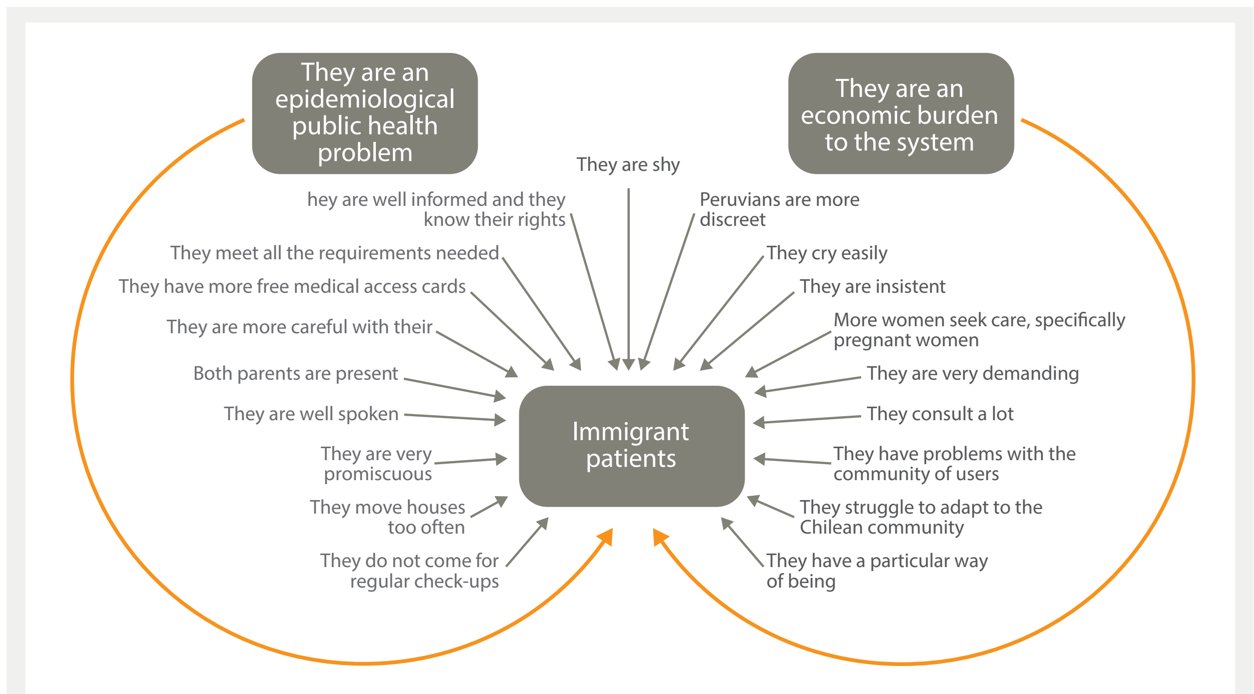


Figure 1. Officers' perceptions on immigrant patients. Santiago Metropolitan Region, Chile, 2009.
Source: Own Elaboration.

each unregistered person, since the financing of Public Health System is organized according to the number of registered people, that is to say, *per capita*: the health centers receive a subsidy for each registered person. The following section will expand on how this influences the violation of the most basic principles of the health care system.

Public Health System-undocumented immigrant patients relation

The data collected shows that the difficulties that undocumented immigrants face in order to access health care are reinforced by two aspects: 1) the non-compliance of ministerial agreements and 2) the agents' personal criteria.

When analyzing the enforcement of inter-ministerial agreements extending health coverage to "irregular" patients, data reveals a lack of compliance to these agreements. Particularly, certain cases have been found in written media in which the access of this population to SPS is questioned. For instance, a woman was detained for five days in the Hospital de Arica for an alleged unpaid debt after giving birth in that hospital. According to institutions and groups of immigrants of the region, this is not an isolated case. The digital newspaper *El Morrocotudo* published this story on September 17, 2014, with the following headline: "Migrant organizations denounce alleged case of discrimination on the Chile-Peru border."[32] The National Institute of Human Rights of Chile (INDH) [*Instituto Nacional de Derechos Humanos*] confirms that the Tarapacá Hospital only issues birth certificates of immigrant children if all birth-related costs incurred in the hospital are fully paid. In many cases, mothers lack the money necessary to pay and they run away from the health center without the certificate; thus, their children cannot be registered in the Register Office. The undocumented status of these children prevents them from accessing social rights. The INDH reports documented cases, based on which it

