LARR Latin American Research Review

Borzutzky, Silvia. 2021. Seven Recent Books on Health Care in the Americas. *Latin American Research Review* 56(2), pp. 533–542. DOI: https://doi.org/10.25222/larr.1550

BOOK REVIEW ESSAYS

Seven Recent Books on Health Care in the Americas

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This essay reviews the following works:

Health Equity in Brazil: Intersections of Gender, Race, and Policy. By Kia Lilly Caldwell. Urbana: University of Illinois Press, 2017. Pp. xii + 226. $28.00 paperback. ISBN: 9780252082474.

State of Health: Pleasure and Politics in Venezuelan Health Care under Chávez. By Amy Cooper. Oakland: University of California Press, 2019. Pp. 216. $29.95 paperback. ISBN: 9780520299290.

Social Policies and Decentralization in Cuba: Change in the Context of 21st Century Latin America. Edited by Jorge I. Domínguez, Maria del Carmen Zabala Argüelles, Mayra Espina Prieto, and Lorena G. Barberia. Cambridge, MA: David Rockefeller Center Series of Latin American Studies, Harvard University, 2017. Pp. 282. $24.99 paperback. ISBN: 9780674975309.

Movement-Driven Development: The Politics of Health and Democracy in Brazil. By Christopher L. Gibson. Stanford, CA: Stanford University Press, 2019. Pp. 328. $30.00 paperback. ISBN: 9781503607804.

A Right to Health: Medicine, Marginality, and Health Care Reform in Northeastern Brazil. By Jessica Scott Jerome. Austin: University Press of Texas, 2015. Pp. 192. $21.95 paperback. ISBN: 9781477311318.

Uneven Social Policies: The Politics of Subnational Variation in Latin America. By Sara Niedzwiecki. Cambridge: Cambridge University Press, 2018. Pp. xvii + 256. 256 pp. $34.99 paperback. ISBN: 9781108454896.

Banking on Health: The World Bank and the Health Sector Reform in Latin America. By Shiri Noy. Cham, Switzerland: Palgrave Macmillan, 2017. Pp. 241. ISBN: 9783319617657.

This essay is written while COVID19 is devastating Latin America and the Caribbean, where over five hundred thousand people have died.[1] The pandemic has demonstrated the tremendous health and economic inequalities that exist throughout the region, and this is especially apparent in some of the countries with the highest number of fatalities, like Brazil and Mexico. These inequalities are analyzed in the books reviewed in this essay. While there has been improvement in the access to health in the region, inequalities continue.

The books raise essential questions about who in the region gets health care and the interdependent roles that societies and governments have in the process. These books break new ground and, in two different forms, contribute to our understanding of some of the most important health care systems in the region. One group of books focuses on the role of social movements in determining who gets and does not get health care, while another set of books answers the same question by highlighting the role of national and

[1] Ana María Ríos, "Latin America: COVID-19 Deaths 2021, by Country," Statista, January 4, 2021 (updated March 22, 2021), https://www.statista.com/statistics/1103965/latin-america-caribbean-coronavirus-deaths/.

subnational governments in policy formulation and implementation. Both the analysis of the role of social movements and of the differences between policy formulation and implementation are critically important to understand the content and impact of health policies and represent important approaches to the field.

What the authors of these books also make clear is that health policies are far from universal. Instead, they are fragmented and respond to the power and actions of critical groups or individuals in critical roles in specific times and places. To end inequality and expand care to all Latin Americans, what is needed is a universal approach and the recognition that health care should not be parceled out in regional, economic, gender, or ethnic terms. Only this approach will allow the people in the region to fulfill their capabilities and contribute to their societies' development and success.[2]

Brief Historical Overview

While the history of health care policies in the region dates to the late nineteenth century, policy development has been inconsistent across the continent and within countries. Policy advances have resulted from the demands of domestic political actors such as the organized, urban working class and the influence of international actors, who have provided models and often funding for health policies.

Health policies in the region were linked to the development and strength of the union movement and the very poor working and health conditions of the working class. In the context of the early industrialization process and the social turmoil of the early twentieth century, a few South American governments responded to the workers' demands with limited social policies to prevent further revolutionary upheaval, as was the case in Argentina in 1915 and in 1924 in Chile.[3] Health care and other social policies in Latin America were also the result of international influences and actors. Early approaches were influenced by the Bismarckian model developed in 1889, which called for the establishment of compulsory, occupation-specific, social security/sickness funds for organized urban workers. In later years, the influence of the International Labor Organization was critical in the promotion and expansion of social security and the health policies embedded in those programs. In the second half of the twentieth century, both the World Bank (WB) and the US government shaped the intellectual contours of social policies in the region by fostering the privatization or partial privatization of health services.

