

1 N: Gootenberg, Paul and Luis Reygadas, eds.
2010. Indelible Inequalities in Latin America: Insights from History, Politics and Culture.
Durham: Duke University Press.

Health Policy and the Historical
Reproduction of Class, Race, and
Gender Inequality in Peru

CHRISTINA EWIG

Social policies, such as pensions, healthcare, and antipoverty programs, are often conceived of as tools to ameliorate inequalities. Yet, as first observed by the well-known scholar of welfare states, Gøsta Esping-Anderson (1990), social policies provide benefits and serve to stratify societies along multiple cleavages. In other words, social policies may in fact (intentionally or unintentionally) reinforce or even create certain inequalities. Because social policies often segment different groups into different kinds of social-benefit systems, the concept of "stratification" has been used to explain the negative effects of social policies on societies. However, as Charles Tilly notes, the idea of vertical and horizontal stratification fosters "an illusion of a continuous, homogeneous two-dimensional grid within which individuals and aggregates of individuals occupy specific cells and move along geometric paths" (1998: 28). Instead, he argues, a relational analysis that incorporates structure and agency is needed in order to move beyond static and unrealistic analyses of social life. Tilly's categorical and relational theory of inequality provides a more dynamic tool than the geological stratification metaphor would allow, for example, how organized groups in civil society, states, and state social policies interact with the "bounded categories" of class, race, and gender to ameliorate or accentuate inequalities over time. The long-term construction of inequalities can be uncovered through historical analysis of the formation of health policies in Peru from the late nineteenth century forward. Following Paul Gootenberg's suggestion, I seek to provide a more historically grounded vision of how inequalities are constructed and maintained, but also how these change and indelibly camouflage themselves over the long haul.¹

In addition to providing more historical grounding to Tilly's theory of durable inequalities, I contribute to broader intellectual debates on the relationship between gender and race and social policies by examining these relationships in the Latin American region. While scholars have offered rich analyses of how social policies perpetuate gender and racial inequalities in advanced industrialized nations, historical feminist welfare state analysis in Latin America is, as of yet, a nascent field of inquiry.² While works by Malloy (1979) and Mesa-Lago (1978, 1989) are considered classic comparative-history accounts of social-policy formation in Latin America, they focus primarily on the role of class power and state responses to class-based actions and ignore gender and race.³ Class may be fundamental to understanding social policy formation in Latin America, but these historical formation processes were also based on gendered and racialized relations of power.

Pre-existing class, race, and gender inequalities in Peru served to shape the formation of Peru's health system in ways that reflected those inequalities. Once established, the resulting health system served to reinforce and perpetuate inequalities by privileging some groups over others, in a feedback effect. Yet such inequalities were neither rigid nor permanent. While the "bounded categories" of gender, race, and class continue to be immensely important in structuring Peruvian inequality, they have morphed and changed along with the transformation of health policies, helping to reshape Peruvian inequalities over time. These changes, in fact, provide clues as to the specific tools one might use to move closer to the goal of greater equality in the future.

Categorical Inequalities and Health-Policy Formation in Peru

Tilly argues in *Durable Inequalities* that bounded pairs such as male-female, aristocrat-plebian, citizen-foreigner and more complex categories such as race (often reduced to white-black despite this category's far greater complexity) "do crucial organizational work." By this he means that social organizations such as communities, workplaces, corporations, and state institutions adopt these categories as a shorthand for deciding who shall be allotted certain privileges or benefits. These allotments are often contested, but longstanding belief systems such as religion and "common knowledge" more often justify and perpetuate these categorical inequalities, usually by making these categorical inequalities appear to be the result of individual decisions or traits. These asymmetries are not between separate entities, but

rather are intimately bound together.⁴ That is, the benefits of the one side depend crucially on the wants of the other and are predicated on the social construction of these binaries.

These categorical inequalities, Tilly explains, are created by two primary causal mechanisms: exploitation, "which operates when powerful, connected people command resources from which they draw significantly increased returns by coordinating the effort of outsiders whom they exclude from the full value added by that effort"; and opportunity hoarding, "which operates when members of a categorically bounded network acquire access to a resource that is valuable, renewable, subject to monopoly, supportive of network activities, and enhanced by the network's *modus operandi*" (1998: 10). The critical difference between these two mechanisms is that the second mode is accessible to relatively weak groups, while the first is exclusive to real powerholders.

In Peru, the bounded triad of class, race, and gender existed in Peruvian society prior to the advent of the health system and were the result of previous social processes of exploitation and opportunity hoarding. These existing bounded pairs, in turn, played important roles in shaping the terms of the formation of Peru's health system. Once formed, the health system proceeded to use these binaries as part of its justification of its own structure of benefits, thus reinforcing the inequalities inherent in these binaries. Yet Peru's history of health-policy formation demonstrates that these categories were not static and their related inequalities were also not entirely "durable." The categories shifted over time—as did the structure of the health system itself as a result of contestation of particular groups' and of government (re)actions. While health policy both reflects and reinforces broader inequalities, Peru's history of health policy also reveals a certain dynamism by showing how these inequalities are renegotiated over time and how social policies play a part in these shifts.

Peru's health system was constructed in a two-stage process. It began, much as in the rest of Latin America, in the late nineteenth century with the development of a public-health system, which was formed in an internal "colonizing" process. I use the term colonizing to mean a process similar to Tilly's exploitation, in that "powerful, connected people" commanded the process and sought specific returns, particularly economic benefits. However, this process was quite a bit more complicated than simple exploitation, in that while elites had an instrumental economic interest in improved national public health, they also harbored more nationalist desires for national

development and social progress. They often intensified their campaigns with foreign cooperation, making this process in some ways akin to foreign colonization, though it was primarily a nationally motivated internal colonization process. I also use the term *colonization* because it was used by key protagonists in the founding of state public-health services, figures who characterized public health as an important tool for the state to gain control over, or internally "colonize," geographically isolated portions of Peru's national territory, such as Amazonia or the high Andes. In sum, the formation of the public-health system was a process of internal colonization, born partially of national development imperatives that included economic growth and resource exploitation as well as greater political and social control over the national territory. At the same time, however, the state and the many doctors, nurses, and health professionals in its service saw their project of building a public-health system as part of the betterment of the population and their life conditions, even though the means used to achieve this were rarely democratic or egalitarian.

This historical process of internal colonization depended on the assumption of the bounded pairs female-male, indigenous-Creole, and elite-popular class (a division that has a variety of historical nomenclatures in Peru). In brief, male, Creole oligarchs devised the public-health system in part out of a desire for the uplift of the targeted populations of women, indigenous peoples, and the poor, but also in part out of their desire to exploit these groups so that they might contribute the human resources necessary for the economic and social development of the Peruvian nation as a whole. Because its designers employed unequal categorical distinctions to justify its mission, the public-health system that emerged had important stigmatizing aspects that served to further reinforce these categorical inequalities over time. These stigmatizing effects were brought into greater relief during the second major phase of health-policy development in Peru.

