Crises and Health
CGIS-S 030, 1730 Cambridge Street, Harvard University
Tuesday 4 May 2010

Speakers and Participants (note: this is not an exhaustive list of all attendees)

Sunil Amrith (SA)
Jeremy Ball (JB)
Iris Borowy (IB)
Arachu Castro (AC)
Paul Cruickshank (PC)
Christina Ewig (CE)
Monica Garcia (MoG)
Miguel Glatzer (MiG)
Gilberto Hochman (GH)
Felicia Knaul (FK)
Terry Martin (TM)
Pedro Ramos Pinto (PRP)
Emma Rothschild (ER)
Amartya Sen (AS)
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Melissa Teixeira (MT)
Mary Wilson (MW)
Ramiro Guerrero (RG)

Introduction and Session 1: Brazil and Public Health

ER opened the seminar by introducing Gilberto Hochman, a historian of public health with a focus on Brazil. GH considered how public health was integrally linked to the formation of the state, and his research studies the historic configuration of the health system and health policies in 20th century Brazil. He described population, disease, and health as fundamental dimensions of the nation state alongside territory, identity, and citizenship. All these issues, he explained, engage with state powers and state capacities.

GH pointed out that when scholars consider economic crises and health in Latin America, they come up with a picture defined by the negative experiences of the 1970s and 1980s. During these periods of fuel and debt crises, many countries privatized social security programs and imposed restrictions on health systems. International agencies, such as the World Bank and IMF,

disregarded the health agendas of Latin American governments, both dictatorial and democratic, and imposed their own.

However, by taking a more long-term historical perspective, GH demonstrated how the negative impacts of economic crises in 20th century Brazil actually produced important institutional changes in sanitary authority and the configuration of state authority. Contrary to the approach of international agencies, these responses were guided by problems and challenges on the national agenda. Crises stimulated state reorganization, expansion, and incorporation of new territories and populations. These reforms were not necessarily democratic, but, GH noted, they did not necessarily lead to exclusion, reduction of rights, or privatization. Indeed, by the 1980s creating a more democratic health system with universal access, social control and participation was central to dialogue on health reform in Brazil.

GH focused his talk on crises and sanitary reforms in the first half of the twentieth century, particularly during WWI and the Great Depression. These crises urged state authority to give new responses to health problems which were aggravated by but not directly caused by the crises themselves. These experiences demonstrated how the state turned crisis into an opportunity for reform. GH described two prominent elements of state authority that shaped the response of health reformers at this time. First was the issue of national identity. Health reformers had to develop systems to reach a community of sick, illiterate, and 'miscegenated' people in order to produce healthy workers for a national project of development and modernization. Second, health reformers had to consider the territoriality of state power in order to strengthen public authority in the large expanses of the country's hinterlands. GH argued that the options presented, paths followed, and alternatives abandoned during these moments of reform were bounded by the crises, but not determined by them.

GH then proceeded to discuss, more specifically, the crisis and health reform in Brazil between 1915 and 1920. With an economy based on agricultural products, Brazil suffered severely during the conflict of 1914-1918. The Americas were shielded from the calamities of armed conflict, but they experienced a severe fall in the export of primary products and import of manufactured goods. These economic difficulties precipitated a period of intense political and social crisis. Strikes, peasants' revolts, and intellectual criticism ensued. Dissenters began to openly question the liberal-oligarchic model that had been in place since the inauguration of the republic in 1889, and the government also faced criticisms that it was "from the coast and for the coast" with little regard for its inland population.

Until that period, public health had been a relatively limited project, focused on preventing epidemics and sanitizing areas of contact between the agricultural export economy and human

flows, especially in coastal cities and ports. The physician Miguel Pereira encapsulated the sense of the uncontrolled sanitary crisis in October 1916 when he exclaimed, "Brazil is still a great hospital." This metaphor became a rallying point for the nationalistic movement for rural sanitation and helped to reorient public health to the needs of the inland population. The diagnosis both crystallized demands for positive action from the government and presented the possibility of shaping a new Brazilian identity, distinct from that of being a huge hospital with a diseased population.