While none of the books reviewed below deal with Chile, this country provides an excellent historical example of policy emergence and evolution because health policies developed because of both internal demands and external influences and serves as a cautionary tale because the policy evolution has been far from linear. A systematic approach to health began in 1938, after the election of the Popular Front president Pedro Aguirre Cerda and his Socialist minister of health, Dr. Salvador Allende, and culminated with the establishment of the National Health Service in 1952, charged with providing curative services to blue-collar workers and the indigent. Once Dr. Allende was elected president in 1970, he attempted to democratize health institutions and made them more responsive to community needs. However, universalization was reversed in 1979 when the Pinochet dictatorship embarked on a sweeping health sector reform based on neoliberal doctrines and supported by international financial institutions (IFIs). A private health insurance system, around the Institutos de Salud Previsional (ISAPRES), was developed alongside the state system, which experienced reduced fiscal support. Democratization and failures in health coverage led to a partial reform under the Universal Access with Explicit Guarantees (AUGE) system in the early 2000s, which guaranteed coverage for a predetermined number of diseases in the private and the public sectors. Yet again, in late 2019, dissatisfaction with the system led 46 percent of Chileans to demand health policies based on equity and inclusion.[4]

The study of the emergence and evolution of social policies in the region began in the 1970s with the work of Carmelo Mesa-Lago, who focused on the role of critical pressure groups in the emergence of those policies in the 1910s and 1920s. James Malloy's analysis emphasized the role of the Brazilian state in the policy process, while I have argued that in the case of Chile, early policies resulted from state initiatives shaped by interest groups through their representatives in Congress. In the 1970s a different blend of private sector actors generated the Pinochet dictatorship's market-oriented pension and health care reforms. Those

2 Ingrid Robeyns and Morten Fibieger Byskov, "The Capability Approach," in *The Stanford Encyclopedia of Philosophy* (Winter 2020), edited by Edward N. Zalta, https://plato.stanford.edu/archives/win2020/entries/capability-approach/.

3 Silvia Borzutzky, *Vital Connections: Politics, Social Security and Inequality in Chile* (Notre Dame, IN: University of Notre Dame Press, 2002), chap. 1.

4 Centro de Estudios Públicos, *Estudio nacional de opinión pública*, no. 84, December 2019, www.cepchile.cl/cep/site/docs/20200116/20200116081636/encuestacep_diciembre2019.pdf.

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

reforms in Chile and elsewhere favored the private sector and reduced state involvement in the provision of health and other social policies, fostering greater inequities in the access to health.[5]

In the twenty-first century, policy analysts have paid attention to the nature of political systems, the structure and ideology of governing political parties, the role of unions and interest groups, and the policy legacies. Civil society mobilization, international actors, and economic performance are also seen as defining the content of health and other social policies. For instance, Jennifer Pribble, as well as Evelyn Huber and John Stephens, and Gosta Esping-Andersen focus on the role of leftist parties.[6] In addition to party ideology, Pribble is concerned with the parties' internal organization, electoral competition, and the connections between the party elites and the base. Her framework also highlights how previous policies or policy legacies "shape the distribution of power and interests within the policy sector."[7] Rosanna Castiglione's work highlights the ideological positions of policymakers, the patterns of distribution of governmental authority, and the actions of nonstate actors in addition to policy legacies. Christina Ewig and Stephen Kay pay attention to the role of business groups affected by the "post-retrenchment policies" or reforms carried out after the 1980s' privatization.[8] Last, Candelaria Garay shows that "the choice of policy models is related to the actors involved in the negotiations around policy design, their preferences and institutional power."[9] Focusing on the international environment, Juliana Martínez Franzoni and Diego Sánchez Ancochea argue that internal political elites and international actors contribute to the legitimation of ideas and the mapping of possible policy options available at any given time.[10]

The books reviewed below build on this rich analytic tradition and open new areas of inquiry by looking at the role of social movements and subnational governments in the dual processes of policy formulation and implementation. Simultaneously, they contribute to our understanding of policy unevenness and the struggle for equity and inclusion while also demonstrating that access to health in Latin America continues to be the result of the power of interest groups—in the form of social movements—and their capacity to influence government, as well as the complex relationships between national and subnational governments and between policy formulation and implementation.