In this phase, one can identify an important shift in two of the bounded pairs and in the process by which the health system was constructed. Industrialization, migration, and urbanization led to the emergence of two new classes of workers in mid-twentieth-century Peru: urban factory workers and middle-class professionals. As a result, the elite-popular category in Peru began to lose some of its significance, and rather than a new binary, a triad of the poor-worker-elite emerged, with the new urban workers and middle-class professionals representing a very small and thus new group of elites. With this shift, one also sees the emergence of a related new racial triad of

indigenous-mestizo-white, which begins to displace the indigenous-white binary, in that a notable portion of urban Peruvian society, including the new class of workers and professionals, begin to identify as mestizo, or mixed race, rather than as white or indigenous.⁵

These shifts in categories contributed to a new process of health-policy formation, one akin to Tilly's notion of opportunity hoarding, but which also involved a government reaction of cooptation. In a context of scarce resources, workers used their newfound political power to demand better health services, but they did so in an exclusive manner that left the existing, poorly supported public-health system intact, while layering on top of it a better, higher-quality system serving only these workers. The state, in a manner reminiscent of Bismarck's Germany, recognized the political advantage to separate but unequal health systems, as this form of organization limited state expenditures and served as a political tool for coopting the emerging political actors.

The layering of a better health system on top of the old, however, reinforced the bounded categories of poor-worker and indigenous-mestizo, as the new health system provided more and better resources to mestizo workers than to the indigenous poor. Moreover, the layering further accentuated the bounded category of male-female. The separate health social-security systems erected for the middle and working classes served primarily male workers, with extremely limited coverage for spouses and children. This change in the health system left the public-healthcare sector feminized in two senses: first, it was the only system free of direct cost to the majority of women and the poor and, second, one of its priorities was to exert control over women's biological reproduction. A further distinction between the two systems was that the newer social-security health system came to be viewed as an exclusive right earned by its beneficiaries, while the services of the public-health system, which had never been explicitly fought for, continued to be viewed as a "welfare" benefit in the stigmatizing sense and as a policy apparatus through which national economic objectives were privileged over individual well-being.

Colonization: Health Care for the Poor

Peru's public-health system was formed largely through a process of internal colonization, a process that included the exploitation and control of human resources in order to serve broader, instrumental national economic objec-

tives. But this form of colonization also incorporated the nationalist objective of national betterment through better health, though the means by which this was achieved were often authoritarian and explicitly drew on racial and gendered bounded pairs.

The establishment of Peru's state public-health system can be traced to the late nineteenth century and the early twentieth, spurred by economic development and the related expansion of the state.⁶ From 1890 to 1930, Peru experienced dramatic economic growth. According to one estimate, from 1900 to 1929 the economy grew seven-and-a-half times in terms of gross domestic product (Boloña 1994, cited in Contreras 2004: 177). Economic growth led to an expanding state. Between 1920 and 1928 the number of public servants in Lima almost tripled, from 5,329 to 14,778 (Contreras 2004: 184). At the start of the twentieth century, two issues in particular became major state foci, which in turn shaped the evolution of public-health policy. First was a desire to increase national population in order to meet the labor demands of the expanding agricultural and mining sectors (Contreras 2004; Mannarelli 1999). This goal was sought in the public-health arena through control of epidemics and via policies to reduce infant mortality. A second central focus was a desire to extend state control over interior zones of the national territory with the objective of fostering their economic potential. Public health was seen as an essential tool for such control.

Scarcity of labor, and the related concern about low population levels, became a point of debate in the late nineteenth century as a result of the abolition of slavery, in 1855, and the dramatic era of export growth that followed (Contreras 2004:188). Peruvian elites, like those in other Latin American countries, began to debate the best means to increase the population. Urban elites advocated white European immigration, invoking the premises of eugenics popular at the time, that Europeans would "civilize" and populate the country, creating the basis for a robust internal market" (Contreras 2004: 190).⁷ Landowners, by contrast, sought cheap manual labor for their plantations and were not willing to pay the high wages necessary to compete with neighboring Chile, Brazil, or Argentina for attracting European workers. Landowners were content with Asian immigrants, who hailed first from China and later from Japan. For a variety of reasons, immigration rates to Peru proved minor compared to other Latin American countries. In 1876 foreigners constituted 4 percent of the population and in 1940 just 1 percent. In 1940, 46 percent of these foreigners were Asian and 21 percent were European (Contreras 2004: 194).

Unable to lure significant numbers of immigrants, the Peruvian state turned to mortality reduction as a demographic and labor policy (Contreras 2004). It did so in two major ways: by actively fighting epidemics and by initiating the first maternal-child health programs with the aim of decreasing infant mortality. In response to the bubonic plague that threatened Peru's coastal cities and towns between 1903 and 1930, the Peruvian government established the first national public-health institutions (Cueto 1997: 27). Key among these was the Dirección de Salubridad Pública (Public Health Board) established in 1903, the precursor to today's Ministry of Health (Cueto 1997: 35).⁸ The Dirección de Salubridad Pública was a section of the Ministry of Development (Fomento), a fitting institutional home in that it reflected the views of civilian elite political leaders, who saw state oversight of public-health matters as intrinsic to economic progress and development.

In this colonizing process, in which public health was promoted with an eye toward economic development, crusades against certain diseases became conceptually tied to poverty and race.⁹ Justification of these public-health programs and the manner by which they were implemented (often in top-down authoritarian style) were rooted in the reinforcement of unequal categorical pairs of popular class-elites, indigenous-white, and foreigner-citizen. These binaries often bled together in reality: the rates of mortality related to the plague, for example, were higher among persons of indigenous descent and Asian immigrants because these groups were generally poorer and had limited access to healthcare, and thus were more susceptible to disease (Cueto 1997: 50). But race and class convergence was played on by those who acted on behalf of the state, with real consequences for the social policies that resulted. The historian Marcos Cueto writes about the plague in the following terms: "The disease was associated with misery, poor living conditions, and what was even worse: to be considered *chino* [Asian] or *serrano* [indigenous and of the highlands], for some the scum of the earth" (Cueto 1997: 51). As a result, to be targeted by public-health officials was to be racially stigmatized, so much so that upper stratum Peruvians often hid their illnesses. The early public-health system came to be understood as a tool to eradicate disease among populations deemed to be more susceptible to ill health due to their individual "racial" characteristics, rather than due to the structural underpinnings of racial and economic inequality that actually enhanced their susceptibility. Framing health policy in this way not only ignored these real inequalities, but also reinforced them.

