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Editors

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Part III Racism Xenophobia and Struggles Over Migrant's Rights

Chapter 9
When Migrant Pain Does Not Deserve Attention: Institutional Racism in Chile's Public Health System

María Emilia Tijoux Merino and Constanza Ambiado Cortés

We dedicate this text to Monise Joseph, Joseph Henry, Benito Lalane, Rebeka Pierre, Wislande Jean, Joane Florvil, and to those who have confronted institutional racism in public health services in Chile.

9.1 Introduction

The analysis of institutional racism and its links to the abuse of immigrants requires analyzing "race" and racism, concepts seldom used in research on contemporary immigration in Chile. These concepts have, better yet, been resisted and replaced by euphemisms, such as "exclusion", "discrimination", or "criminalization". In view of this and due to the frequent abuses that migrants experience, our research has focused for several years on the forms and manifestations that anti-immigrant racism has acquired in Chile.[1] The centering of racism in the analysis of immigration is an urgent task, especially as the current government implements migration policies that seek to "put the house in order" (Cooperativa.cl, 2018; EFE, 2021). This potent slogan has been used by President Sebastián Piñera since 2018, when he took office for the second time. He has fostered discourses that characterize immigration as a "problem" and that blame immigrants for uncertainties and

The research we present in this chapter results from the FONIS project SA1810123 entitled "The Challenge of Cultural Competences in Primary Health Care: A Study of Socialization among Immigrant Users and Healthcare Professionals in the *Comuna de Quilicura*," which was carried out between 2019 and 2021 under the direction of María Emilia Tijoux.

[1] For more, see Tijoux (2016); Tijoux and Córdova (2015), among other articles and book chapters.

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precariousness in Chilean society. When authorities and institutions construct, repeat, and promote these notions of immigrants, many people consider them as truths and act accordingly, thus naturalizing the assumption that citizens' lives are worth more than immigrants' lives.

We understand racism as a system of ideologies, discourses, practices, representations, and stereotypes; a social relationship; and a system of power that racializes immigrants, communicating to them that the outside is their true place as they momentarily occupy a space that pertains to the sovereign (Tijoux & Trujillo, 2016). Deployed in various forms and shifting over time and across societies, racism is plural, violent, and cunning. The furtive violence of everyday racism comes from laws and protocols that generate or reproduce hierarchical "differences" and inequalities.

The term "institutional racism" emerged in 1964 in the United States, after the abolition of segregation. Carmichael and Hamilton (1967) were organizers, activists, and intellectuals who promoted "black consciousness" or "Black Power" and who theorized the existence of a veiled racism that stemmed from colonialism, slavery, and class relations and saw ingrained in institutional practices. These authors argued that colonial and slave histories continued to shape the "inferior" status of the colonized and to naturalize the "superior" place of the colonizers, and that these forms of racialization were propagated through contemporary political, economic, and social institutions. That is, racism was not only expressed in prejudices and stereotypes, but also written into legislation, regulations, and administrative rules, without necessarily being overtly expressed. Institutional racism had become part and parcel of the structure of the dominant social order.

Institutional racism was also a subject of analysis in the United Kingdom. It was evident in London during violent events against the black population in 1981, when a teenager died as a victim of police brutality in Brixton. The government commissioned Lord Scarman[2] to write a report, which highlighted conflicts with police who used force indiscriminately. A new code of behavior for the police was drafted, but it was never enforced. Scarman concluded that the police force was "institutionally racist" (Law, 2015). In 1993, also in the United Kingdom, a British teenager from Plumstead (London) named Stephen Lawrence was murdered while waiting for a bus. This time the report was entrusted to William McPherson,[3] who referred to the "subtle" nature of institutional racism, which he considered as harmful as "confessed" racism. For McPherson, when an institution did not provide a person with an adequate professional service because of his or her skin color or origin, this constituted a form of racism. In addition, the report warned that what was most

[2] However, Margaret Thatcher rejected the idea that unemployment and racism had been the cause of the riots.

[3] Sir William McPherson, a retired High Court judge, is the author of an extensive report on the murder of Stephen Lawrence in the United Kingdom. The report made 70 recommendations to show "zero tolerance" for racism and included measures to transform the attitude of the police and to get the civil service, the judiciary, and other public organizations to respond and change their attitudes (Quinn, 2019).

serious was the permanence of this form of racism, since the police as an institution refused to recognize it or to combat its existence and causes.