Society-Driven Policy and the Role of Social Movements

The authors of the books reviewed in this section highlight the actions of social movements defined by gender, race, and location. The focus on societal actions and demands via social movements explain policy success, policy inclusion, policy implementation, and policy unevenness. Because they also focus on Brazil, together they provide a very comprehensive view of the role of social movements in the Brazilian health sector and the way in which a national health care program has been implemented.

Movement-Driven Development: The Politics of Health and Democracy in Brazil by Christopher Gibson "aims to explain how and why Brazil experienced such an extraordinary, if subnationally uneven, pattern of social development, despite a recent history of rampant infant mortality and an ignominious reputation as the worldwide champion of inequality" (2). Gibson argues that even under those unfavorable conditions, practically minded civil society actors, which he calls "pragmatist publics," have made subnational health agencies more responsive to the needs of excluded citizens. Thus, in the post-dictatorship years, the Sanitarista Movement (Movimiento Sanitário) was central to public health reforms by codifying the new right to health and establishing the new Unified Health System (Sistema Único de Saúde) (2). The book also successfully addresses a much larger and critical question: how highly unequal societies can overcome, paternalistic domination geared to undermine social development and the provision of public services (5).

[5] Carmelo Mesa-Lago, *Social Security in Latin America: Pressure Groups, Stratification and Inequality* (Pittsburgh: University of Pittsburgh Press, 1978); James M. Malloy, *The Politics of Social Security in Brazil* (Pittsburgh: University of Pittsburgh Press, 1979); Borzutzky, *Vital Connections*.

[6] Jennifer Pribble, *Welfare and Party Politics in Latin America* (Cambridge: Cambridge University Press, 2013); Gosta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton, NJ: Princeton University Press, 1990); Evelyne Huber and John D. Stephens, *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*, (Chicago: University of Chicago Press, 2001).

[7] Pribble, *Welfare and Party Politics*, 13.

[8] Rosanna Castiglione, "Determinants of Policy Change in Latin America: A Comparison of Social Security Reform in Chile and Uruguay," *Journal of Comparative Policy Analysis* 20, no. 2 (2018): 189; Christina Ewig and Stephen J. Kay, "Postretrenchment Politics: Policy Feedback in Chile's Health and Pension Reform," *Latin American Politics and Society* 53, no. 4 (2011): 67–99.

[9] Candelaria Garay, *Social Policy Expansion in Latin America* (New York: Cambridge University Press, 2016), 301.

[10] Juliana Martínez Franzoni and Diego Sánchez Ancochea, "Cómo alcanzó Costa Rica la incorporación social y laboral?," *Revista de la CEPAL*, no. 121 (2017): 132–147. For an excellent review of these policies see Merike Blofield, "The Politics of Social Policy in Latin America," *Latin American Research Review* 54, no. 4 (2019): 1056–1064. https://larrlasa.org/articles/10.25222/larr.817/.

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

Brazil's health care system was initially structured during the Vargas administrations (1930–1945 and 1951–1954) around a model that limited inclusion to organized labor, the military, and civil servants. While the military dictatorship (1964–1985) solidified an exclusionary, patronage-fueled health sector, Sanitaristas demanded that health be defined as a universal citizenship right. As health services expanded in the post-dictatorship period, movement-driven development explains the pattern of policy expansion. As Gibson argues, maximal gains in social development outcomes occur when activists consistently leverage the new democratic offices to transform a universal citizenship right to health into concrete capabilities that allow subnational entities to deliver basic public services (13). Thus, the expansion of health services was not simply a result of the transition to democracy but resulted from Sanitaristas' demands for competent public providers and access to well-run public health clinics. The Sanitaristas ability to target those resources to critical places resulted in important reductions of infant and child mortality rates.

The focus in this compelling book is on the role of the Sanitaristas' social movement, which was able to link societal health needs with political institutions and to promote a universal citizenship right to health. The Sanitaristas' biggest challenge was to transform the patronage-fueled, fee-for-service model of privately administered health care that benefited the highest income groups into a more democratized health care system. Health democratization involved the restoration of democratic rights and processes, the codification of a universal right to health, decentralization, and disrupting the control that right-wing parties had on the policy process (54). Additionally, Gibson introduces a new way of looking at Brazil's democratization, suggesting that pragmatist publics' mobilization molded political institutions around principles of equality and universality and thus contributed to democratizing not just the health care system, but also the entire political structure.