While the fight against the plague gave rise to the colonization process

that eventually resulted in the state public-health system, that system remained rudimentary until the 1920s. This began to change when the regime of Augusto Leguía (1919–1930) began to strengthen state public-health activities with the aid of foreign counterparts. Having closed the congress immediately after his election as president in 1919, Leguía's "oncenio" regime was notably authoritarian. It was also characterized by its dependence on foreign support—financial and technical—for achieving its development objectives (McClintock 1999: 316; Cueto 1992: 9; Klarén 2000). Leguía enhanced the state in part through spending: social spending between 1920 and 1929 increased annually at a rate of 11.6 percent (Portocarrero, cited in Arroyo Laguna 2000: 190). The fight against another epidemic, yellow fever, served to expand the state's public-health infrastructure with the help of the New York-based Rockefeller Foundation.¹⁰ The outbreak of yellow fever in Peru in 1919 coincided with renewed interest on the part of the United States and European powers in economic expansion into Latin America, Africa, and Asia. The Rockefeller Foundation was alarmed by Peru's yellow fever epidemic, which it saw as a threat to regional trade, potentially infecting ships and spreading the disease to the United States (Cueto 1992). The foundation provided Peru with substantial financial resources and key technical support through the appointment of American physicians to lead Peru's anti-yellow fever campaign.

Reflecting Leguía's governing style and racist attitudes toward Latin America in the United States, the yellow fever campaign was carried out in an authoritarian fashion.¹¹ The American physician who led the campaign, Henry Hanson, ignored the Peruvian cultural norms and attitudes surrounding healthcare, including the customs of self-medication and reliance on native healers. Cueto writes of the episode, "The attitudes and responses of patients were treated as primitivism to be brushed aside" (1992: 21). Hanson's entourage of forty cavalry and a cruiser of sailors and marines controlled migration from affected areas, prevented public gatherings, and imposed a quarantine on the sick (Cueto 1992: 15). Similar to previous periods, Hanson depended on these strong-arm and technical solutions to attack the epidemic and the individuals affected by it, rather than addressing the social and structural factors related to the spread of the disease.

Next to the focus on quelling epidemics, maternal-child health services formed a second strategy for increasing population levels. The early maternal-child health services in Peru demonstrate once again the resonance

of the instrumental objective of economic development behind the formation of Peru's public health system: maternal-child health services were viewed as key to reducing infant mortality and thereby enhancing the labor force and in turn economic development. These services were motivated in part by statistics from 1903–1908 that showed that one-quarter of all children in Lima did not live to one year of age (Contreras 2004: 203–5). While many of the professionals involved in the design and delivery of these early maternal-child health services had a sincere desire to protect and promote human life, a parallel objective of this program, from the viewpoint of the state, was to raise population levels. Population, writes Contreras, was still "viewed as a form of capital" (Contreras 2004: 205n18).

Reflecting the general medical consensus in Peru at the time, the maternal-child health program was premised on the belief that infant mortality could be prevented by mothers (Mannarelli 1999: 73). The new maternal-child health services were to be managed primarily by professionally trained nurse midwives. The initial goal was to appoint one nurse-midwife to serve in each province, a goal that was reached in just half of all provinces by 1916. The government directed these midwives to offer free obstetric services day and night, to provide two hours of daily consultations to pregnant mothers, and to write regular reports to the central government on the number of registered births and child vaccinations. The historian Carlos Contreras notes the authoritarian side of the program, in which infant diets were closely monitored, mothers were compelled to follow the hygienic procedures indicated by nurses, and vaccinations were obligatory (2004).

While racial binaries were central to the fight against epidemics, the maternal-child health program exemplified the ways in which the female-male categorical binary was also at work in the formation of the public-health system. While some may quibble as to whether Peru's early maternal-child health program was indeed authoritarian or simply the practice of the time, the format of the program did demand much of mothers as individuals and identified mothers as the cause of infant mortality. Peru's policy at the time reflected a global early-twentieth-century infatuation with holding women individually responsible for the successful re-generation of the national population. Individualization of the problem of infant mortality, with responsibility falling disproportionately on one side of the female-male categorical divide, diverted attention from the root cause of child mortality: poverty. In the process, individualization drew on and reinforced the une-

qual categorical binary of female-male. Women became intimately responsible for social reproduction (and in fact blamed for child deaths), while males conversely had little such responsibility, or guilt.

While population was viewed as a form of national capital on the road to development in the early twentieth century, so were the rich untapped resources of the interior of Peru's national territory. The state, led by Creoles of European descent, justified its closer control of distant territories within Peru partially based on the belief that it was necessary for the state to "civilize" the native populations. State public-health services, based on Western biomedical practices, were viewed as an important part of this "civilizing" process and were premised on the indigenous-white binary.

In the late 1930s and early 1940s, amid an economic spurt and urbanization, major efforts were made for an effective state presence in the Amazon jungle region in eastern Peru. Similar but more limited efforts registered in the sierra (Cueto n.d.: 26). State expansion into the Amazon was intrinsically tied to foreign interests, particularly American ones, in rubber and tropical agricultural products. In 1942, the wartime government launched the Peruvian Amazon Corporation (Corporación Peruana de Amazonas), and in 1943 the Board of Eastern Affairs, Colonization, and Eastern Lands (Dirección de Asuntos Orientales, Colonización y Terrenos de Oriente). The former was charged with overseeing rubber production while the latter authorized land use for cattle and tropical agriculture (Cueto n.d.: 14).

Public-health services played a vital role in state colonization of the interior. As a part of this economic oversight, in 1940 the Ministry of Health, Work, and Social Provision established an office to oversee the public-health concerns of the Amazon region. This ministry had been established, in 1935, under the dictatorship of General Benavides and replaced the old Dirección de Salubridad Pública (Cueto n.d.: 17–18). The government of Manuel Prado (1939–45) significantly expanded the financial resources and personnel of this ministry and in 1942 directed it to focus exclusively on health issues, renaming it the Ministerio de Salud Pública y Asistencia Social (Ministry of Public Health and Social Assistance) (Cueto n.d.: 19). This fortified ministry contracted well-known Peruvian doctors, such as Maxime Kuczynski-Godard and Carlos Enrique Paz Soldán, to lead its efforts to colonize the Amazon. Paz Soldán himself explained, "The modern colonizer is a hygienist. Without health, there is no lasting possession of the earth" (quoted in Cueto n.d.: 23).

Paz Soldán and Kuczynski-Godard were both pioneers in the field of

social medicine, helping to establish social medicine in Peru beginning in the 1920s (Cueto 2002). Social medicine, which gained significant influence across Latin America in the 1930s, is often dated to the intellectual work of Rudolf Virchow, of Germany, who argued in the late nineteenth century that multiple social conditions, not unitary "scientific" factors, were significantly related to illness (Waizkin 1998). Social medicine's recognition of the broader social factors behind ill health might have led to an important shift in Peru's public-health system, perhaps toward a less instrumental and ultimately more egalitarian health system. Yet, despite the many noble objectives behind the social-medicine approach of Paz Soldán and Kuczynski-Godard, these men were also products of their times, in which the unequal binary of indigenous-white was widely accepted. As a result, the racial undertones of their hygienic colonization, in both the Amazon and the sierra, were clear.