In Chile, research on racism against the Mapuche people characterizes a nation-state that has signaled the Mapuche out as the "Other" or as a danger and threat. In this context, racism is often expressed in terms of the ethnocentricity of decisions made by dominant groups, as Verónica Figueroa (2020) points out. Chilean racism is a legacy of colonial domination and it is lodged in hierarchical racial categories linked to capitalism – which, like racism, also veils its violence (Millamán, 2001). Some studies on institutional racism in Chile address laws and policies, including the uneven uses of the anti-terrorist law (Pairicán, 2014). The Inter-American Court of Human Rights has annulled convictions against Mapuche people, arguing precisely that they suffered discriminatory treatment. In fact, the racial unevenness of police operations and the abuse of power against the Mapuche people have been the subject of multiple studies (Araya et al., 2020; Arroyo & Torreblanca, 2020).

Yet, in Chile, racism has also been present in institutional contexts, such as education – for example, in the differentiated treatment of students in schools where whiteness is a clear measure of socioeconomic differences (Webb & Radcliffe, 2018); or in the media, whereby the Chilean press constructs negative images of the Mapuche people as the Other, as opposed to the Chilean (Sáez, 2014). Indeed, institutional racism in Chile is pervasive and has existed for a long time (Diario Uchile, 2021).

Although the literature on immigration in Chile has not focused on racism as a category of analysis in institutional forms, recent literature in migration studies has documented the distinct legal and administrative conditions that immigrants face, as compared to citizens (Cabieses et al., 2017; Liberona, 2015; Liberona & Mansilla, 2017; Núñez & Torres, 2007; Scozia et al., 2014).

Given this fact, this chapter proposes to contribute to the debate and research on racist discrimination suffered by immigrants in public health centers in Chile. This research demonstrates the everyday reproduction of institutional racism in the field of health services. Methodologically, we worked through a qualitative approach and analyze the comments of public health professionals in semi-structured interviews and those of immigrants in focus groups. Beyond the everyday institutional racism that we observed, racism was also quite evident in overt stereotypes and prejudices used to explain or justify unequal treatment or mistreatment.

9.2 Access to Healthcare and Immigration in Chile: A Necessary Review

In recent years, health research has taken interest in immigrants. In a literature review, Zepeda Vega and González Campos (2019) point out that most of the research conducted has focused on describing the health conditions and precariousness of immigrants and on barriers to healthcare access, as forms of discrimination and exclusion. Many of these studies are descriptive. Some describe the health

vulnerability of immigrants from demographic data and health behaviors, observing that migration itself is often the result of conditions of impoverishment and precariousness that adversely affect health in the first place (Benítez, 2018; Cabieses et al., 2017; Cabieses & Oyarte, 2020). Others study healthcare spaces to describe both individual discriminatory acts and institutional and legal problems inhibiting access to healthcare rights (Bernales et al., 2017; Cabieses et al., 2017; Cortés et al., 2010; Liberona & Mansilla, 2017; Núñez & Torres, 2007; Torres & Garcés, 2013). There are also a few studies that have attempted to describe the discrimination perceived by immigrants in health centers in psychological terms, including the effects of discrimination on the mental health of immigrants (Lahoz & Forns, 2016; Ramírez-Santana et al., 2019; Urzúa et al., 2016).

We are particularly interested in developing studies on barriers, discrimination, and the exclusion of immigrants in the healthcare system, in a context where access to healthcare for immigrants is uncertain and confusing. In recent years, the Ministry of Health has generated decrees that ensure medical benefits regardless of migratory status, such as emergency care or healthcare during pregnancy, but, despite these legal advances, people are still widely excluded from the healthcare system and those who do access it are often treated as a burden to the system (Cabieses et al., 2017; Liberona, 2015). The social welfare system has been repeatedly studied to demonstrate inequalities in access to healthcare. For example, data from the 2017 Casen Survey estimated that the percentage of non-coverage among adult immigrants was 15.8% and that of children under the age of 18 was 20.2%, higher figures than those detected a decade prior. A secondary analysis of this survey concluded that immigrants are 7.5 times more likely to have no health insurance, as compared to Chilean citizens (Cabieses & Oyarte, 2020)– a situation that Benítez (2018) suggests should be carefully considered, as this figure has only increased despite the fact that legislation *expanded* access to these services (e.g., formally enabling affiliation to the public healthcare system, Fonasa,[4] among undocumented persons).