The author uses statistical analysis and the comparative-historical case study approach to assess the uneven reduction of infant mortality rates and access to health care between 1985 and 2014 in four major cities. Chapter 3 offers detailed multivariate regression analysis which allows Gibson to conclude, with 99 percent confidence, that Sanitarista office-holding was positively associated with reductions in infant mortality and mortality rates for children under five. The statistical analysis also shows that municipal spending on health and sanitation is associated with both outcomes, but left party ideology, participatory-democratic institutions, and conditional cash transfers all fall short of statistical significance (71).

The next chapters examine the Sanitaristas' role in the cities of Belo Horizonte, Porto Alegre, Curitiba, and Fortaleza. The comparative case study approach shows that some cities achieved greater progress than others, and that progress resulted from the presence of pragmatist publics that maximized social development and access to health care by deepening civil society institutions rather than by the existence of national policies or political ideologies. These conclusions challenge long-standing academic and popular views about the role of ideology in the expansion of social policies. Simultaneously, Gibson shows the limits of movement-driven development as it failed to create a universal policy framework (264).

In *Health Equity in Brazil: Intersections of Gender, Race, and Policy*, Kia Lilly Campbell also focuses on social movements as she explores the role that Black women have had in advancing the policy agenda and shaping health policy with the aim of addressing and reducing gender and racial inequities. Campbell also examines the way in which structural and institutional factors contribute to poor health outcomes among Afro-Brazilians.

The book analyzes the impact of the women's movement, the Black movement, and Black women's movements at the local, federal, and state level. As noted by Campbell, "the study offers a history of health policy development in Brazil and the impact of feminist and antiracist activism on health policy formulation from the 1980s to the mid-2010s" (3). It also includes discussion of the role of transnational advocacy and government efforts to meet the needs of populations marginalized on the basis of gender and race. Campbell, much like Gibson, credits social movements with the expansion of health care services, but here the focus is on the role of gender- and race-based movements and how the health system meets or ignores women's and Afro-Brazilians' demands (12).

The six chapters of the book address the struggle for gender health equity in Brazil, Black women's health activism and the development of intersectional health policy, the development of health policies for the Black population (until 1996 Brazil had never collected health data according to race), strategies to challenge institutional racism, and color blindness in the health sector. Maternal mortality, intersectional discrimination, the human right to health, and the way in which the HIV/AIDS epidemic made gender and race visible in this country are also analyzed.

The role that the Black women's movement has had in furthering the policy agenda is truly important because it has changed and expanded the conversation about race and made it clear that the structural inequalities that have marginalized racial and gender minorities have become a human rights issue,

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

attracting transnational actions. In turn, these transnational actions have produced changes in federal, state, and local policies. Last, the author explores the relationship between the criminalization of Black and poor communities and their poor health care access and outcomes.[11] To remedy these problems, the author calls for data collection and the use of an intersectional framework in policy design and implementation.

Campbell's insightful analysis raises a critical question: How do marginalized or *minoritized* communities (as the author writes, Blacks are not a minority, but are made to feel like one) gain rights since the discriminatory racial gap is rooted in the myth that Brazil is a racial democracy and that policies are universal? As Campbell notes, "while the concept of universality is laudable in theory, in practice it can serve to elide various forms of inequalities because emphasis is placed on the notion of equal access to health care" (178). Thus, because the law is only universal in theory, to achieve real universality the emphasis should be on intersectional policies to recognize how gender, racial, and class inequalities shape the access to health care and patterns of illness and wellness. Much work remains to be done in this area, not only in Brazil but across the world.

Jessica Scott Jerome's *A Right to Health: Medicine, Marginality, and Health Care Reform in Northeastern Brazil* is an ethnography of health care in Pirambu, a favela with a population of nine thousand located in the margins of Fortaleza in the province of Ceará. The author's goal is to explore the relationship between a formal right to health care and the way in which people experience that right. As in the other books, the key questions are who gets this right, its impact on people, and how universal policies interact with the old patronage system that has dominated life in Brazil's Northeast. For instance, in the health sector, small-town mayors often run municipal dispensaries where the rural poor can get medical care or medicines in return for their vote (7). As neoliberal reforms came to Ceará, the international press extolled the moral virtues of eliminating a corrupt system and replacing it with "modern" market policies. However, Jerome shows that patronage and dependency have continued to dominate favela life, as reciprocity among family members, friends, and neighbors, and the presence of good or bad bosses dominate the life of its inhabitants (8). Thus, "in the domain of health, both patronage and reciprocity continued to structure social practice" (8).