Paz Soldán, a prominent physician in Peru and the Latin American region, promoted eugenics as a means of "bettering" the population (Stepan 1991). Initially trained by a French medical officer who had worked in Africa as a colonial physician, Paz Soldán believed that public-health interventions in remote areas could improve the "racial" and moral life of the country (Cueto 2002). Similarly, Kuczynski-Godard vaunted the positive role of the mestizo in the colonization effort, arguing that mestizos were more likely than indigenous peoples to develop healthy hygiene habits and to rationally exploit unutilized land. Moreover, Kuczynski-Godard saw the indigenous shamans' and *curanderos'* opposition to Western medicine as a major obstacle to the colonization efforts in the Amazon (Cueto 2002: 190–91). Similar racial assessments marked the expansion of state public-health services to the Andean region of Peru. Medical officials posted in Puno, the southernmost and highest altitude city in the Peruvian Andes, viewed the spread of Western medicine to the indigenous-descent peasants as akin to the earlier religious crusade of introducing Christianity (Contreras 2004: 203). Despite the expansion of state health services in this period, these services still reached only a fraction of the population. Throughout the 1940s, the poor, in both rural and urban settings, continued to rely on popular medicine and the Catholic charity hospitals in urban areas.

By the end of the 1940s, the formative period of the public-health system was over. Colonization campaigns in the interior had subsided and a new focus took root: the rise of mobilized urban working and middle classes in the coastal cities of Peru. From the 1930s to the 1950s, the state created

multiple, separate health systems for these formal-sector and mostly male workers. The process of creating social-security healthcare had some minor impacts on the public-health system. The state social-security system built a few clinics and hospitals in outlying areas to serve those workers who were insured under the newly formed social-security health system yet far from the main social-security hospitals in urban centers. In some cases, these clinics could also be used by public-health-system patients (Mesa-Lago 1978). Other than this indirect form of expansion, the usual trends dominated the public-health system, such as the influence of foreign interests. For example, in 1957 the Pan American Health Organization and UNICEF led new efforts to eradicate malaria (Cueto 1997: 161-68). As a result of foreign cooperation, the public-health system gained growing numbers of personnel, better training, and financial resources.

Statistics can demonstrate, from the 1950s on, the scope of the public-health system, and from these one can begin to assess its distributive character. The construction of most of the hospitals had been financed during the 1940s and 1950s by the Inter-American Cooperative Public Health Service, funded by the United States, while six hospitals were transferred to the ministry from Catholic charities (Roemer 1964: 45, 48). In 1957, the Ministry of Health began "a basic plan of public health" that sought to provide basic health services to the population through a network of clinics, each connected to a hospital, organized in twenty geographic zones. By 1960, the Ministry of Health could report operating 32 hospitals, 71 health centers, 142 medical posts, and 177 sanitary posts.¹² Many of these, however, were empty and provided very limited services. For example, mandated full-time posts in practice offered services only three hours a week (Roemer 1964: 39-45). Each rural post served a population of about 17,000 people, a ratio that was in reality far worse due to inconsistent staffing. In addition to these primary health facilities, the government, in 1960, had 131 "botiquines populares," or pharmacies, that made low-cost medicines available to the population.

Contrary to what one might expect, the radical, nationalist, self-proclaimed Revolutionary Government of the Armed Forces, which took power by coup in 1968 and held power until 1980, paid little attention to the public-health system, despite the keen interest in economic development of the first military president, Juan Velasco Alvarado. This government opted for other avenues toward economic development such as agrarian reform, price subsidies, the organization of the poor in government-organized community groups, and worker participation in the management of firms. Although

novel experiments followed in participatory development in rural areas and poor urban neighborhoods, formal-sector workers were its key perceived constituency. The military government began only a handful of public-health initiatives, including a basic medicine-distribution program, free medical care for birthing and recent newborns, and a basic healthcare plan that emphasized community participation (Bravo Castillo 1980). Under the military regime in 1975, the Ministry of Health managed a total of 103 hospitals, 344 health centers, and 994 sanitary posts. Given that the total population had grown from about 10 million in 1960 to some 15 million by 1973, the expansion of hospitals and health posts did not keep up with the population. The fraction of the population that primary health establishments served had improved little since 1960; in 1975, one health center served 29,771 persons, and another health post served a population of 14,323 (Orihuela Paredes 1980: 8-10).

While the military regime had scant interest in strengthening the public-health system, population remained a core government concern, as it had been since the beginning of the twentieth century. The first Velasco government made longstanding state pronatalist practices more explicit. Velasco's pronatalist stance stemmed partially from a Catholic tradition, but was also a nationalist reaction to perceived imperialist interference by the United States, which was now actively promoting population control throughout Latin America.¹³ When Velasco resigned, ceding to more conservative generals, the centrist and free-market-oriented regime of General Francisco Morales Bermúdez (1975-80) reversed the pronatalist stance and in 1976 outlined Peru's first official population policy. Morales may have been acquiescing to the influence of the United States, but clearly he was reacting to the rapid rise in population in Peru over the prior two decades. This first population policy reflected international currents of the time by making the "Malthusian" connection that population control now was a prerequisite to sustained economic development (Varillas and Mostajo 1990: 380).¹⁴ The new policy included access to artificial contraception, but considered procreation to be the decision of the couple, using the Catholic concept of "responsible parenthood," in which couples are encouraged to use natural means to decide family size (Guzmán 2002: 190). Although it reflected new international trends, this was still a dramatic reversal from traditional policies based on the idea that increased population was a pure economic gain. It shared with previous policies, however, a responsibility placed on women as mothers for the material well-being of the nation.

By the end of the military period, the government faced a severe economic crisis, which contributed to a deterioration of the public-health system. In 1978, the military imposed the first in a series of economic austerity measures that severely restricted the reach of its few public-health initiatives. In 1980, the Ministry of Health budget composed just 3.5 percent of the general budget, down from 17 percent in 1968, prior to the military takeover (Ortuela Paredes 1980: 7). By 1980, with few funds left for social needs, the already weak infrastructure of the public-health system built during the mid-twentieth century was in disarray. The minister of health under President Fernando Belaúnde Terry (1980–85), the first democratic government following the military, described the state of the health system: “The public hospitals—not those of the social-security system—were in a state of calamity. The patients who went to be hospitalized had to bring their own mattress and sheets.”⁴⁵ In 1980, the Ministry of Health was responsible for providing healthcare to 70 percent of the national population, yet only reached half of that segment.