The economic crisis of the 1920s deepened problems that had existed previously. The metaphor of a diseased country and the distribution of images of the sick population accelerated important health reforms. The nationalistic public health movement created the groundwork for the first nationwide public health policies during this period. A federal agency was created to deliver standardized and coordinated public health services for rural populations and, although it was not an official ministry of health (which would only be created in 1953), it represented an important step forward for Brazilian systems of public health. The establishment of rural prophylaxis centers as part of this movement presented populations in rural and inland areas with their first contact with positive state authority. In response to a question, GH clarified that this was one of the first interactions between the state and these populations that did not revolve around the collection of taxes or policing of behavior. The interaction of public medicine and the public was among the first examples of positive services in Brazil.

Health reform was part of a larger project of hierarchical and medical incorporation of inland territories into the care of the state whereby the population became "objects" of public medicine. The changes of the 1920s, GH stressed, were not significantly bounded by ideas of citizenship rights. The limits to these reforms were defined by elite landowners who controlled the oligarchic political coalitions then in power. Public medicine was mediated through their decision whether or not to allow state health authorities onto their privately held lands.

The second series of reforms GH addressed relate to the economic crisis of 1929. Alongside the ideal of a new republic, a renewed country, and a new Brazilian man, a different agenda for public health emerged during the regime of 1930-1945. This approach sought to produce an identity for Brazilian workers by associating formal work and citizenship. The goal of the regime was to produce a strong state separate from and autonomous of the various social classes in society. GH described the country as a corporativist state with a populist ideology. While the creation of a Ministry of Education and Public Health in 1930 suggested that social services would feature prominently in the political agenda, the domestic and international economic crisis paralyzed efforts at active public health policymaking. During this time, much of health policy

was limited to epidemic prevention efforts already implemented under the previous administration, but even these suffered as a result of economic and political crises.

GH went on to discuss how the administration of public health and the state management of health care became divided throughout the twentieth century, with public health programs in one ministry and state health services hived off into another. Public health was in care of unorganized populations such as rural communities and non-organized workers, while state health services were structured for those formally employed and recognized by the state. This division only ended in 1990 with the total integration of these services under a united ministry of health. GH closed by pointing out the connections between arguments for health reform and pro-democracy movements. In the 1980s, public health reforms became engaged with discussions over health as citizenship rights, universalization, decentralization, participation, and social control.

ER commented that GH's talk was a model of how the history of public health is also political history, urban/rural history, and economic history. ER explained that, as GH had described, the history of public health is in many ways a view into the health of the state. She asked GH to comment on modern circumstances and the applicability of lessons in the Brazilian experience to other parts of the world. She pointed out that much of the Brazilian experience, which "went against the winds" of its past legacy and international expectations, was evocative of the current process of reform in India. In response, GH explained that the Brazilian experience is indeed very different from the situation that might be found elsewhere because of its historical trajectory towards democratization in the 1980s. He explained that this was an example of where health and the right to health was linked to democratization and universalization, not just the segmentation of clients like urban and rural workers to different systems. He argued that this made all the difference in constructing a big coalition that is very difficult to disrupt today. PRP commented on the emerging creation of parallel systems of care with the middle class moving out of public services and into the private sector in an "Americanization" of health care. Another participant suggested a valuable next step in research would be to explore the transition in state priorities in Brazil form a focus on race to a focus on disease.

Session 2: Past Global Crises: Exploring the role of international health organizations

MoG presented her work on the League of Nations Health Organization (LNHO) and how it developed its data on the health effects of the Great Depression. The LNHO was created in the early 1920s as a technical organization focused on the epidemiological studies of disease at the beginning of the 1920s. It performed the function of what Bruno Latour has called a center of

calculation, a site where information, data, and scientific knowledge is produced in order to make some kind of calculation. As the global economy entered the Great Depression, the LNHO began studying the effects of the depression on health through death rates and morbidity. Their research produced puzzling results; the data, which showed no significant impact on health, went against medical reports from doctors who claimed to be seeing increasing undernourishment and malnutrition. The Health Organization set an agenda to study the effects of the depression on health, and it sought to determine statistical methods to study it. It decided to focus on malnutrition through research on thousands of families affected by the industrial depression, and it sought a varied range of data. Their methods analyzed wages, income, housing conditions alongside age, weight and height (using sacratama and pelidisi methods) and they sought signs of anemia, fatigability, avitaminosis and rickets.