Social movements dating back to the dictatorship began to emerge in Fortaleza as people demanded roads, electricity, and sanitation. Those demands increased with the transition to democracy in the mid-1980s. The vivid history of the exclusionary nature of Brazil's health care system, presented in chapter 2, highlights the importance of social movements in the process of policy expansion, while chapter 3 focuses on the democratization of health care through health councils. The health councils (also analyzed in Gibson's book) sit at the intersection of national policy and traditional approaches since they are national in nature but controlled at the local level. Undoubtedly, for the residents of Pirambu, health is both a favor and a right. Jerome also highlights the deeper causes of illness in low-income communities; people in those communities understand that the roots of their health problems are hunger, unsanitary living conditions, and lack of safety, among others. That poverty is the main disease appears to be quite clear to those in the favela.

The conclusion drawn from these three excellent books is that while the 1988 Brazilian health reform aimed at creating a universal system in which health was considered a citizen's right, that right becomes effective only through the actions of the social movements based on gender, race, or location. While this approach has benefited groups that greatly needed health access, it has also left others out, making the principle of universality meaningless at best and harmful at worst. Additionally, we learn that universality is mediated by long-standing patrimonial relations which involve personal dependence and often corruption. That poverty is the real cause of most of the health problems experienced by the population is not surprising, but it is yet another conclusion made by these authors.

The Role of Subnational Governments in Policy Implementation

I have placed the review of Niedzwiecki's outstanding book *Uneven Social Policies: The Politics of Subnational Variation in Latin America* in the middle of this essay because her complex analysis of policy implementation at the subnational level serves as a perfect bridge between the societal role discussed above and the institutional role discussed in the last three books, and it allow us to continue analyzing Brazil with a very different lens.

Niedzwiecki locates her analysis of Conditional Cash Transfers (CCTs) and health policies in Argentina and Brazil at the subnational level and is concerned with the reaction of subnational governments to national

[11] Diego Armus, "Disease/Health/Medicine/History: On the Consolidation of a Subfield of Study," *Latin American Research Review* 54, no. 4 (2019): 1065–1071, http://doi.org/10.25222/larr.1102; and Kathleen Musante, "Indigenous Peoples, Postcolonial Ontologies, Neoliberal Regimes, and Approaches to Understanding Medical Pluralism in Latin America," *Latin American Research Review*, 54, no. 1 (2019): 269–276, http://doi.org/10.25222/larr.790. (I also found this while searching for the citations to the previous studies: Brian Wampler, "Developing Political Strategies across a New Democratic and State Architecture," *Latin American Research Review*, 53, no. 4 (2018): 708–725, http://doi.org/10.25222/larr.356).

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

policies. Her essential question is why subnational governments reject some (and not all) national policies that could benefit their inhabitants (1). Niedzwiecki's answer harks back to the notion of policy legacies developed by Pribble but makes a critical contribution to the field by moving the analysis from the national to the subnational level, showing how "multiple levels of authority mediate the process through which policies on paper become realities for citizens" (2). The analysis allows the author to account for variations in implementation within a country and to explain why some policies deliver votes to incumbent governments while others do not. From Niedzwiecki's insightful vantage point successful implementation depends on positive policy legacies, a competent state capable of delivering the services, and political calculations about the policy impact on the politicians' electoral interests (3).

In this carefully researched book, the argument is about political calculations, and the author offers a complex and effective analytical framework to show that for policies in which national attribution of responsibility is not clear, subnational leaders will be able to claim credit for policy success regardless of their political alignment with the national government. Conversely, for policies with clear attribution of responsibilities, both national and subnational leaders who are aligned with the president can obtain electoral gains from the successful implementation of those policies (13).