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

states: "These situations could constitute violations to the current regulations."[33]

Since 2006, there have been stories published in the press that question the medical attention provided to immigrants in the SPS. The border area is particularly sensitive to this issue. Using the headline, "Foreign patients to blame for health losses,"[34] the director of the Health Care Service of Arica [*Servicio de Salud Arica*] talks about the increase in health care provided to foreigners who do not have social security benefits and cannot pay the amount required by the Emergency Unit (15,000 CLP per person, equivalent to 22 USD) and by the Maternity Service (minimum of 150,000 CLP, equivalent to 220 USD) of the Hospital Dr. Juan Noé in Arica. She states: "We don't receive any extra resources despite being a city bordering two countries and for providing health care to foreign patients. We use our own resources, and that is to the detriment of other health care practices."[34] On the other hand, the director of the Municipal Health Center of Iquique [*Salud Municipal de Iquique*] (Tarapacá Region) stated in the School for Managers of Migrant Health Care [*Escuela de Gestores en Salud Migrante*], organized by MINSAL in the city of Iquique on December 11, 2014, that this "*underfunding*" of the SPS was due to the high demand of immigrants without social security benefits (information recorded in our field notes).

In addition, it has been confirmed that neither a policy for the diffusion of the agreements nor training sessions aimed at agents are ensured. Each Health Service is simply allowed to apply its own policy towards this population. Ordinary Resolution A-14 No. 3229,[35] establishes:

> In order to faithfully comply with these ministerial provisions, Health Care Services directors should inform all workers under their responsibility about these measures and get coordinated with those in charge of the Aliens and Migration offices under their geographic jurisdiction. [Own translation]

In accordance with this provision, the Central Metropolitan Health Service handed out a document regarding how officers should approach immigrants in all their health centers, in which "different categories of immigrants" are mentioned. Its goal is that officers encourage undocumented immigrants to regularize their status as well as to use their "personal judgment" – depending on the situation – to determine when to provide an immigrant with an exceptional treatment based on the observance of human rights, but also in accordance with the provisions on public health protection issued by MINSAL. The document also mentions that there is an epidemiological problem which the government of Chile must tackle for the sake of the common good.[36] However, the predicament arises when this population is presented as a "problem" in a document which is not duly explained in a training course but just distributed. As a consequence, officers develop a negative perception regarding the patients belonging to this group.

When analyzing the 1975 Decree Law No. 1094, known as the Aliens and Migrations Act (which regulates immigration in Chile), we observed that it provides for the application of "discretionary judgment" in the case of the issuing of visas. This means that the criteria are divided into situations in which authorities either *must* or *could* forbid entry to the country and reject or revoke a visa. The same discretionary judgment, applied to this study, has caused acts of discrimination in immigrants' access to health care. Below, two illustrative cases are highlighted.

Case 1: In 2008, a Peruvian woman was absolutely desperate after having waited for almost two hours to be admitted to the delivery room in the Hospital San José. She finally went to the bathroom in the health facility and gave birth to her child. This scene was recorded by her partner using a cell phone, and the incident was extensively covered by the media. The baby's father filed a malpractice suit against the hospital, since he claimed having felt "mistreated and abused," for not receiving the expected standard of care. The story

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

was published by the digital newspaper *El Mercurio Online* on April 9, 2008 under the headline "Woman gives birth in the bathroom of Hospital San José."[37]

Case 2: On October 7, 2014 an infant of Bolivian parents died. He had presented diarrhea in the early hours of the morning and, according to the parents' report, the child did not receive timely care. There were several reactions, among which the one from the INDH stands out: "A nine-month-old baby, of Bolivian parents, passed away in Arica for not receiving medical attention," a news article published by *Diario Uchile* on October 10, 2014, under the following headline: "INDH blames public health for infant death."[38] The reason to deny the care was economic. "The Hospital Juan Noé would have denied them medical care because they did not have the amount of 30,000 CLP that the hospital had charged." The information was published by *Biobiochile*, on October 8, 2014, with this headline: "Hospital in Arica under investigation for alleged medical care denial to a Bolivian baby who died in Azapa."[39]