Other qualitative studies address the everyday forms of discrimination that cause immigrants to avoid seeking healthcare in the first place (Cortés et al., 2010; Núñez & Torres, 2007). Some studies highlight the poor treatment or lack of respect that immigrants face (Torres & Garcés, 2013), insofar as immigrants are treated as illegitimate patients (Liberona, 2015; Liberona & Mansilla, 2017). In this sense, Liberona (2015) argues that the legal framework enables uneven treatment, generating feelings of anger or frustration among immigrants. This author highlights that the relationship between patient and professional is already asymmetrical, which amplifies any characterization of the immigrant as an "Other". By the same token, Liberona and Mansilla (2017) document the predisposition of some health officials to negatively perceive these patients, qualified in some instances as an economic burden for the system and an epidemiological risk for national public health. This study demonstrates that even with regulations that ensure a certain baseline of care, such a baseline is often not met due to the discretionary provision of services.

[4] Fonasa refers to Chile's public health insurance system, which provides financial coverage for healthcare in public and private establishments.

Bernales et al. (2017) points out that another challenge for the care of immigrants is the instability and lack of knowledge about regulations and care strategies. They add that institutions lack tools and implementation strategies for culturally-sensitive care. Finally, these authors consider that healthcare workers are vulnerable to the demands of health authorities to perform new tasks without new resources and to implement regulations without having participated in decision-making or having been trained.

In terms of immigrant children and pregnant women, Cabieses et al. (2017) point out that, although their rights to healthcare are recognized by the state, they are subject to the discretion of administrative bureaucracy and the whims of healthcare officials, permitting inequalities in the quality of service provided. They also highlight that the lack of information regarding regulations and rights for the protection of immigrants shapes their arbitrary treatment.

In sum, research suggests that discrimination is pervasive. It is important to consider the causes of this mistreatment. On the one hand, the historical-political construction of Chile as a white or Eurocentric nation-state persists as a legacy of colonization and, on the other hand, the state actively reproduces immigrants as a "problem". Sayad (1999) argues that thinking about immigration requires thinking about the state, since –fundamentally– this is the organism that defines the immigrant. We must examine state institutions to understand the reproduction of anti-immigrant racism and the ongoing racialization of groups, not only as the effect of intentional action, but also of policies that passively differentiate and impact racialized groups differently. After all, differences in "race" do not exist as a biological or cultural fact, but because individuals and institutions treat distinct groups of people differently, *as if* race did exist (Fassin, 2002).

Immigrants are exposed to various forms of mistreatment that begin with their emigration, multiply during their journey(s), and continue after crossing borders or immigrating. The most frequent health problems during their migrations include injuries, hypothermia, burns, anemia, cardiovascular problems, and complications related to pregnancy and childbirth, among others. They are also subject to violence – particularly children – and disease during the journey. They often need access to appropriate healthcare.

9.3 Daily Interactions in Healthcare Centers: Between Treatment and Mistreatment

In this section, we present part of the results of a FONIS study that we conducted between 2019 and 2020 in public healthcare centers in the city of Santiago de Chile.[5] The objective was to analyze the social interactions between healthcare

[5] Fonis project SA1810123: "El desafío de las competencias culturales en la atención primaria de salud: estudio de la socialización entre usuarios inmigrantes y profesionales de la salud en la Comuna de Quilicura", directed by María Emilia Tijoux.

professionals and immigrant patients – mainly of Haitian, Venezuelan, Peruvian, and Colombian nationalities.

The professionals' criticisms of immigrants were directed at their lack of knowledge of the Chilean way of life, the country's social norms, and, above all, healthcare regulations. However, these criticisms extended to comments on intimate family life, childcare practices, housing, dress, and speech and communication. Some professionals argued that those who arrive in a new country should prepare themselves, be aware of the culture and of the limits of their own cultures, and recognize the limits of their integration.