This research was conducted in several countries, and MoG focused her talk on evidence from the USA and Austria. In the US, with the support of the American Public Health Service and the Millbank Foundation, researchers collected data from 12,000 families in 8 cities. The American researchers found a casual relation between change in income and ill-health with two potential explanations divided between nurture or nature. They hypothesized that either this higher rate of sickness was due to the crisis itself or, alternatively, that the depression may have been a sifting process separating the fit from the unfit. In Austria, researchers studied connections between unemployment, nutrition, and physical development. Their conclusions and theories focused on potential causal relationships between health and employment. People could be constitutionally unsound and thus be more likely to fall victim to unemployment, or less favorable social surroundings could lead to poor health which could lead to unemployment, or some combination of the two. Complicating things further, they believed unemployment could cause ill-health or poor social surroundings, leading to a downward spiral. MoG explained that despite this knowledge of adverse effects of the economic crisis on health status, the LNHO stood by its statistical data on death rates and morbidity, and it found that there was no effect of the Great Depression on health. Thus, claims relying on LNHO reports, which state that the Great Depression had no effect on health status, must be reconsidered.

PC brought the timeframe of the discussion forward to discuss how changes in development thought in the 1970s spurred new developments in public health. International health programs responded to the economic and political crises of the 1970s. He explained that concerns for the wellbeing of the poor stood as crucial proxies for the relationship between developed and developing countries. New ideas about development emerged which offered two trajectories for developing countries to follow. Some camps framed development as capital accumulation, while others focused on development as social transformation. The crises of the 1970s created and

defined both of these intellectual currents and their influence on policy in many developing countries.

SA pointed out how economic expertise enters the field of public health at these moments. Whether it is economic indicators or economic ideas, he suggested it was important to understand how that transmission of ideas—or resistance to such transmission—works at moments of crises. MoG pointed out this relationship between economic and health ideas in the context of her work on the LNHO. At one point, the medical director of the LNHO had left-leaning tendencies, and through his influence and the work of others in the organization, there was a careful shift from a focus on morbidity to broader notions of social medicine. LNHO research reports stressed that the organization offered a view of the economic crisis from the perspective of health experts and did not engage with sophisticated economic thinking themselves.

SA then asked about whether the idea of crisis as opportunity provides a useful way of thinking about the effects of crisis on international organizations. PC found that crisis did provide opportunity via the reevaluation of the goals of development. The community of leaders in development and public health organizations is very small, and with only a handful of individuals at the top, homogeneous perspectives developed over time. PC argued that crisis allowed a questioning of previous models. SA closed his comments by pointing out how many of the shifts of the 1930s and 1970s did not last very long, and he stressed this almost cyclical element in the history of public health. TM tried to bring GH's paper from the morning into connection with PC's. He pointed to shifts from socialist, social democratic, or welfare state models of public health to new models in the 1970s. He argued that transnationality itself would have a bias against the statist social democratic mode, and he wondered whether the actual actors see transnationality as itself a casual factor in the decline of the statist approach to public health.

Session 3: Latin America and Crises: managing health

CE presented her paper on post-retrenchment politics in health reform programs in Chile. She described a move to the left in Chile, where discontentment with neoliberal reforms of the 1980s and 1990s led to a move away from a market oriented structure towards state involvement in social politics. Her project was to develop a framework to understand the current politics of change. Citing Chile as a bellwether for regional social policy trends, she laid out two motivating questions: why did the basic parameters of retrenchment from the 1980s remain intact for as long as they did? And why did the politics of recent reforms differ from previous periods?

Policy change in Chile can be divided into three periods, expansion, retrenchment, and post-retrenchment, and in her research, CE found policy feedbacks from retrenchment in post-retrenchment politics. Stronger private business interests, learning legacies (such as the acceptance of market participation in the social policy realm), and lock-in effects (such as institutions that become so entrenched that they become difficult to change) are all results of the retrenchment period. This buildup of inertia has lead to incremental political change and more fragmented policy systems. Building on insights from theories of welfare state development and retrenchment, CE found that new reforms, combined with learning legacies and lock-in effects, have resulted in greater equity albeit in an incremental and fragmented fashion.

AC presented her findings on inequality in access to health care during the [current?] economic crisis in Latin America. In Latin America and the Caribbean, the World Bank estimates that poverty has increased by 8 million who are earning less than $1.25 a day. These trends threaten to worsen already existing low social indicators. One of the most immediate consequences has been the increase in infant mortality, and the current crisis has translated into increased malnutrition and higher high school dropout rates.