Illegitimate patients

The relationship between patients and health care professionals is always asymmetrical. Those who have studied this problem claim that the patient-therapist relationship is a social relationship, and that even clinical relationships are in fact power relationships.[25] In our study it has been observed that, in the immigrant/health care officer relationship, this condition can be observed more clearly, as the immigrant represents alterity, that is to say, the "other," the person beyond the border of "us" (the national community). For this reason, officers question the immigrants' access to health care based on the differentiation assigned to them according to their legal or administrative status, and according to practices or any characteristic defined as cultural or physical, among others. The main consequence is that inequality in health occurs between the national and foreign communities. The connotation of the term "new users" as opposed to "community of users" is decisive and shows from the start the division established between "those who belong here" and "those who come from outside." The condition of alterity of these patients and the asymmetry in power relationships emerge as a defensive weapon to protect "our" interests. Thus, nationality, migratory status, and economic capacity appear as subjective criteria (symbolic justification) in order to decide who is a legitimate patient of the SPS and who is not. This occurs despite the fact that, from a legal perspective, the notion of illegitimate patient is untenable since there is a regulatory commitment to provide health care access to certain categories of undocumented immigrants.

In the case of the pregnant woman, her migratory status is irrelevant, since there is an evident predisposition to not respond to the emergency. In the case of the infant, if the family group is undocumented, the denial of emergency care due to non-payment prevails. The child's parents are Bolivian, indigenous people, and undocumented, which is why officers propose private attention.

It is noted that, in the area of access to health for the undocumented, the health inequality is greater because inter-ministerial agreements to provide medical care to certain groups of undocumented immigrants are not always enforced. When considering undocumented immigrants as an economic burden to the SPS, officers demand payment for private health care, thus breaching the agreements. It is observed that the criterium applied always depends on the health care officer, never on the regulations. Lesselier applies the term "infra-rights," which is used to solve complex and conjunctural situations: "a great part of the status of foreigners is governed by so-called 'infra-rights': those at the reception desk, the circular letters and the discretionary power of administrative authorities."[40] [Own translation].

Similarly, Bec states that inequality is a social relationship that promotes poverty, "to reason in terms of inequality is to reason about a reality in which core interdependen-

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

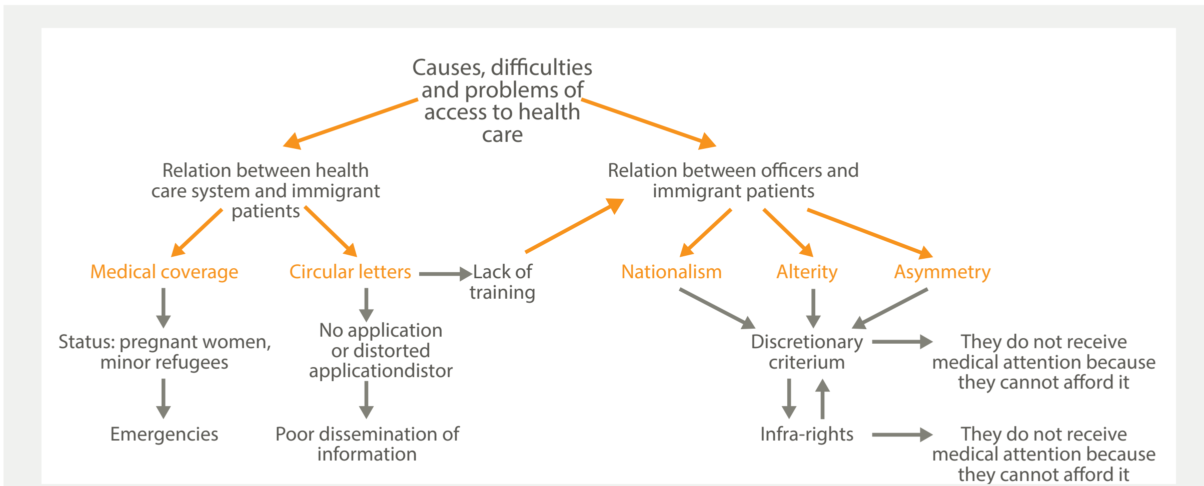


Figure 2. Map of conceptual articulation of results.

Source: Own elaboration using data from Liberona Concha.[8]

cies unfold between individuals and social groups." The author associates poverty with the very functioning of society, "in the simultaneous crossing of individual journeys and economic and social mechanisms."[41] A supplementary way of observing and describing inequality takes into account a distinction between two different orders of things: on the one hand, inequality creates differences and, on the other hand, real or alleged differences "tolerate" inequality. The perpetuation of this distinction would help link culture with society and economy with politics, creating variable relationships that could be analyzed as interethnic or "interracial" relations.[42] Therefore, for the case studied here, it can be claimed that access to health care for undocumented immigrants in Chile is based on these uneven interethnic relations (Figure 2).