Public healthcare became even more scattershot under the new democratic government, as part of an overall policy trend toward “crisis” social-policy interventions while allowing the traditional social-policy structure to wither. The centrist Belaúnde administration raised popular expectations as the first government to be elected when the entire population had suffrage, yet it languished under a continuing economic recession.⁴⁶ Debt servicing and military spending to combat growing rebel movements in the sierra absorbed most of the national budget, with few resources dedicated to improving the health sector (Davidson and Stein 1988). As the state retracted social-policy commitments on health funding, it turned to “emergency” social policies such as those that funneled international food donations to women’s groups in poor communities. As a hedge against the worsening economy, the government encouraged the proliferation of communal soup kitchens run by women volunteers in poor communities, kitchens originally founded by the Catholic Church. The spread of informal kitchens continued after Belaúnde and became politicized as political parties set up their “own” kitchens during subsequent governments (Barrig 1992). With the incorporation of illiterates, a new and substantially poor electorate thus became the object of clientelist politics. This trend hit the health system by siphoning off social spending to a series of emergency programs that served the dual purposes of aid and clientelism.

The late 1980s stand out as a failed attempt to rectify the downward

course of the public-health system. Disillusionment with the Belaúnde government resulted in a dramatic turn of the electorate toward the political Left. In the 1980s, the Izquierda Unida united several Left parties, and for the first time the older populist Alianza Popular Revolucionaria Americana (APRA) party was allowed to run a candidate, in the presidential elections of 1985. Following the presidential victory of APRA candidate Alan García (1985–90), his minister of health, David Tejada de Rivero, worked to reverse the decrepit state of Peru’s public-health system and to shift its mission toward primary healthcare. Prior to his service as minister, Tejada had worked for eleven years as assistant director of the World Health Organization (WHO), where he had helped to organize the Alma Alta conference, which had defined the original principles of “primary healthcare,” in 1974. Primary healthcare shifts the emphasis away from Western hospital-based health services to basic and preventative healthcare services thought to more effectively address the most common health needs of the poor in developing nations (Cueto 2001: 56; Cueto 2004).

In his first year in office García also passed a national population law, which reiterated the church position of responsible parenthood, but also established the right to a choice of contraceptive methods and individual freedom from manipulation or coercion in matters of family planning (Varillas and Mostajo 1990: 322–23). The government then developed the National Population Program (1987–1990), which outlined goals for reducing fertility rates and providing contraception coverage. However, it secured only modest funding. The program’s plan spawned the first family-planning programs in Peru’s social-security health system and in Peru’s state-run public-health system (Guzmán 2002). Notably, the National Population Program was a component of the National Plan for Development, evidence of the continued association of population issues with economic development. Tejada’s campaign for primary care and the launching of state family-planning services were overshadowed, however, by the economic and political crises that confronted the García administration.

This history had important results in terms of reinforcing categorical inequalities. Historically, when the state did bring health services to rural and provincial areas, officials viewed the spread of Western medicine as part of a colonization and civilization process, an approach that left little room for utilizing allopathic medicine along with local, popular medicinal practices. These developments also reinforced racial differences between the urban-educated and European or mestizo doctors who strove to bring a

measure of modernity to the indigenous "backward" populations. A similar process occurred with the female-male binary. Women's fertility was subjected to economic development, and the binary of female-male was further essentialized, with such control being made to appear acceptably "natural." Moreover, the public system, although it served the majority of the population, received much less state financial support than the social-security health system, which was created through the "cooptation path." Therefore, the poorest and the indigenous populations were left with scant or no access to healthcare. Women, stuck in the public-health system because the social-security system largely excluded them, also faced lower-quality health services than working- and middle-class males. With the advent of a better financed and higher quality social-security health system, some class, racial, and gendered binaries became further embedded. But the story of cooptation also highlights some important changes in these inequalities as well.

Opportunity Hoarding and Cooptation: The Social-Security Health System

Between 1930 and 1950, during a period of rapid economic change and urbanization, Peru began a second important phase in the formation of its health system. This second phase was characterized by Bismarckian-style cooptation of the middle and working classes into the state-run health insurance programs that became known as social security, and by opportunity hoarding by the coopted groups who sought to maintain exclusive rights to these new benefits.¹⁷ Authoritarian rulers representing oligarchic interests promoted the creation of social security in response to political pressures from particular interest groups, primarily the middle- and working-class employees newly mobilized in both unions and political parties. These groups represented new political interest groups that also forced a shift in the traditional categorical binaries of class and race. Popular groups—elites no longer could suffice here—and new bounded pairs of poor-worker and worker-capitalist emerged. Racial binaries also changed, with the growing consciousness of the mestizo, with which many workers identified. Thus the new triad of indigenous-mestizo-white began to take precedence over that of the older divides of indigenous-white or foreigner-citizen.

While growing in political clout, the organized middle and working classes still constituted a minority of the Peruvian population—the vast majority still being poor peasants and now those in the urban informal sector.

Workers in the middle and working classes essentially constituted their own elite. Rather than banding together and demanding better health benefits for all, this new elite acquiesced to the divide-and-conquer tactics of the state and resorted to classic opportunity hoarding. With their newfound political and economic power, these primarily male union members were able to demand, and then dominate, better-quality healthcare services, services that continued to be denied to the poor, indigenous peoples, and women. This hoarding served to reinforce and even accentuate categorical binaries of class, race, and gender.

General Benavides, appointed president by the congress in 1933, took the first steps in the cooptation process that eventually evolved into social-security healthcare. He came to power soon after the political ascendancy of APRA, an opposition party representing the middle classes and the upper stratum of Peru's working classes. In 1931, APRA held its first national congress, which produced a number of social-policy proposals, including the creation of a social-security system (Cotler 1978: 236). In an attempt to pacify the working-class followers of APRA, the Benavides dictatorship instituted the Ministry of Health, Labor, and Social Welfare in 1935 and decreed social-security health insurance for blue-collar workers in 1936 (the Seguro Social del Obrero, or SSO). With one hand, Benavides launched these programs to appease these class-based demands, while with the other, he severely repressed their political voice in APRA. Besides coopting the demands of urban workers, Benavides expanded already existing social-security health benefits for civil servants (Mesa-Lago 1978: 116). Workers in both of these sectors accepted these separate benefits, thus reinforcing divisions among themselves, and between themselves and the country's poor majority.

After the Benavides regime, restrictions loosened on working-class organizing, and the number of legally recognized unions rose. Thus, the civilian presidency of Manuel Prado y Ugarteche (1939–45) faced increasing pressures from organized class interests. Toward the end of his term, Prado legalized the APRA party, providing a significant opening for class-based political opposition (Cotler 1978). Escalating pressures from the working and middle classes through both union and APRA demands led Prado, in a manner begun by Benavides, to coopt these sectors through expansive social policies, including health policies. Prado expanded the workers' social-security health system established by Benavides, opening six SSO hospitals between 1941 and 1944 in Lima and other cities (Mesa-Lago 1978: 117). The

first of these was the Hospital Obrero de Lima (Worker's Hospital of Lima), inaugurated in 1941, the very first social-security hospital in Latin America (Roemer 1964: 26).