Immigrants struggled with facing professionals who considered them as a distant or incomprehensible Other, an issue addressed by Simmel (1908) when examining forms of socialization through reciprocal interaction. The "form" is dictated by the institutions and the "content" is dictated by the actions, decisions, or purposes of those who participate in the interaction. And yet it seems that even when the encounter took place in isolation, the social distance between the immigrant and the healthcare professional remained.

The interactions narrated by professionals and patients showed their social positioning in the context of healthcare. The person was recognized first as a migrant and then as a patient who, being an immigrant, carried a stigma. "Being a patient" referred to a denomination and a place that was earned. That is, the immigrant had to adapt to the context in order to become recognized as a patient. A sort of "conversion" was necessary, which implied a radical transformation to replace one habitus with another (Bourdieu & Passeron, 1977), a process that Durkheim (1938/1990) refers to as a new vision of the world that can emerge under pressure.

One professional explains how they seek to educate immigrants under the precepts of Chilean principles:

> If you manage to educate them well, yes, they do take care of themselves, and that is why it is also perhaps more complex to educate a Haitian patient, because first there is a language issue that, that needs to be improved, and the other thing is that it is also cultural, of, of awareness that, that oral health is not just about going to fix [something], or to clean, or to take out, but also involves personal work at home. Here we try to educate them in the sense of oral hygiene and everything, we give them a hygiene kit as well, so we try to focus our treatment on educating the patient, but patients who come for sporadic consultations, it is more difficult. (E12)
>
> C: Is it difficult for them to follow a treatment, indications?
>
> Yes, it is difficult for them to follow instructions, sometimes even to ask for medication, you give them an indication here and finally you have to accompany them to the other place where they have to go because sometime they even run away. (E12)

The professionals' treatment was ultimately rooted in assumptions about cultural behaviors or social and psychological characteristics of immigrant groups. Some argued that when an immigrant had a "more acute", "more complicated", or "more compromised" health condition, there was "not much to reverse" (E25), due to the "bad" (E29) or "super limited" (E11) education of the immigrant (E20). Some participants pointed to Peruvians and Haitians as those with "less awareness" (E31) or "more backward" (E13) practices, due to their "limited cultural wealth" (E3). Others conjectured that there were "many illiterate people" among these immigrant

groups – unlike Venezuelans, who were "well educated" (E4), "super prepared" (E25) and "take very good care of their health" (E10). These professionals also commonly doubted that immigrant patients could understand medical indications and worried that their health could become complicated if, for example, immigrants ingested a medicine incorrectly or did not correctly clean their children's noses when they had respiratory problems. In short, multiple medical professionals in our study complained of supposedly essential characteristics of most immigrant groups that made their work difficult, rendered treatment less effective, and restricted their treatment options.

Peruvian and Haitian cultures, for these professionals, were also marked by "machismo" (E3), "religion" (E1), and "a magical religious thinking" (E24) that showed "many perceptions that are almost myths, almost based on legend, almost like the perceptions of old ladies" (E11). The professionals argued that the consequences of these beliefs were evident in patients' evasion of recommendations and their use of alternative treatments, including Haitian women who sought out "permanent" contraceptive methods or persistent poor "habits, aptitudes" (E18) among some patients regarding hygiene or newborn feeding. In short, some professionals reflected, "it is not easy to take care of immigrants" (E12); "it is difficult to educate them" (E1); "it is hard for them to follow instructions" (E15), until "they learn Chilean behaviors and customs" (E28). Thus, some professionals described seeking a balance between patient punishment and treatment flexibility:

> We go between two poles, between punishment and flexibility, so we try to find agreements in this. Always looking for balance. That is what I am aiming at. And the work is also oriented to that, understanding that people have their thoughts, their culture, their religion in some cases where, uh, the intervention that one can do has to look for that. To find the balance between all that. (E24)

In turn, the migrants in this study referred to the treatment they were given as distant encounters that lacked empathy and consideration for what they requested or felt. They pointed out that professionals avoided looking at them, did not touch them, and sometimes did not speak to them. They noted that some immigrants avoid healthcare centers due to abuses of power, medical negligence, and humiliation. These relations also led some to try not to get sick or save money to pay for a private clinic, avoiding public healthcare centers, except for emergencies:

> Yes, I went and they were taking out my tooth, because it hurt me a lot and I felt that my face was like – I don't know exactly, and I started to scream a little bit because it hurt me, and the doctor told me "but if you keep screaming, I'm going to put you outside, because you Haitians scream for anything, you always scream, whatever, for whatever, you scream, if you keep on like that I'm going to put you outside", that's what he told me. And I find that unfair because we are people and we have feelings, we can feel things, even though – I don't know – yes, I am Haitian, but that doesn't mean I have no feeling, I can't feel, I can't feel something, I can't hurt, I can't scream, I can't say what I feel; I left that day very disappointed because I find that very unfair, that he said that to me. (FG4-E1)

For the professionals, the immigrants tended to represent a sicker body "with more damage" (E19), with "very high blood pressure" (E25), with untreated diseases or late diagnoses, lacking previous examinations, clinical records, or prescriptions.

In other words, for many of the research participants, the immigrant patient appeared as an irresponsible and damaged subject – particularly Haitians, as compared to Chileans. That is, the professionals criticized Haitian patients in particular for the poor public health system in Haiti and their lack of knowledge of the Chilean system.

This sum of "problems" worried these professionals because of the limited resources they had available, as these patients required more attention and more time for care, a problem for a system where "time is money" (E19) and "resources are lacking for so many people" (E6).

We would like to consider closely a series of commentaries from among these healthcare professionals:

> The foreigner usually consults when it is more complicated; the Chilean consults when he starts to feel small discomforts, then yes. So, when you see a foreigner, generally in your office, you have to think that they already represent more work than you would expect for a Chilean (...). Acute symptoms such as respiratory, more in children; abdominal, but acute; it is very unlikely to detect patients (...) with chronic pathologies – that is, that is done along the way, because they consulted for something acute, you see that there is something and you start there, as if to look for some chronic disease, and then you start, you try to say, come to check-ups, comply with treatment, but more foreigners consult for some acute symptoms. (E1)
>
> I have not had the chance to talk to them about this; it is my perception, but no, you see them here, because of their indicators; they are patients with uncontrolled pathologies, that they... I don't know, you ask them, 'how long ago did you arrive?' I don't know, say, 6 months, 3 months, 1 year, and do they go to the doctor's office? No, they have no awareness, I don't know if they are educated – (it is) cultural, as far as I have been able to understand". (E31)

According to some professionals, migration had not only changed things in daily interaction in the healthcare office, but, more broadly, it also affected the Chilean public health system due to changes made in relation to this "type of patient". This is how another professional put it:

> the issue of immigrants is an issue that is not well examined yet (...) today I was told about the issue of health check-ups: Patients you ask for an examination do not understand or do not want to understand – for example something as basic as a hip X-ray – to see if there is a type of dysplasia, and they do not bring it – that is, they are not aware because they do not give it importance, because in their countries they are not important, and mainly the Haitian population is the one that has more problems with language, and suddenly they understand if radiography is said similarly in Creole as in Spanish, and yet they do not do it because they do not give importance to the issue". (E4)

The "difference" of the immigrant person, rooted in the idea of a homogenous "multitude", seemed to increase the workload by producing an "overload of care" (E2) that supposedly "stresses" (E8) and "collapses" (E31) the public health system:

> In terms of the patients, the population covered is also different, for example, this CESFAM, which covers a large population, a lot, we attend many, many patients with over capacity – that is, the schedules we have are sometimes not enough for the number of people who are enrolled. (E2)

> With immigrant patients, to be very honest, for example, Haitian patients, it's as if I see them all the same – I see them all the same; I wouldn't know how to tell them apart. There is a Haitian woman who has learned a lot of the language, and she is very cool, and we have seen her, and we recognize her, but not the other patients, no. (E32)

According to these professionals, the overload had negative effects on care and impacted material or infrastructural resources, due to the need to translate information into Creole, request more tests or supplies, or respond to more acute medical crises:

> Yes, yes definitely, if in the end the materials should be of the same quality for everyone, it should be the same quality of material for two people, but there are situations in which this has not happened because there are no resources, so we already had a certain stock and that is what we had; now we are trying to make an effort to translate it and have another alternative, and so that is the reason why they are not the same, and now we do not have the resources that were destined for this, we no longer have enough ... (E27)
>
> at the beginning it was atrocious because we were used to people coming from Peru, then they started to arrive, I don't know, Colombian women and men too; they took a lot; they came to take tests or preservatives; what do I know, but, just when they came to us (...) and we already could not work well, that is when Haitians started to arrive. (E20)
>
> we have had an increase in Haitian pregnant patients and therefore an increase in the number of deliveries here for a long time... there were many years during which no deliveries were attended here; however, with the Haitian population, I mean, we have to attend I don't know, 5 or 6 deliveries a month. Here or sometimes at home, so obviously we have had to increase our resources also (...) ... because if before we used to manage, for example, a delivery kit, which was in case of emergency, now we have had to buy 4 more, for example. (E31)

A noteworthy, repeated criticism of Haitian patients – mainly women – considered them to be irresponsible because of the large number of children they had and a perceived lack of care for them. The following interviewee hardened her criticism further, adding that they waste supplies and that "all of them" get pregnant:

> ...Haitian women, who have many children – in fact, they do not take care for themselves, and they come here because they have missed their menstrual periods and have they taken a pregnancy test? No. They want that since somehow or other all the supplies are from the public service; then you have to go and buy the pregnancy test – I don't have money. We have pregnancy tests here that are for specific issues – rapes – and [despite] giving them a medicine, giving them the prescription, and [giving] them the pregnancy test, (...) they are all pregnant, with small babies! (E32)

Regarding the expense or what is explicitly stated about the "theft of resources", this interviewee relates part of an experience and her feelings of injustice:

> Just as the doctor told me when she was operating on me, there are nurses who have told me – that is, they feel that we are stealing resources from them because there are Chilean people who are also dying of cancer and they say: if they give that hour to you or they give that treatment to you, they are taking it away from a Chilean. It has happened to me; it has happened to me, but I say that it is because, of course, I have a serious disease, which many Chileans also have, and even some have told me – that is, it happens mostly in the infirmary and in the reception area, when you enter the hospital, for example. They receive you because you have to give your history and everything; it bothers them because they have to attend to the immigrant and they feel that the immigrant is being given priority over the Chilean. (FG7-E3)

According to some interviewees, Haitian patients –particularly women– did not want to learn Spanish. In turn, the Creole language, understood as a barrier, was criticized and racialized. The professionals said that the person had to arrive speaking Spanish to be able to communicate or the presence of cultural facilitators who spoke Creole and Spanish (generally Haitian professionals from various fields with an ambiguous name and role) were required to translate. Moreover, however, professionals argued that beyond language, the "complexity" of communication had a cultural or educational origin:

> Haitian women do not have a good command of the language. I feel that they do not make any effort; they are not going to make any effort to learn it because of a cultural issue (...). So, I don't know if they didn't understand because now I tell you, that's why I tell you, they didn't understand or there is a cultural issue of putting up with the pain because it hurts, having a baby hurts. So, because here, as I said, the population increased, the number of maternity care centers increased, but at the same time, many of these mothers arrive to have their baby here, but to have a baby is a process, at least a couple of hours, sometimes hours, but at least a couple of hours, 2 hours, so for that lady to arrive with her baby hanging here, she has to endure it. So, I don't know why she didn't go to the hospital, with all the risk involved in having a baby in the street, or at home, or even here, because as I said, we are a basic service, if a baby comes with a complication, it obviously complicates the situation, but I don't know if they don't understand, they didn't understand the instructions, or they don't have [the means] to move and they went straight to the hospital, but finally they still arrive here, and they collapse here. We have no more care to give them than primary attention, an evaluation, a quick monitoring of the baby, and then to the hospital. (E31)

A Haitian patient who had arrived a little late for her appointment told us about the differential treatment she received:

> I was pregnant; I am aware that I am late, I arrive 5 minutes later than the time I should be seen, and I say, "madam I am late" and she [says] "no, the midwife is not going to attend you" (…) and I was waiting, waiting, and another person was coming. I don't know what nationality, she was white, and the lady was pregnant – the same, we had the same time and I arrived first, and when the lady passed, the official said "go and sit down, they will weigh him" and I said "but, lady, if I and she had the same time, why did you let her pass and I didn't?" "Ah, no, you are very negligent, you don't come on time". It was my second time. I left the office crying because these things seem very, very, very bad to me. (FG4-E2)

Sometimes it seems that there is an intention to understand. But in professional-patient interactions, racial discrimination often predominates, couched in criticisms about the adaptation of the person to Chile, the need to educate himself or herself, and ultimately the criticism for coming to Chile in the first place:

> I went to the course, as I tell you; we obviously learned several tips (…) When I can, when I have the time, I try to apply them; it is not a thing that I practice on a daily basis, but I try a little to practice it a little when I can (…) ... It was actually optional to attend that course; it was not mandatory; I wanted to go, as to understand the subject a little bit more and to be given some tools to be able to at least ask basic questions ... (…) But I also feel that there is a lack (…) That is, we are willing to do it, but why do we have to adapt ourselves to them? (E31)

According to some professionals, learning Creole would encourage the immigrants to become accustomed to a supposed dependency:

> I think we are going to end up learning Creole faster than they [learn Spanish] (…) '*Kouche sou vant piki*' [meaning] 'lie down on your belly to get your medicine'. And they laugh, and they understand right away, but that is still one way or another encouraging them not to learn. (E32)

Like any other person, a migrant patient needs care in health centers, but as we have already said, due to the treatment received, they often prefer not to attend or to seek the means to obtain private care. This is what a Haitian mother and a Venezuelan father did:

> I came here in the SAPU, with my son. He had a strong pain in his ear, and I came, and the child was screaming, screaming, crying loudly, and he had such a high temperature. I went to the window and they registered me; about 1 hour passed, it was about 5 in the morning because the child could not sleep all night. I came at 5 in the morning and they made me wait about 1 hour, 1 hour and a half, and they never called me. They had not called any of the wards and another person started talking and I went to the window and I said, but the child is crying and has a fever, and there was a lady there and she said 'you have (...) you have a thermometer? and do you know that the child has a fever?' I told her, but madam, it is not my son's normal temperature and she ignored me (...) And when I went to [name the private clinic] and saw the pediatrician, she looked, touched the baby, said, "What hurts?" (…) And in the end she discovered that the child had an ear infection. That's why he had such a fever. (FG4-E2)
>
> They had the child's shirt taken off; she saw her from far away; she didn't even go to see her or anything, and she said it was plague and gave her some medicine and the child got over-infected and we had to go to the [name of a private clinic]. (...) In other words, the girl was even in intensive care. The doctor told my wife at that time that if the antibiotic drugs, which were high spectrum, did not do anything, they could not do anything more; if they did not have any effect at that moment, he did not have to do anything with the child, in other words; she practically died. (FG7-E2)

It is not a matter of different cultures, but of sick people and emergencies to which one might react in similar ways. Although there are deficiencies in the public system that are expressed in the precariousness of hospitals and health care network centers, the lack of supplies, and the poor mental health of professionals, the way in which immigrants are treated differently under the guise of cultural difference should be considered:

> How do I tell you? Well, they are different cultures, therefore they have (…) other ways of expressing themselves (...) Sometimes they are (…) very confrontational let's say. From the window, they arrive demanding attention. I don't know on what grounds – they come in as if one has to give them priority (...) and then they are left waiting, and their waiting time increases, but it is not a matter of discrimination. If we attend to them, as I said, urgently (…) suddenly in the staff it generates a kind of rejection because one already knows that a Haitian patient is approaching and is already ready (…) not to fight, but is already ready to have an exchange of words, to tell you something... (E31)

The following quotations reflect additional criticisms regarding the poor management of pain among Haitian immigrants, as compared to Chileans:

> I imagine that because of a cultural issue, they have a different way of handling pain... Pain, illness, so you see, pain is super subjective – that is, the same pain will hurt you differently than me; it will hurt you in one way; it will hurt me in another way; it will hurt the other person.... but they are very extroverted in that sense; they scream; they do not care if there