However, there is another element to take into consideration: one of the main perceptions of officers regarding immigrant patients is that they represent an economic burden to the system. This situation is directly related to the fact that FONASA does not grant an extra subsidy for the health care authorized and promoted by the regulations. Thus, the pressure caused by the lack of resources, combined with little to no training in terms of rights, is presented as the perfect scenario to discriminate with full legitimacy. Following this logic, it can be said that the inter-ministerial agreements that elicit legal reforms agreed upon at a political-normative level, when not supported by the resources and/or the adequate planning for their implementation at an executive-administrative level, are the leading cause of the problem addressed in this research work.

CONCLUSIONS

The difficulties that undocumented immigrants face to access health care in Chile are affected by the perception of officers who, after elaborating their own system of representations, regard them as a burden to the system rather than as a legitimate part of the community of users. The data mentioned here support the idea that both infra-rights, as well as discrimination against the group that represents alterity in the system, occur regardless of the social position, educational level, age, or sex of the health care officer but because of their xenophobia and prejudices derived from nationalist notions.

These negative perceptions, together with the discretionary powers exercised by health

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

officers, could invalidate rights established in the Chilean legislation or set forth in international treaties and inter-ministerial agreements. Moreover, this situation can generate more poverty for the undocumented who have no other choice than private health care.

However, this investigation also reveals that a large part of the responsibility falls on those who define the regulations and do not take into account any additional resources, nor elaborate a national policy to ensure the diffusion of agreements, or provide proper training and relevant sensitization to officers. Therefore, we would be dealing with discrimination at an institutional level and not only at an individual level of health care officers, which paves the way for further analyses that we hope to address in the future.

These conclusions have implications for the research development in this area as well as for professional practice and focalized health policies. By providing empirical data, future studies can use them to analyze the advances or setbacks in the application of policies aimed at this group. Additionally, they can be a reference for specialized studies in the theories of interethnic relationships. Regarding health practice, the aim of this work is to help health care professionals put themselves in the shoes of the other person and reconsider their roles in the social relationship between patients and therapists. Finally, these conclusions help visualize problems of a relational nature, in which individuals are the ones who make decisions beyond the legal frameworks. This could help understand why obstacles persist where solutions have already been provided.

ACKNOWLEDGMENTS

This research was funded by the National Commission for Scientific and Technological Research of Chile [Comisión Nacional de Investigación Científica y Tecnológica], through the Attraction and Insertion of Advanced Human Capital Program No. 79140078 of 2014 entitled "Interethnic and crossborder relationships within the current international migration framework" ["Relaciones interétnicas y transfronterizas en el marco de las migraciones internacionales actuales"]. We would also like to thank the Vice Rector's Office of Research, Innovation and Postgraduate Studies [Vicerrectoría de Investigación, Innovación y Postgrado] of the Universidad Arturo Prat for granting the funds to attend an International Congress, which resulted in this article.

REFERENCES

1. Ministerio de Desarrollo Social. Encuesta de Caracterización Socioeconómica Nacional: Contenidos: Inmigrantes [Internet]. 2013 [cited 1 Mar 2016]. Available from: https://tinyurl.com/y7v68npb.

2. Texidó E, Gurrieri J. Panorama migratorio de América del Sur 2012. Buenos Aires: OIM; 2012.

3. Departamento de Extranjería y Migración, Ministerio del Interior y Seguridad Pública. Migración en Chile 2005-2014 [Internet]. 2016 [cited 10 Mar 2016]. Available from: https://tinyurl.com/grb856c.

4. Departamento de Extranjería y Migración, Ministerio del Interior y Seguridad Pública. Caracterización de la migración en chile: Una Mirada desde instrumentos gubernamentales [Internet]. 2014 [cited 10 Mar 2016]. Available from: https://tinyurl.com/ybofpmew.

5. Castles S. Migración irregular: causas, tipos y dimensiones regionales. Migración y Desarrollo. 2010;8(15):49-80.

6. República de Chile, Presidenta. Instructivo Presidencial N° 9, Política Migratoria en Chile. Santiago: 2008.

7. Naciones Unidas. Convención internacional sobre la protección de los derechos de todos los trabajadores migratorios y de sus familiares [Internet]. 1990 [cited 10 Mar 2016]. Available from: https://tinyurl.com/yakn8akk.