Prior to the 1940s, the working and middle classes of Peru had organized separately, each with their own distinct unions or associations.¹⁸ The middle class in fact had a history of its own class-based strikes dating back to 1915 and achieved their first social-policy victory in 1924, under the Leguía regime.¹⁹ By the 1940s, however, APRA had succeeded in blurring the lines between the working and middle classes and had managed to attract the associations of both strata under its political umbrella. The middle class emerged more militant alongside the working-class unions. The intensified militancy of the middle classes came in part from the election of APRA affiliates to leadership positions in key white-collar worker associations in the mid-1940s, including Peru's major middle-class association, the Asociación de Empleados del Perú (Employee Association of Peru, or AEP) (Parker 1998: 218).

While Prado upheld conservative interests, his democratically elected successor, President José L. Bustamante y Rivero, depended on the political support of APRA.²⁰ The election of Bustamante, in 1945, signaled a brief interlude of influence for the allied middle and working classes. Bustamante recognized a record number of unions in 1946, and white-collar unions in particular reached record levels (Mesa-Lago 1978: 117; Parker 1998: 218). The Bustamante government acted for its constituents by raising the social-security coverage initiated by the prior two administrations. Upper-echelon white-collar workers in specific industries received pensions, and Bustamante established on paper the Seguro Social del Empleado (SSE), a social-security institute to serve the health and pension needs of white-collar workers. Blue-collar workers also claimed new benefits under the Bustamante government, including the inauguration of two new workers hospitals and insurance for occupational diseases. Few of these social-policy measures, however, were carried through prior to the military takeover of General Manuel Odría, in 1948.

Tensions in the working- and middle-class alliance within APRA came to a head with the election, in 1947, of leaders of the middle-class Employees Association. The APRA-backed Employees Association leaders lost the election to opposition candidates, who campaigned on issues that bolstered a distinct middle-class identity—and that explicitly promoted opportunity hoarding rather than solidarity—such as constructing a new social-security

hospital exclusively for white-collar workers (Parker 1998: 221–22). General Odría, taking control of the government via coup in 1948, seized on this demand as a way to coopt middle-class interests and further divide the mobilized middle and working classes. The new hospital and Odría's expansion of the SSE succeeded as a pacifying measure, as the middle-class Employees Association lost strength and voice.

In addition to this co-optation, Odría reinforced patterns of special benefits for specific groups that had begun in the nineteenth century. Under Odría, teachers and railroad and streetcar workers won inclusion in the SSE, separate hospitals were created for the police and the military, and benefits expanded for civil servants. Blue-collar workers were not treated so generally, but they did win some larger subsidies for illness, maternity, and funeral aid (Mesa-Lago 1978: 117–18). Social-policy provision based on occupational group continued after Odría, most notably in health policy when President Belaunde's government laid out a separate health and pension system for fishermen, in 1965.

The 1930s through the 1950s was the critical period for the buildup of the state social-security healthcare systems, though the 1960s also saw some expansion. In addition to the fund for fishermen, in the 1960s the state initiated new social-security benefits for white- and blue-collar workers, some of which had been legislated but not implemented earlier (Mesa-Lago 1978: 118–20). The Ministry of Public Health expanded in the early 1960s, putting up twelve new hospitals in order to serve those insured persons who lived in areas without SSE or SSO hospitals, as well as the uninsured poor.

The process of cooptation led to separate state health-insurance systems for the middle and working classes, each with their own health-insurance programs and hospitals. The white-collar, middle-class, social-security health system was not only separate from the blue-collar one, but clearly superior. The white-collar Hospital del Empleado, constructed by Odría, rivaled the quality of private clinics (Parker 1998: 222). As an indicator of the lavish resources concentrated in this one hospital, its ratio of employed personnel was 3.1 per hospital bed in 1962. In addition, 270 soles (about USD \$11) per day was spent per patient at the employee hospital, as compared to 150 soles per day at the worker's hospital. Moreover, if white-collar employees opted to use private instead of state health services, they were subsidized for their expenses. They opted for private services about 50 percent of the time in the 1960s (Roemer 1964: 32, 35).

These systems were financed as “pay as you go” social-security systems,

that is, by salary contributions from the employee and the employer into a state fund. These public funds also benefited from other sources of income including fines and donations, as well as yields from investments. When first initiated, employers paid the equivalent of 2 percent of an employee or worker's salary to the SSE or SSO (Mesa-Lago 1989: 187). In 1962 the SSO required from blue-collar workers a contribution of 3 percent of salary, plus 6 percent from the employer and 2 percent from the government. White-collar workers in 1962 gave 3 percent of their salary, and private employers 3.5 percent, whereas public institutions contributed 3 percent and the government just 0.5 percent (Roemer 1964: 25, 30, 31).²¹ Unfortunately, the pay-as-you-go health system suffered from evasion of payments by employers (Mesa-Lago 1978: 139). Moreover, workers' contributions, given low salaries and a cap on payments at 500 soles (per a 1950 law), did not come near to covering the real costs of the health services provided. Deficits were often subsidized by the state.

The military government of 1968 was especially supportive of unions and therefore put more resources toward social security, thus insuring a growing share of the population. The share of population covered by social-security healthcare was 8.8 percent in 1969, rising to 10.1 percent by 1973 (Orihuela Paredes 1980: 10), and to 17.4 percent by 1980 (Mesa-Lago 1978; Mesa-Lago 1989: 183). The resources workers received were not just material, but also came in the form of authority and access to power. In 1969 administrative councils composed of representatives of the government, the insured, and employers were formed for both the SSO and the SSE, so that workers would have a role in managing their own pension and health programs.

In 1979 the working- and middle-class systems were unified to some extent when the military government, in one of its final measures, overcame some of the past tendencies toward opportunity hoarding and cooptation, and combined the SSE, SSO, and civil servants' state health-insurance systems. In 1980 the pension system merged with the social-security system as the Instituto Peruano de Seguridad Social (Peruvian Institute of Social Security, or IPSS). This consolidation only partially fulfilled the military's hopes for reform of the health sector. According to Roger Guerra García, who sat on its health-reform commission, the military's plan was a "socialist vision" of a single national health system that would have combined all the components, including "the social security and the armed forces health systems" with the separate public-health system. It faltered, in part, "be-

cause there was not the support from the people," an indicator of the degree to which opportunity hoarding had become ingrained.²²

A number of factors led into a crisis of social security in the 1980s and 1990s. The stratified health systems originating from the cooptation path were poorly managed, especially from the 1970s on. The military used the SSO and SSE funds for other purposes without investing them wisely (García 1998 and Mesa-Lago 1989). According to one source, only 30 percent of payments collected by the state for social-security healthcare actually went to fund health services under the military government (Orihuela Paredes 1980: 8). The inflationary economy of the 1980s also led to a severe deterioration of the real value of social-security deposits. The deepening economic collapse of the 1980s also meant a reduction of formal-sector jobs, curtailing the already small pool of contributors.²³

The historical formation of Peru's social-security health system resulted in a highly unequal system in terms of the substantive distribution of health resources, which in turn reinforced the categorical inequalities of class, race, and gender. In terms of class, the social-security health system offered urban formal sector workers a "sanitized" health system of higher quality and resources than the public-health system that served the poor. The separate middle-class and military social-security systems were of even higher quality, thus further distinguishing these better-off groups from typical workers. Even after expansion of social-security coverage under the military government between 1968 and 1980, in 1980 only 17.4 percent of the total population was insured (Mesa-Lago 1989: 183). Fifteen years later, in 1995, the state social-security system insured just 26 percent of the population, the public-health system served 52 percent, and a full 20 percent of Peruvians had no access to sufficient healthcare.²⁴ Despite serving only a fraction of the population, the social-security health system absorbed nearly the same amount of government-directed resources as the public-health system, making Peru's distribution of healthcare resources highly inequitable along class lines. According to the Ministry of Health estimates, based on their own and IPSS data, spending per patient in the social-security health sector in 1995 was more than three times that spent per patient in the public-health sector. Not only did workers gain better-quality health services than the poor majority, but they also gained "voice" through access to decision-making under the tripartite social-security governance system left by the military.