Despite positive economic growth before the crisis, the % of GDP allocated to public spending at that time did not change in Latin America, and now with negative economic growth, some governments might decide to decrease health budgets. With a decrease of exports from Latin America of 11%, unemployment is expected to have grown from 5.8% in 2008 to 6.9% in 2009 among men and from 8.8% to 10.1% among women. AC described in detail the effects of the crisis and health system fragmentation in Columbia. Recent changes have led to a lack of epidemiological surveillance, inadequate diagnostic capacity, underreporting, inadequate clinical management, limited health promotion activities, and an increasing reliance on individually focused prevention information as opposed to community based prevention interventions.

IB turned the group's attention to the Cuban experience. Between 1989 and 1993 Cuba faced a fall in imports by 75% and a reduction of GDP by 35%. During this period, IB explained, the economic changes had both negative and positive effects on health. Cuts in water quality, inconsistent garbage disposals, and decreases in immunization had adverse effects on the population. Simultaneously, however, her research had found a reduction in obesity and decrease in diabetes and coronary heart disease/stroke mortality indices, and she found a paradoxical increase in life expectancy.

To explain this improvement in health, she pointed to factors such as a more equitable social gradient, changes in food sources and transportation, increasing social support, among others. Despite the economic crisis, per capita expenditure on health did not decrease. Food was a major

concern in this period because Cuba depended heavily on imports, and changes in trade between 1989 and 1992 led to a decline in imports of 81% in fertilizers, 72% in animal feed, 62% in fungicides and herbicides, and 92% in agricultural fuels. In response an urban agriculture movement began with spontaneous backyard planting. This movement received support from private groups, such as the Australian Conservation Foundation, and from Cuban government. For its part, the government set up an urban agriculture department, offered the right to any land in usufruct ownership, legalized some private markets, and offered outreach help by extension workers. In terms of transportation changes, IB pointed to the production and importation of about 1 million bicycles that were used to supplement and replace auto transport and which led to increases in physical exercise.

IB stressed the peculiarity of Cuba: its tradition of prioritizing healthcare, small population with unique dynamics, and network of state and non-state organizations. But she offered the tentative conclusion that crisis could become an opportunity to increase health if health care expenditures were maintained, if formal and informal networks were able to reduce material and psychological stress, and if diets were improved. She explained that further discussion and research had to address the questions of how exactly crisis and health were defined and measured.

Session 4: Health Rights and the Welfare State: a Lusophone perspective

PRP explored some of the origins of the Portuguese welfare state. The first systematic state interventions in healthcare and social provision were developed by Salazar's Estado Novo in 1928-1944 following the 1933 constitution and the 1944 Estatuto da Assistencia. PRP explained that a lot of the current explanations are not sufficient to explain how the Portuguese welfare state emerged. Portugal had no fascist system as in Italy; Portugal had fascism without a movement. In the Portuguese case, the ideology of corporatism as an ideology was more rhetorical than practical. There was, in a sense, corporatism without corporations, and PRP explained that the limited industrial development of Portugal at this time relativizes the theory of working class pressure.

Building off of existing theories, PRP hoped to look at different origins for the Portuguese welfare state. His argument was divided into three categories. First, reform was motivated by a crisis of imperial anxiety. This component was rooted in Portugal's imperial nationalism with a rhetoric of unified metropole and colonies. Second, reform was part of colonial governmentality. Since the late 19th century, the state had provided healthcare for European settlers. As 'rights' expanded to indigenous populations in 1920s—at least rhetorically—some actual services followed suit. Finally, he cited reform pressures from individuals such as Norton de Matos, High Commissioner of Angola, who were aided by the notion of empire as a civilizing mission.

PRP then explored a few implications of his framework. The imperial-authoritarian origins of social citizenship have potentially long-term consequences, and he asked if these were still responsible for the large gap between rich and poor [countries?]. Center-periphery relationships shaped both the colonies and the metropole, with the colonial space as a site of production of social, political, and scientific knowledge that in turn shaped the metropole. In closing, he took a more abstract approach and discussed the social construction of crisis and its relationship to reform. PRP argued that the effects of any sort of crisis, economic or otherwise, would be mediated by the specific types of anxieties it generates as much as by material and objective factors. He stressed that the idea of connecting crisis and change had to consider this mediating concept.

