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Medicine And Public Health: Latin America

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Latin America

European academic medicine and religious-based healing were pillars of colonial power in Latin America. From the late colonial era through the wars of independence (1810–1826) and until consolidation of nation-states around 1870, the official medical model was the transplanted Iberian regime of state licensing, policing, and advisory councils. A period of reform under the Spanish Bourbons, echoed in Brazil, continued after independence. Surgery and anatomy instruction were promoted, as were sanitary reforms like cleaning streets, moving cemeteries outside of cities, and creating health councils to organize vaccination and quarantine, and distribute information about epidemics. The official system worked in conjunction with frail university medical faculties, hospital asylums for care of the sick and aging administered by the church, and a relatively small number of licensed physicians, surgeons, midwives, and apothecaries based in the larger cities.

Over the second half of the nineteenth century, licensed medical practitioners grew in number as men, mostly of the middle and upper classes, began to supplement study at the national universities with training in western Europe. Medical instruction was reorganized along French clinical and bacteriological lines. Professional medical associations and national journals appeared in many countries, and physicians promoted hospital reforms reflecting a new age of heroic surgery, bacteriology, and patient care. This marked the beginning of the struggle between religious and nonreligious approaches in caring for the soul of the interns, especially evident in the creation of schools of nursing, often in conjunction with midwife training. Nursing, which had previously been done by hospital servants of both sexes administered by the Sisters of Charity, was now feminized and subject to physician oversight, while midwifery was gradually drawn into the medicalized environment of the hospital birthing room.

Promoters of hygiene reform (*higienistas*) set the political agenda for public health, especially in the larger cities, conceiving of health mainly in environmental terms, and individual medical care and assistance as less relevant. *Higienismo* was an enlightened and sometimes authoritarian way to bring some order to fast-growing urban centers, and its leaders were in the vanguard of liberal-positivist states that sought “order and progress” in a time of accelerated transformations brought about by export-led development booms. Associated with *higienismo* was the emergence of new public figures, such as the social doctor who worked in, and sometimes created, the new state agencies and philanthropic groups devoted to some medical care and social assistance, and to the building of basic collective infrastructure (namely sewage and drinking water networks). Especially in the realm of assistance for poor mothers and babies, this was a specialty that attracted the first

generation of women physicians who entered the profession starting in the 1880s. The region also witnessed the rise of the political doctor, with many physicians active in the state executive branches and as elected parliamentarians.

Starting in the 1920s states established medical benefits under social security oriented particularly toward workers (especially in key export sectors), state employees, and the lower middle classes in the massive urban centers. At the same time, often in collaboration with powerful international public health philanthropies, the Rockefeller Foundation in particular, states began to focus on controlling tropical diseases like hookworm, malaria, and yellow fever. This facilitated the arrival of public health in the countryside. As an increasing proportion of physicians trained in the United States, medical instruction was reoriented according to the model of integrated teaching hospitals and laboratory medicine. Also spurred by foreign actors, governments moved to create ministries of health, and as a result of a massive offering of scholarships, training of physicians, nurses, and public health experts was integrated with the U.S. system, especially during and after World War II.

Coinciding with Latin America's great demographic boom of the postwar period came the modernization of health infrastructure, in some countries with the virtual universalization of social security, in others with fragmented systems, more or less inclusive of the majority of the population. The process was characterized by the increasing protagonism of the state over health. The environmentalist emphasis receded, facilitating an agenda focused on providing health care and assistance. That charismatic reformist presidents like Juscelino Kubitschek (Brazil) and Salvador Allende (Chile) were physicians underscores the populist flavor of the health policies of the era. A more varied company of international actors included new philanthropies like the Kellogg Foundation, U.S. medical institutions promoting particular techniques, and also the Pan-American Health Organization (PAHO) as regional incarnation of the World Health Organization. A first generation of health planners emerged, educated in new public health schools affiliated with universities or state agencies, working with central or provincial governments, and often further trained and supported by PAHO. These planning initiatives emphasized normative centralization of services and executive decentralization, and were usually top-down, paying limited attention to community participation in defining problems and proposing solutions.

Following the oil shocks and the debt crisis, and as the shortcomings of the developmentalist model were registered in public health, the 1980s and 1990s were periods of retrenchment in the provision of state health care, with many rural health initiatives scrapped, and the building of new hospital infrastructure. The dominant model was generally radical privatization of what had been perceived as state responsibilities. Physician numbers exploded with the proliferation of private medical schools, feeding into the privatization of medicine and also exacerbating trends toward medical specialization (trends that were already well established by the 1950s, in spite of a rhetoric aiming at forming

generalists). A parallel process was visible at the level of international actors, with burgeoning clinical trial agreements between Latin American hospitals and physicians, and pharmaceutical companies.

Alternative Medicine

Medicine and public health practices have been sites of intense conflict and interchange between official medical practitioners on the one hand, and indigenous, African, and popular mixed-race healers on the other. Popular healers have often been lightning rods for political rebellion and resistance, the most famous case being the Brazilian mystic Antônio Conselheiro (1830–1897). Especially before the 1950s, and more in the rural areas than in the cities, hybrid healers proliferated to the point that medical pluralism became characteristic of many health cultures, not only from the perspective of those looking for care and services but also as a result of exchanges among herbalists and university doctors as well as the increasing offering of over-the-counter medications used by alternative and orthodox medicines. Despite significant mixture with Western medical beliefs and practices, forms of traditional medicine have retained their integrity: for example, shamans and midwives in the indigenous areas of Mexico, Guatemala, Bolivia, Peru, and Ecuador; or the *condomblé* and *Santería* practices still prevalent in popular medicine in Brazil and Cuba, respectively. Other traditions have been modernized and adapted to urban society, such as Spiritism in Mexico. Medical systems imported to the area in the nineteenth century, especially homeopathy, have also proved influential, sometimes serving as bridges between official and popular medical cultures.

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