But the impact of the cooptation path on inequality was more widespread

than these statistics suggest: the strategy of separate systems for separate groups also further reinforced existing racial inequalities. The population insured by the social-security health systems, by nature of its birth through cooptation of working-class unions and middle-class associations, was overwhelmingly mestizo. Formal-sector workers, even if originally of indigenous descent, through a combination of migration to cities, cultural adaptation to the dominant coastal culture, and economic mobility in formal-sector employment, had become mestizo. The middle-class further differentiated itself from workers in part based on lighter skin color (Parker 1998). The social-security health system rewarded these urban white and mestizo populations. Those departments with the greatest percentage of insured populations were also those with the highest index of urbanization (Mesa-Lago 1989: 182-85). Ninety-eight percent of the self-employed, who composed a significant part of the economically active population, went uncovered in 1981. These included indigenous peoples in agriculture and the large share of female informal-sector workers in "personal services." The separate, stratified social-security system thus reified not only class positions, but also racial privilege.

The dichotomy between the public-health system for the poor and the social-security health system for workers was in and of itself highly gendered. The workers covered by the sso and sse were primarily male breadwinners, with few women included, due to their historically low levels of paid employment. Moreover, urban women in paid employment were (and remain) largely in the informal sector or domestic workers, which were not initially covered at all by sse or sso. The gendered division of coverage nominally improved in the 1970s, when the military government incorporated domestic workers into the social-security system (Mesa-Lago 1989: 178).²⁵ However, this reform was mitigated by domestic employers' evasion of payments, which was greater than the already high rate of evasion by employers in general. With the economic crunch of the 1980s, more women entered the workforce, but they did so largely in the informal sector, which remained effectively outside of social security.²⁶

Wives or common-law partners of male workers were not much better off. The dependent coverage of sse and sso was extremely limited.²⁷ Originally, wives of insured male workers received only maternity healthcare—all other healthcare for wives was either through the public-health system or paid out of pocket in the private sector. In 1975, children under one year of

age were added as dependents (Mesa-Lago 1989: 181; Roemer 1964). It was not until March 1979 that the outgoing military government, as part of its consolidation of the sse and sso systems, expanded dependent coverage to include a worker's spouse and children under the age of eighteen. Current legislation covers spouses, minor children, and disabled adult children who are unable to work. Dependents were, and continue to be, covered by the same contribution cap as an individual worker. The legislation of 1979 also allowed independent workers to voluntarily join the social-security health system. However, women workers were not able to carry a spouse or dependent on their social insurance policy until 1992, further demarcating women as lesser citizens. The highly limited dependent coverage for most of the history of the system, and the exclusion of women workers from the right to carry dependents, effectively made social-security care a male domain and feminized the public system. While raising the status of male workers, the social-security health system treats women as actors based solely on their role in the reproduction of the labor force.

Conclusion

The categorical inequalities of class, race, and gender influence the formation of Latin American social policies, and social policies in turn serve to perpetuate or reinforce these inequalities, and even spawn new ones. The historical formation of health policies in Peru was influenced by the discriminatory suppositions of doctors, policymakers, and international agencies about the relationships between gender, class, race, and disease. Commonly held cultural beliefs about categorical inequalities—such as notions that the poor and especially indigenous peoples and nonwhite immigrants were the carriers of disease, or that mothers were responsible for high rates of infant mortality—played into the ways in which Peru's public-health system was structured. The public system that served these groups was top-down and authoritarian, reflecting the disparaging, "colonizing" attitudes of elites toward the poor, nonwhites, and women. The founding of the public system was not premised on citizens' rights to health, but rather on the belief that health and population control was fundamental to economic progress. In the formative period of this colonizing path, the public-health system's target population was not even considered citizens, if one considers suffrage to be central to citizenship. These founding biases help

explain the fact that Peru's public-health system has remained of inferior quality and limited reach in comparison to the social-security system that followed it.

But racist, classist, and gendered discourses only partially contributed to the bifurcated nature of Peru's health system. The dual system also reflected broader changing historical power inequalities in Peruvian society, during the transition from an oligarchic to a more modern and urban society of unequals. Those groups that won political voice in the mid-twentieth century, the working and middle classes, effectively claimed for themselves a better state health system—the social-security system—via a process of co-optation hoarding, combined with cooptation by largely authoritarian governments. The male, mestizo leaders of the organized working and middle classes claimed a new and better health system, but it was strictly bounded. They sought to express their newfound influence by perpetuating inequality and upholding their status differences with others through unequal social benefits. Weak Peruvian governments also knew that politically dividing threatening new political groups into competing camps was crucial to their own political survival, resulting in the cooptation pattern.

Disparities in power rooted in class, gender, and race became solidified and reinforced in the two-tier health system that resulted from the combined colonization and cooptation processes. The resulting bifurcated health system also added new inequalities, most clearly in access to and quality of health services, between the working classes, the middle classes, and the rich; between men and women; and between whites, mestizos, and immigrant and indigenous peoples. This inequitable distribution of health services between the social-security and public-health systems continues: in 2000 only 30 percent of Peruvians enjoyed health insurance. The rest paid out of pocket for healthcare or depended on the vagaries of the public system.²⁸ In the late 1990s clients of the public-health system still faced enormous gaps in recognition between the largely mestizo, middle-class health personnel and their own understandings of health and disease, a rift that has both racial and gender dimensions (Ewig 2006a). Moreover, during the long presidency of Alberto Fujimori (1990–2000), women continued to be the target of authoritarian population-control measures. Fujimori's Ministry of Health led mass sterilization campaigns against indigenous women, premised on the belief that reducing population growth would improve Peru's economic indicators (Ewig 2006b).

The residuals of the historically classist, racist, and sexist foundations of Peru's health system remain in many ways today, yet this history also kindles some hope for identifying paths toward the erosion of inequality in the future. The fact that mid-twentieth-century workers could claim a "right" to healthcare from the central government provides hope for an alternative health system in the future. One lesson to be taken from this history is that the coupling of economic and political empowerment of citizens can lead to the expansion of social rights, including the social right to health. However, one also can glean that key to a more equitable health policy are political alliances that cross class, race, and gender divides, rather than divisions that foster opportunity hoarding.