MT discussed questions of health, economic crisis, and integration in colonial Mozambique during the Salazar government of the early 1930s. She explained how the crisis had a different meaning in the colonies than in the metropole. In the metropole, social security programs and welfare state planning emerged during the early years of the crisis in the early 1930s under a corporatist framework, but this model was not exported to the colonies until 1937. The period saw interest in a revamped colonial project. While other colonial powers were shifting from direct rule to indirect rule, Portugal attempted the opposite, and to do so they needed a strong imperial narrative. The early 1930s saw the construction of a new colonial ideology fused to Portuguese nationalism, whereby empire was seen as a way to escape provincialism and underdevelopment.

But, MT stressed, the empire would not happen organically. It would require effort: schools needed to be opened and hospitals needed to be built. In Mozambique, there was intensified attention to expanding health and sanitation services. The Portuguese attempted to prove that they could be civilizing colonizers to distill international criticism. Medicine provided a way for the colonial state to insert itself into he daily lives of the people, and it also created colonial heroes out of selfless doctors. To achieve effective intervention, the Portuguese needed to prove they could tame the tropics, and so colonial administrators paid close attention to Brazilian works in tropical medicine. The perceived importance of continued white settlement in Brazil and in Africa heightened discussion of race, and the efforts to define, survey, and control indigenous populations separated the Estado Novo from earlier regimes.

JB brought up Angola as another example of Portuguese imperial medicine. Initially, the first objective of medical care in Angola was to protect the military and settlers. The health services provided very little real medical care to the vast majority of Angolans. It was only after WWII that there was a change in rhetoric for private companies to create an efficient medical service

along the lines of the ones already in place for European workers. Such a service was meant to give effect to Portugal's civilizing mission in the area. After the waves of African independence in the 1960s, there was a massive investment in social services in Angola as a way to win the hearts and minds of the people and convince them of how valuable Portuguese colonialism was.

MiG brought up the modern experience of the Portuguese welfare state and health inequality. In his analysis of social payments, Portugal spent 15.6% of GDP in 2008 while the 12 wealthiest countries in the EU spent closer to 16.1%. Because Portugal is less wealthy than these countries, it could be argued that it was over-spending. Social payments continue to rise, and it spends more on education and health than its EU neighbors. Drawing on the preceding discussion of race in the colonies, MiG discussed the current immigration situation in Portugal. Portugal is becoming diverse again with the migration of Eastern Europe and from the former colonies. The politics of this immigration is notably different from other EU countries because there is no far right reaction to immigration.

Conclusion

AS described a few striking issues arising from the talks. First, he asked how a general sense of crisis arises in the public and in government. Does crisis emerge objectively or is it discovered in a subjective way? Next, AS turned to the issue of authoritarian origins. In terms of the demand, nothing excites the demand for healthcare as much as democracy, but in terms of the ability to successfully deliver it, authoritarianism has a definite advantage. Paul Krugman has pointed out that when US social services were first introduced, the only person that was quoted was Bismarck. The democratic demand for healthcare played a big part during Obama's election, but problems arose in its implementation. There are difficulties that the democratic exercise creates. AS closed by discussing the different models of colonial experience. There is a contrast between North and South America. There was much less inter-population mixing in the British Empire, especially when one considers, for example, that few products of Anglo-Indian marriages grow up and become part of the establishment. To what extent is there a contrast in the style of governing of the empires? And how can this be related to that question about intermarriage?

ER commented on how impressive it had been to have specialists in different geographical areas interacting during the workshop. As she had hoped, the history of health was in conversation with other kinds of history and not only within in its own specialization. Picking up on MiG's talk, ER discussed the rise of the perception of social expenditure in Portugal as the "nightmare of the bond market" as a negative side to that otherwise encouraging story of social security. For The experience in relation to financial markets raises interesting questions about some of the larger narratives of public health and global public health. The wave of market fundamentalism

in the 1980s had more influence over state policies and international governmental organization policies than it has now, with sharp cutbacks in public expenditure in developing countries and with IMF austerity plans. The rise of international NGOs and foundation expenditures and development targets has affected the suddenness of the shift to more conservative approaches. The Gates Foundation, for example, would not be subject to austerity policies of the IMF, which presents an interesting moment in relation to the international governance of health and the role of public expenditure. ER concluded by reminding everyone of the Brazilian model that was emerging and the prospects for "south-south" cooperation in the future.

FK thanked the group for their presentations and for their efforts at collaborating across schools and disciplines for the workshop. She encouraged the group to make their research available to the wider public and, if possible, to publicize it in multiple languages to increase accessibility. A few of the essays presented at the workshop are being prepared for journal publication.