Response to Robert Jackson

RONN F. PINEO*

In my view, historians have long given scant notice to the topics of health care and disease, matters that actually deserve much attention. Robert Jackson rightly calls for a fuller understanding of the causes and responses to health conditions and has highlighted several themes, especially poverty and underdevelopment, for more discussion. I welcome the opportunity to further open up this topic, first by offering some additional observations on the case of Guayaquil, and second by sketching a few hypotheses for consideration as we take up the study of comparative health conditions in other Latin American cities.

As Jackson points out, even before the development of a modern scientific understanding of the origin and spread of disease, some public health care measures were still effective. Quarantining and vaccination, he correctly notes, proved fairly successful in combating illnesses like bubonic plague and smallpox.

In Guayaquil, as elsewhere, the prevailing notion that disease stemmed from evil, putrid airs—miasmas—led officials to call for cleanup campaigns to rid the city of the sources of these foul winds. Obviously such measures could be beneficial. Draining pools of water shrank mosquito-breeding areas, thereby reducing the risk of malaria and yellow fever. Hauling away human waste, offal, and garbage reduced the chance that drinking water and food would be contaminated, thereby lowering the threat from enteric disorders, cholera, and typhoid fever. Cleaning and disinfecting living quarters reduced the risk of tuberculosis, and controlling the flea population in dwellings helped lower the threat from bubonic plague and typhus.

*Towson State University

Nevertheless, in the days when physicians and health care officials lacked a complete understanding of the origin and spread of many of these afflictions, control efforts still had a hit-or-miss quality. Cleaning all of the belongings of bubonic plague victims in an autoclave was costly and not really necessary. There was no benefit from fumigating all the letters coming in from infected ports. Firing cannons into the air just spread alarm. And special city expenditures for religious ceremonies benefited presumably only the souls, not the bodies, of the pious.

Jackson suggests that popular opposition to public health care programs could have contributed to the bad situation in Guayaquil. No doubt, although little evidence of public footdragging exists, let alone of sharp opposition to sanitation measures. Elsewhere there was such evidence. The bloody 1904 anti-vaccination riot in Rio de Janeiro provides one such example.[1] There, workers and others responded to the sanitation and beautification program with what authorities characterized as fear born of ignorance. However, the Rio de Janeiro program went forward without consulting the workers or considering the effect on their lives. City authorities tore down countless ramshackle tenaments but did nearly nothing to create replacement low-cost housing. Police just threw people out into the streets. The vaccine was to be mandatory, given by force if need be. For working-class families the picture that emerged was altogether unacceptable—arrogant city officials aided by thuggish cops noted mostly for beatings and extortion going door to door, hoisting up the skirts of daughters, wives, mothers, and grandmothers and plunging a needle into the buttocks.

In Guayaquil vaccinations were not given forcibly, and the city lacked the resources for anything so ambitious as the wholesale removal of substandard housing. Actually, evidence suggests that the Guayaquileños cooperated with health officials. For example, when Guayaquil sought to battle back against the invasion of bubonic plague after 1908, the city health director, L. A. Cornejo Gómez, noted in his annual report that the public had supported the quarantine, cleanup, and vaccination measures taken.

Jackson notes one puzzling finding from my research on Guayaquil—that yellow fever appears to have claimed more males than females—and suggests that "men may have refused to take female family members to public hospitals" because these places were regarded as death traps. However, one difficulty with Jackson's proposed explanation is that it fails to

1. See Teresa Meade, "'Living Worse and Costing More': Resistance and Riot in Rio de Janeiro," *Journal of Latin American Studies*, 21:2 (May 1989), 241–266; and Jeffrey D. Needell, "The *Revolta Contra Vacina* of 1904: The Revolt Against 'Modernization' in the *Belle-Epoque* Rio de Janeiro," *HAHR*, 67:2 (May 1987), 233–269.