The book's first two chapters provide valuable contributions to our understanding of the politics of social policy in decentralized countries and a theoretical framework that explains social policy implementation. The framework includes policy alignments, policy legacies, and territorial structure among others. Chapters 3 and 4 discuss methods, research design, and statistical analysis. Chapter 5 analyzes CCTs in Argentina and Brazil, while chapter 6 deals with health policies in these two countries. In the case of CCTs, the author argues that a positive configuration of political alignments, territorial infrastructure, and policy legacies accounts for the successful implementation of Bolsa Família in Brazil. Conversely, in the case of Argentina's Asignación Universal por Hijo a negative configuration of the same variables explains the program's lack of success.

This is a very rich book and multiple conclusions can be derived from the analysis, including the important roles that subnational governments and policy implementation have in linking the policy processes with outcomes. Niedzwiecki additionally reaffirms the importance of policy legacies, but by focusing on within-country variations she makes yet another critical contribution to the understanding of social policies. Last, as she indicates in the final pages of the book, the analytic framework is universal in nature and should be applied and expanded by others. We will return to the contributions made by Niedzwiecki in the conclusions.

International Organizations and International Health Trade: The World Bank, Venezuela, and Cuba

Shiri Noy's *Banking on Health: The World Bank and Health Sector Reform in Latin America* compares the World Bank's role in Argentina, Costa Rica, and Peru. The author's central question is why the World Bank (WB), with its immense power, has not uniformly imposed a neoliberal health model in Latin America (2). The answer, according to Noy, lies in each state's autonomy and capacity to implement its own agenda, while ignoring the fact that the dependency on funding alters that capacity.

Noy argues that the role of the WB can be best understood as a policy advisor; that the formulation of health policies is mediated by national institutions; and that the WB has shifted from emphasizing neoliberal ends, market approaches, and individualism to neoliberal means, programs and projects that use market tools and logic (3). In this resolute defense of the institution, Noy provides often contradictory and confusing analysis. For instance, she tells us that the impact of IFI's loan conditionality remains inconclusive, but on the next page, the truth is unveiled as she writes about the negative effects of these policies on infant mortality rate in sub-Saharan Africa. As for the beneficiaries of the policies, the author tells us that among the WB's central goals is privatization and private sector investment, which might increase efficiency but also undermines the notion of health as a universal right. The author rightly argues that increased privatization has worked in the interest of foreign corporations and has increased their role. However, Noy ignores the effects of those policies on the citizens. Shouldn't one assume that if privatization has worked in the interest of foreign corporations and insurance companies, it has not worked in favor of the people who are insured by those companies and has not favored equity and inclusion?

The same lack of concern with the societies' well-being is found in the analysis of Structural Adjustment Programs, which are defined "as somewhat successful in stimulating economic growth" (50). Yet, on the next page Noy argues "that the negative outcomes of adjustment programs … led to fierce criticism of the Bank" (51). Subsequently, Noy discusses Structural Adjustment policies with a "human face," but it is hard to find the examples of that human face. As it is well known the policies led to the regional "lost decade," as per

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capita GDP fell from 112 percent to 98 percent of the world average and the poverty rate increased from 40.5 percent to 48.3 percent of the population.[12]

The book's conclusions are unsettling. Noy argues that some of the reforms reduced public financing but that much of the expected state retrenchment and neoliberal shifts did not materialize (170). The key words are "expected state retrenchment." Expected by whom? What about the impact of the privatization of social services in Chile, Peru, and across the region? What would have been a significant retrenchment? The abundant literature on retrenchment's negative impact indicates otherwise and undermines the author's defense of the institution.

Both Jessica Scott Jerome and Amy Cooper, the author of *State of Health: Pleasure and Politics in Venezuelan Health Care under Chávez*, are medical anthropologists, but they offer very different analyses of the countries they study. While Jerome provides the reader with a critical analysis of the Brazilian health care system's operations in a favela, Cooper offers a joyful analysis of the Venezuelan case as she repeatedly argues that health care under Chávez made disenfranchised people feel valued and empowered. I call it a joyful analysis because the author tells us that she "was forced to acknowledge that joy, excitement, and satisfaction were central to people's experiences of Barrio Adentro and other health care programs" (3). Thus, the health system elicited pleasure among the poor and working-class Venezuelans because increased access to services made them healthier and produced sensual and social pleasure. Additionally, patients and health care activists expected programs not only to cure disease but also to increase social equality and gratify marginalized people (10, 11).