> are children, if there are patients in pain as well. For them their pain is their pain and they scream wherever they are and they scream and throw themselves on the floor. So, in other words, you see the Chilean patient, on occasion some may have fainted and everything, but in general the Chilean patient talks to you, explains to you: 'It hurts, I feel bad' (…) He complains, but the Haitian patient does not. He screams; he screams; sometimes they are here, here we have a little treatment room where there are several patients undergoing treatment and they are undergoing treatment and they are screaming... (E31)
>
> Suddenly when the Haitian girls arrive with a lot of pain (...) I don't know if I should say loud, but they express a lot of pain. So, they scream; they cry, they faint, but the fainting was not fainting, so they kind of decompensate the SAPU environment, and therefore one has to run, go in, and then it turns out that it was not so bad... (E29)

These quotations refer us to Barkat's (2005) notion of "body of exception", whereby he refers to a body subjected at all times and in all places to the state of exception. Only some bodies are subjected to this state. In this case, it is the bodies of immigrants, due to racism. Beyond stigmatization or exclusion, what we observed was indifference to the suffering of immigrants. Is it perhaps a matter of "letting him/her die" (Foucault, 1976)? In this regard, Tevanian builds on Barkat's concept, arguing that it helps us to "think the aesthetic dimension of the social and political problem that is discrimination: inequality in treatment goes hand in hand with a difference in perception, and therefore with a particular aesthetic relationship of the body of the other" (Tevanian, 2017, p. 59).

Even when immigrants in this study were received by health professionals who expressed their goodwill or conviction of public service by pointing out that they attended everyone equally, a closer look did not reflect equal treatment. Rather, a socio-political construction of the immigrant intervened – a construction that the state has cultivated through racializing discourses and practices that have been disseminated by the media and repeated by a large part of Chilean society. These conditions expose immigrants to mistreatment in different forms, even when such treatment is delivered along with kind words. The immigrant person often recognizes racist mistreatment that is veiled by polite gestures and, although they may not understand it, the very repetition of discriminatory acts, words, and gestures instills in immigrants the notion that they occupy a different status in the healthcare system than Chilean citizens.

9.4 Final Words

Racism is a socially constructed system that has been anchored in our institutions for a long time. The ideology on which it is based is the belief that there is a hierarchy among essentially distinct human groups. To understand this ideology at play in the public health system in Chile – as in the education or justice systems, we should look to its modern origins in the transatlantic slave trade of the sixteenth century, where racism was the central ideology for justifying the slave trade. Contemporary discrimination is often ingrained in systems or institutions that organize and treat people differently, according to their skin color, culture, sex, social class or origin, in effect denying or limiting access to rights, goods, and services.

In this chapter, we set out to describe the institutionalized racism that affected immigrants in Chile in the public health system and the ways in which immigrants have resisted and endured it. The stories of the medical professionals brought us face to face with an everyday racism embedded in the functioning of health institutions. For the professional, we found that the "immigrant" is often conceived of as a contradictory figure. On the one hand, it is an object of charity, a poor stranger who should be helped. On the other hand, this subject is often conceived of as an external threat to the system that over-uses and abuses limited services. The professional blames the healthcare system in abstract terms, but also feels authorized, due to their role as "expert", to deliver uneven care based on racialized characterizations of patients. The healthcare system, in turn, endows them with a decision-making power to act upon immigrants according to their discretion. Among immigrants, we documented stories of repeated mistreatment and discrimination that led some to evade the healthcare system altogether. Others were even left with feelings of helplessness. As one patient observed, "One cries no more (…) I for example am not going to do anything. What am I going to do? Nothing" (FG4-E1).

Foucauldian biopolitics refers to a new logic of government in Western liberal societies that promotes wellbeing and productivity through healthy living and regulations that protect and cultivate the population. However, as Foucault pointed out, this concern focuses on "saving" *the population*, while exposing external Others to risk and death. This becomes increasingly clear in relation to migrations taking place throughout the world during the COVID-19 pandemic. In this context, the Chilean state has set out to "order the house", expelling, persecuting, detaining, and depriving immigrants of rights, diminishing the immigrants' pain in relation to that of the Chilean population. Thus, it is necessary to examine the Chilean state to identify the policies and institutions that do not recognize the equal rights of all human beings and enable the reproduction of racism in public health spaces.

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