TABLE 1: Infant Mortality in Guayaquil, Ecuador (Selected Years, 1898–1914)

Year	Births	Deaths (0–1)	Infant mortality rate
1898	3,102	674	217
1905*	3,324	1,096	330
1907	3,161	1,104	349
1909	3,586	960	268
1914	5,720	1,125	197

*Estimate

Sources: Adapted from Ronn F. Pineo, "The Economic and Social Transformation of Guayaquil, Ecuador, 1870–1925" (Ph.D. diss., University of California, Irvine, 1987), Table 8 and Appendix 25.

clarify why Guayaquil men would avoid sending to quarantine their ill female loved ones and then turn around and pack off their sons, brothers, and fathers or even go themselves. Jackson goes on to suggest that Guayaquil hospital and quarantine records would not reveal a hidden female population of yellow fever deaths. However, this uneven gender ratio of yellow fever deaths also appears in the records of the Guayaquil cemetery. For poor families burials were free, paid for by the city's charitable society. It seems unlikely that people would find some place to secretly bury female family members who died of yellow fever, only accepting free burial in sacred ground if the victim were male.[2]

Jackson argues that more attention should be given to poverty in explaining the high death rates of Guayaquil. It is true that the poverty of most Guayaquil residents probably contributed greatly to their often poor state of health. As Jackson suggested, infant mortality rates do provide further indirect evidence of poverty.

But if the limited comparative evidence seems to suggest that Guayaquil was more *unhealthy* than other cities in South America, there is no real way of knowing if the people of Guayaquil were *poorer*. For example, even if we could estimate the average weekly earnings of a typical Guayaquil family—a nearly impossible task given the loose, day-to-day nature of most employment arrangements—this would tell us little about how they ate and cared for themselves. Men unable to locate paying work might still bring home some fish. Families might borrow food or money from relatives or neighbors. And the transitory nature of Guayaquil's popula-

2. One lifetime resident of the city, noted Guayaquil historian Julio Estrada Ycaza, suggested to me another explanation for this finding. Estrada said he had long noticed a difference in the way that Guayaquileño women and men respond to mosquitoes: women wave and swat mosquitoes away; men do not and regard such behavior as effeminate.

tion permits only general estimates of the proportion of the city living in poverty.

Finally, Jackson suggests that the issue of underdevelopment be given more attention. On this we are in accord. As research into health conditions in other Latin American contexts goes forward, the theme of underdevelopment certainly merits careful consideration. Several themes, it seems to me, are worthy of our attention.

Guayaquil was just one South American example of early capitalist urbanization in the periphery of the international economy. During this laissez-faire stage of development, the economic system went largely unregulated and urbanization proceeded in a generally disordered, unplanned, and out-of-control fashion. In premier wealthy nations, developments associated with advanced industrialization brought into question this "night-watchman" notion of government and gave rise to the modern welfare state. This changing vision of the appropriately larger role of the state achieved its fullest expression in the successful industrialized nations. Only they could afford it.

Positioned at the periphery of an international economy structured to benefit the developed nations at the center, Guayaquil and other South American cities found themselves at a marked disadvantage. Because cities at the center had more money, health care, sanitation, and, most importantly, living standards all improved. Prosperous nations turned their considerable resources on public health-care problems. European governments funded successful health and welfare programs. Their medical schools were the best in the world, due in no small measure to relatively generous state support. Government in the United States, especially at the state or local level, had by the 1890s accepted its central role in protecting public health. True, developed nations sometimes squandered revenues, but they had more to waste. New York Health Director Herman Biggs commented in 1911, "Disease is largely a removable evil."[3] That is, health care could be purchased. Cities like Guayaquil, I suggest, could not afford to buy.

The triumphant capitalism of the core nations not only created an industrial elite, it also gave rise to the development of a large middle class. Just as the capitalist industrialists in the core pressed hard for a state-funded infrastructure, the middle class used its growing resources to build political power and to successfully demand that its needs be taken seri-

3. Quoted in George Rosen, *A History of Public Health* (New York, 1958), 464. The chief of New York City's Health Department, Dr. Sigismund S. Goldwater, said in 1915, "Public health is purchasable; within natural limitations a city can determine its own death rate." Quoted in John Duffy, *A History of Public Health in New York City, 1866–1966* (New York, 1974), 271.

ously. This aroused citizenry could defeat entrenched interests that stood to lose financially from the passage of sanitation reforms. In the developed world, this emergent middle class formed the driving force for progressive change, founding voluntary organizations and agitating effectively for legislation. In periphery cities like Guayaquil, the nature of capitalist development generally excluded the emergence of a sufficiently large middle class. Without this group the call for reform may well have been weaker.

As study progresses on the history of public health, I would suggest for consideration the hypothesis that the nature of capitalist development in cities like Guayaquil could not create the circumstances that might have encouraged more effective programs against the conditions that bred disease.