Undoubtedly, Chávez was determined to change the way in which the country's oil revenues were used. Barrio Adentro, which is the name of the comprehensive publicly funded health care program, was the centerpiece of the Bolivarian Revolution's effort to reduce socioeconomic inequalities by providing universal primary and preventive health services to underserved communities. To accomplish its goal of serving seventeen million Venezuelans, or 63 percent of the population, the program used thirty thousand Cuban doctors, who made up 80 percent of doctors working in the program (21, 22). The presence of thirty thousand Cuban doctors, their training, their medical philosophy, and their approach to patients allowed the Venezuelans to get health services and feel empowered. In subsequent chapters, Cooper analyzes the role of spiritual healing, plant-based medicine, and health care activists, as well as support for indigents, among other topics. She concludes with a quick review of the Venezuelan situation at the time of the writing.

Cooper paints a picture of happy Venezuelans cared for by wonderful Cuban doctors, but what is not included here are the high costs of this joy both for democracy and for the Cubans. Has the destruction of the country's democratic institutions and the economic crisis affected Venezuelans' health and happiness? While so much happiness is attributed to the presence of Cuban doctors, what is the impact of been cared for by doctors that were essentially exchanged for oil? That those doctors and nurses had little to say about where they would be sent and what part of their paycheck would go to the Cuban government is not mentioned either.[13] And what about using Cuban doctors to coerce people in impoverished neighborhoods to vote for Mr. Maduro or his candidates?[14] Last, Cubans have had to make do with a shortage of doctors because of the oil-for-doctors' scheme devised by Raúl Castro and Hugo Chávez. The book reviewed below will highlight those connections.

Social Policies and Decentralization in Cuba deals with the major social policy changes enacted in the Seventh Congress of the Cuban Communist Party held in 2016, which proclaimed ambitious social programs but had little money available to pay for them. While Raúl Castro promised that his policies would not imply a rupture with the ideals of the revolution, he argued for the establishment of "an efficient and sustainable system," not just the promotion of justice (2). The off-loading of health and education costs from the central government to local budgets was one way of achieving these goals and undermining the two jewels of the Cuban revolution: education and health care.

The Cuban economy suffered catastrophic problems because of the collapse of the Soviet Union and of the Venezuelan economy under President Maduro. Economic crises have been followed by limited market reforms including taxes on enterprises, reduction in state employment, and social policy changes. To improve

[12] José Antonio Ocampo, "The Latin American Debt Crisis in Historical Perspective," Initiative for Policy Dialogue, March 25, 2013, pp. 1 and 26, http://policydialogue.org/files/publications/papers/The_Latin_American_Debt_Crisis_in_Historical_Perspective_Jos_Antonio_Ocampo.pdf.

[13] "The Hidden World of the Doctors Cuba Sends Overseas," BBC News, May 14, 2019, https://www.bbc.com/news/uk-48214513.

[14] Nicholas Casey, 'It Is Unspeakable': How Maduro Used Cuban Doctors to Coerce Venezuela Voters," *New York Times*, March 17, 2019, https://www.nytimes.com/2019/03/17/world/americas/venezuela-cuban-doctors.html.

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

a very unfavorable international economic situation, Cuba's export of services increased by 93 percent, and health care exports were a substantial part of that increase. The export of health care providers involves sending medical personnel to work in other countries under bilateral, intergovernmental agreements. In these agreements, the contracting government pays the Cuban government, which in turn pays the Cuban health care workers. While these deals have improved Cuba's trade balance, they have endangered the health and well-being of Cubans because more than fifty thousand health care personnel, or one out of five professionals, were deployed in sixty-eight countries in 2015 (15). The impact has been felt mostly by the poor. It is noteworthy that Presidents Trump and Bolsonaro engineered the removal of over ten thousand Cuban doctors and nurses from poor areas of Brazil, Bolivia, Ecuador, and El Salvador.[15]

The chapter "Looking at Health Care in Cuba: Social Policy in the Context of Widening Inequality," by Susset Fuentes Reverón, successfully explores the combined effects of growing economic inequality, increased poverty, and the wider role of the market on the health care sector. Fuentes Reverón traces the negative consequences of the 1990s economic crisis, the recovery in the early 2000s, and the new Revolutionary Health Program, which has been criticized by both analysts and users. Users complain about long wait times, limited access to medicines, unsanitary facilities, and management problems, among many others. Further reforms were enacted in 2009 but have had limited success.