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

8. Liberona Concha N. La prise en charge des immigrants sud-américains dans le système public de santé chiliIn: un espace de tensions interethniques. [Tesis de doctorado]. Paris: Université Paris Diderot, Paris 7; 2012.

9. Liberona Concha N. De la alterisación a la discriminación en un sistema público de salud en crisis: conflictos interétnicos a propósito de la inmigración sudamericana en Chile. Revista de Ciencias Sociales. 2012;(28):19-38.

10. Organización Mundial de la Salud. Migración internacional, salud y derechos humanos. Ginebra: OMS; 2005.

11. Centro Nacional para la Prevención y el Control del VIH/SIDA. SIDA: Aspectos de salud pública. México: CENSIDA/INSP; 2006.

12. Molina-Salas Y, De las Mercedes Lomas-Campos M, Romera-Guirado FJ, Romera-Guirado MJ. Influencia del fenómeno migratorio sobre la tuberculosis en una zona semiurbana. Archivos de Bronconeumología. 2014;50(8):325-331.

13. AIDS & Mobility. Sida y movilidad: Situación, políticas e intervenciones (Informe reunión satélite). XIV Conferencia Internacional del Sida. Barcelona: AIDS & Mobility; 2002.

14. Arredondo López A, Orozco Núñez E, Wallace S, Rodríguez M. Indicadores de gobernanza para el desarrollo de estrategias binacionales de protección social en la salud de los migrantes. Saúde e Sociedade. 2013;22(2):310-327.

15. Jelin E. (dir.). Salud y migración regional: ciudadanía, discriminación y comunicación intercultural [Internet]. Buenos Aires: IDES; 2005 [cited 10 Mar 2016]. Available from: https://tinyurl.com/y8ee9p27.

16. Jelin E, Grimson A, Zamberlin N. ¿Servicio?, ¿Derecho?, ¿Amenaza? La llegada de inmigrantes de países limítrofes a los servicios públicos de salud. In: Salud y migración regional: ciudadanía, discriminación y comunicación intercultural [Internet]. Buenos Aires: IDES; 2005 [cited 10 Mar 2016]. Available from: https://tinyurl.com/y8ee9p27.

17. Waldman TC. Movimentos migratórios sob a perspectiva do direito à saúde: imigrantes bolivianas em São Paulo. Revista de Direito Sanitário. 2011;12(1):90-114.

18. Dal Prá KR, Mendes JMR, Mioto RCT. O desafio da integração social no MERCOSUL: uma discussão sobre a cidadania e o direito à saúde. Cadernos de Saúde Pública. 2007;23(Sup 2):S164-S173.

19. Demoscópica. Diagnóstico y factibilidad global para la implementación de políticas locales de salud para inmigrantes de la zona norte de la Región Metropolitana [Internet]. 2009 [cited 10 Mar 2016]. Available from: https://tinyurl.com/y83nbc9d.

20. Vásquez-de Kartzow R. Impacto de las migraciones en Chile: Nuevos retos para el pediatra, ¿estamos preparados? Revista Chilena de Pediatría. 2009;80(2):161-167.

21. Cortéz Salas A. Migración internacional: un desafío para las políticas públicas de Chile. In: Niños y niñas migrantes: Políticas públicas, integración e interculturalidad Santiago: Colectivo sin Fronteras; 2007. p. 105-118.

22. Cortéz Salas A, Reyes GC, Reyes MS. Salud sexual y reproductiva y migración latinoamericana en Chile: Una aproximación cualitativa a las situaciones de riesgos y conductas de prevención del VIH-SIDA. Cuadernos Médico Sociales. 2010;50(4):322-339.

23. Cortéz Salas A, Donoso Orellana C, Loredo Chupán P. Diagnóstico de riesgo y vulnerabilidad frente al VIH/SIDA de jóvenes inmigrantes peruanos. Santiago: Colectivo sin Fronteras; 2007.

24. Núñez N, Torres C. Mujeres migrantes peruanas y salud reproductiva: Usuarias de consultorios de salud de la zona norte de la Región Metropolitana. Santiago: Instituto de la Mujer; 2007.