Diminishing resources have forced the Cuban government to put an end to its commitment to health equity and expansion and resulted in the state's retreat from its health care role. In turn, limited public health services have led to the use of informal channels, including legal and illegal payments to providers. In brief, market reforms and increased inequality have permeated all aspects of society, including the health care system. The author concludes by asking for a more integrated vision in the social policy design, including not only health and education but also housing and employment—two areas which have not been prioritized by the Cuban government in the past. For this reviewer, the central question is this: If the Cuban government cannot fulfill its commitment to health and education, then what is left of the revolution?

Conclusions

Three themes will be explored in this conclusion: the role of social movements, the role of subnational governments, and the importance of policy implementation in ensuring access to health policies. In these three areas the authors have built on existing analytical approaches and opened new ground for future research. The connections between policy expansion and democratization and the need for a universal approach to health care will be discussed as well.

There is analytic continuity in the study of the role of social movements—a form of pressure group—in the actual provision and expansion of health services. Social movements are struggling for specific benefits for specific groups, or regions, and much like the labor unions in the past, they are at the forefront of the battle for health care expansion. In the process, social movements are also expanding democracy as they fight for both policy and political inclusion. Analysts should continue connecting and reconnecting the processes of social policy expansion and democratization because they are joined at the hip. Let us remember that in Spanish and in Portuguese *política* means politics and policies. Democratization means access to power and to the benefits of power, and health care is one of the essential benefits that power brings.

But democratization does not happen by altering only national institutions; it happens also by enacting changes at the subnational and local levels and by eradicating patrimonial relations. Brazil shows that new and older forms of social and political relationships coexist in the health area and in the larger political environment. The authors discussed above have opened the doors for further analysis of these issues as they unveiled how the delivery of a universal service is mediated by the influence of interest groups and preexisting patrimonial relations.

Democratization also entails effective policy implementation. An interesting story about policy implementation is woven through a couple of the books reviewed here. While Caldwell and Gibson highlight the role of social movements in making policies accessible to people, Niedzwiecki argues that effectiveness and implementation depend ultimately on political alignments, the level of cooperation between national and subnational governments, the strength of national and local government, and the policy legacies. Thus, the notion of policy legacies continues to inform the analysis, but it has acquired a new meaning and

[15] David D. Kirkpatrick and José María León Cabrera, "Behind the Curve: How Trump and Bolsonaro Broke Latin America's Covid-19 Defenses," *New York Times*, October 10, 2020, https://www.nytimes.com/2020/10/27/world/trump-bolsonaro-coronavirus-latin-america.html.

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

impact as the focus changes from the national to the subnational level and from policy making to policy implementation.

Most of the authors reviewed here are concerned with equitable and universal policies. This is also an old concern, but unfortunately neoliberal policies, IFI's influence, limited coverage, inadequate funding, and poor administration have stood in the way of universal policies. And, even in those countries in which there is a universal right to health care, there is unequal access due to regional inequalities, traditional patronage relations, and exclusion of minorities or minoritized groups. Thus, while broad policy contours were and still are nationally defined, actual access to health care results from the actions of specific activist groups focused on gender, race, or a locality. As Caldwell makes clear, assuming that policies are color- and gender-blind impedes the universal access to health care.

As the pandemic is showing, it is those without power that are bearing its brunt. States' health care role should be to prevent needless death, illness, and suffering, because only healthy individuals are free to fully develop their capabilities.[16] In order to achieve these goals, the countries should provide universal health systems based on equity and inclusion. Private systems could exist alongside the public ones, but the gap between private and public health care and the gap between the haves and the have nots should be narrowed. As noted by Sara Niedzwiecki, "the challenge is to modify the idea that the public system is poor medicine for the poor" (197). Finally, in the favelas, barrios, *poblaciónes*, and other low-income areas in Latin America, illness results from poverty. Thus, the dual task in a post-pandemic Latin America is to provide universal, good-quality health care and to reduce poverty across the continent.

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[16] Robeyns and Byskov, "The Capability Approach."

https://doi.org/10.25222/larr.1550 Published online by Cambridge University Press

How to cite this article: Borzutzky, Silvia. 2021. Seven Recent Books on Health Care in the Americas. *Latin American Research Review* 56(2), pp. 533–542. DOI: https://doi.org/10.25222/larr.1550

Submitted: 03 September 2020 **Accepted:** 18 January 2021 **Published:** 15 June 2021

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