25. Fortin S, Laprise E. L'espace clinique comme espace social. In: Cognet M, Montgomery C. Éthique de l'altérité: La question de la culture dans le champ de la santé et des services sociaux. Montréal: Les Press l'Université Laval; 2007. p.191-214.

26. Cognet M. Au nom de la culture: le recours à la culture dans la santé. In: Cognet M, Montgomery C. Éthique de l'altérité: La question de la culture dans le champ de la santé et des services sociaux. Montréal: Les Press l'Université Laval; 2007. p. 39-64.

27. Fassin D. Repenser les enjeux de santé autour de l'immigration. Hommes & Migrations. 2000;(1225):5-12.

28. Fassin D. Santé et immigration: Les vérités politiques du corps. Cahiers de l'Urmis. 1999;(5):69-76.

29. Caizzi A. Présence et représentation des usagers aux guichets des caisses d'Allocations familiales. Informations Sociales. 2010;(158):112-120.

SALUD COLECTIVA. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110

30. Fassin D. Discrimination et santé: enjeux politiques et signification sociale. Profession Banlieue. 2002;4(11):1-22.

31. Witker Barra I. Bolivia 2003: percepciones de la crisis en la prensa chilena y su impacto en la seguridad subregional y relaciones bilaterales. Santiago: Academia Nacional de Estudios Políticos y Estratégicos, Ministerio de Defensa Nacional; 2005.

32. Denuncia ciudadana: Mujer migrante lleva 5 días sin poder salir del Hospital de Arica hasta que pague el parto. El Morrocotudo [Internet]. 2014 [cited 10 Mar 2016]. Available from: https://tinyurl.com/krh8lvu.

33. Instituto Nacional de Derechos Humanos. Informe Misión de observación situación de la población migrante Iquique y Colchane. Santiago: INDH; 2013.

34. Cousins P. Las pérdidas en salud con los extranjeros. La Estrella de Arica [Internet]. 2006 [cited 10 Mar 2016]. Available from: https://tinyurl.com/y8gg2tsc.

35. Gobierno de Chile, Ministerio de Salud. Oficio ORD-A-14 Nº 3229 [Internet]. 2008 [cited 10 Mar 2016]. Available from: https://tinyurl.com/yax7luay.

36. Gobierno de Chile, Ministerio de Salud, Servicio de Salud Metropolitano Central. Minuta Atención Inmigrantes. Santiago: SSMC; 2008.

37. Mujer da a luz en baño de Hospital San José. El Mercurio Online [Internet]. 2008 [cited 10 Mar 2016]. Available from: https://tinyurl.com/yajswqsx.

38. González T. INDH condena a salud pública por muerte de lactante. Diario Uchile [Internet]. 2014 [cited 10 Mar 2016]. Available from: https://tinyurl.com/y75zao4b.

39. Mardones C. Investigan si Hospital de Arica negó atención a bebé boliviano que murió en Azapa. Bibiochile.cl [Internet]. 2014 [cited 10 Mar 2016]. Available from: https://tinyurl.com/y98gv7jl.

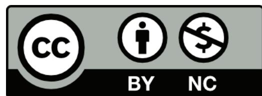
40. Lesselier C. Politiques d'immigration en France: appréhender la dimension de genre. Les Cahiers du CEDREF. 2008;(16):189-208.

41. Bec C. Les pauvres font bande à part. Déviance et Société. 2002;26(2):245-251.

42. De Rudder V, Poiret C, Vourc'h F. L'inégalité raciste: l'universalité républicaine à l'épreuve. Paris: Presses Universitaires de France; 2000.

CITATION
Concha NL, Mansilla MA. Illegitimate patients: Undocumented immigrants' access to health care in Chile. Salud Colectiva. 2017;13(3):507-520. doi: 10.18294/sc.2017.1110.

Received: 26 Aug 2016 | Modified: 31 Jan 2017 | Approved: 13 Mar 2017



Content is licensed under a Creative Commons Attribution-NonCommercial 4.0 International.
Attribution — you must attribute the work in the manner specified by the author or licensor (but not in any way that suggests that they endorse you or your use of the work).
NonCommercial — You may not use this work for commercial purposes.

https://doi.org/10.18294/sc.2017.1110

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English< >Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by Tais Abril Adonis and Rocío Ferraro Torres under the guidance of María Victoria Illas, reviewed by Emily Leeper under the guidance of Julia Roncoroni, and prepared for publication by Cecilia Bruten under the guidance of Vanessa Di Cecco. The final version was approved by the article author(s).