The history of Peru's health system also suggests that categorical inequalities can and do morph and change with broader economic and social developments. In Peru, one saw a shift from strict binaries to triads that introduced greater racial and class fluidity. While, as Paul Gootenberg argues, racial fluidity in Latin America has sometimes been used simply as a foil to mask inequalities in the region, the fact that new categories can be and are introduced demonstrates the possibilities for change and reinforces the contention that inequalities are constructed, and not necessarily durable.²⁹

In addition to a history of political mobilization and changing categories, there are also important egalitarian discourses in the history of Peru's health-policy formation that one can draw on. While these more positive discourses have not yet triumphed, they may constitute the seeds of future, more egalitarian models. Among these discourses is the social-medicine movement in Latin America and its proponents in Peru, which despite its historical shortcomings has laid a discursive foundation that recognizes the centrality of the social determinants of healthfulness, as well as the relationship between broader social policies and well-being (Waitzkin et al. 2002). Social medicine likely influenced former Peruvian health minister and WHO official David Tejada's original formulation of primary healthcare, a notion that remains important in public-health circles today, even though it has moved away from its original, revolutionary meaning (Cueto 2004). Peru's military government of 1968 successfully inculcated Peruvians with the notion of the state as the primary guarantor of social rights (Barrig 1989), a seed that may prove fertile in future efforts toward truly universal healthcare. Finally, in the 1990s Peruvian feminists took up the international call for "reproductive rights," a discourse that has been at least somewhat success-

ful at tempering the long historical practice of population control in Peru, including putting a stop to shameful sterilization campaigns (Ewig 2006b). For those who seek to break the cycle of inequalities begetting more inequalities, these kernels of change must be recognized and strengthened.

Notes

For helpful comments on this essay, I thank Paul Gootenberg and Luis Reygadas, as well as three anonymous reviewers. I also would like to thank the participants in the seminar "Inexorable Inequalities: New Perspectives on Latin American Inequalities," hosted at Stony Brook University on 12 May 2006. I also thank Marcos Cueto and William Jones for comments on an earlier version of this essay.

1. See Gootenberg's comments in the introduction to this volume.
2. Historical comparative work on gender and social policy in advanced industrial countries includes Boek and Thane 1991; Gordon 1990; Koven and Michel 1993; Mettler 1998; O'Connor 1996; O'Connor, Orloff and Shaver 1999; and Skocpol 1992. On race, see in particular Quadagno 1996. Initial works on Latin America include Roseblatt 2000; Dore and Molyneux 2000; Ehrick 2005; and Pribble 2006.
3. More recent comparative-history treatments of Latin American welfare states have expanded their lens to include the roles of democracy (Haggard and Kaufman 2008) and political parties (Huber and Stephens 2005), but still do not incorporate gender or race.
4. See Reygadas's essay in this volume.
5. Mary Weismantel (2001) would disagree, and argues that the indigenous-white binary persists. Following de la Cadena, however, I would argue that the "mestizo" in the Peruvian context is an important identity category. Yet, as Tilly notes, in practice race is often reduced to simple binaries, dependent on the issue in question. Thus white-mestizo might be the operative in contestation between middle-class professionals and workers in Peru, while mestizo-indigenous would be the binary that takes precedence in moments of contestation over resources between the rural poor and the urban workers and professionals.
6. Historians argue that epidemics lead to the establishment of state public-health policy in Peru. This thesis is not inconsistent with the thesis that economic growth and state expansion led to state health policy. I also focus on epidemics, but see state responses to epidemics occurring within a broader context of state expansion. I rely heavily on the work of Marcos Cueto (2002, 1997, 1992, n.d.), who analyzes the social impact of epidemics in Peru and the state responses these provoked. Epidemics affect primarily the poor, and thus their history provides a clear window onto the creation of public-health systems aimed at the poor.

7. All translations of sources in Spanish are my own. For a broader discussion of race and eugenics in the Latin American region, see Stepan 1991.
8. Prior to this time, public health was the responsibility of the poorly funded municipalities (Cueto 1997: 34).
9. Poverty itself is also a racialized experience in Peru. As one moves up the economic ladder from poor to working or middle class, one's racial and ethnic identity also has the capacity to change from indigenous to mestizo. See de la Cadena 2000 for a discussion.
10. For a history of the Rockefeller Foundation and its ties to public health in the Latin American region, see Cueto 1994.
11. For an engaging overview of the role of racism in U.S.-Latin American relations, see Schoultz 1998.
12. A "sanitario," or sanitary technician who had completed primary school and an additional six months of weekly health-related training, staffed the sanitary posts. One or two doctors staffed the medical posts, which were under the loose supervision of a health center (Roemer 1964: 40-41).
13. After the Second World War, the United States led the charge in international population-control efforts. U.S. officials viewed population control as intimately linked to economic development in the Third World and thus vital to its security interests (Hartmann 1995: chap. 6).
14. The classical economist Thomas Malthus argued that population growth, stimulated by the working classes, if left unchecked would outstrip agricultural capacity, leading to a general decline in living standards.
15. Uriel García, former minister of health, interview by author, Lima, 16 April 1998. This phenomenon is not unique to Peru. Throughout Latin America, economic crises led to the collapse of public-health systems, and it became common for patients to provide their own sheets and basic medical supplies.
16. It was not until 1980, which saw the first presidential election after the twelve-year military government, that illiterates were allowed to vote, thereby making Peru an electoral democracy. By disfranchising illiterates until 1980, Peru effectively suppressed the political voice of a large portion of indigenous peoples, the poor, and women (in particular poor indigenous women). As late as 1981, 18.1 percent of the population over the age of fifteen was illiterate. When broken down by sex, 26.1 percent of women were still illiterate and 9.9 percent of men. In rural areas, where indigenous populations dominate, 55.8 percent of women were illiterate and 23.2 percent of men (Peruvian 1981 census data in Blondet and Montero 1994: 61). Literate women were given the vote in Peru in 1955, among the last countries in the hemisphere to grant women's suffrage.
17. The development of the Peruvian social-security health system has much in common with the Bismarckian welfare-state development model in Germany. Both the German and Peruvian health systems were created as largely authoritarian responses to class conflict, and both resulted in systems highly segmented by

occupational group. Milton Roemer's comparative work on world health systems finds that the historically segmented character of Peru's social-security system is not unlike those of the systems of Germany and Belgium, which were also initially subdivided into hundreds of autonomous sickness funds (Roemer 1969: 211).

18. My discussion of the history of the middle class in Peru draws largely on Parker 1998. In Peru, the distinction between *obreros* (workers) and *empleados* (middle-class, white-collar workers) is still important. Parker shows how this distinction came to be, its underlying social (including racial) meanings, and how these evolved in the first half of the century.

19. The policies gained included three months notice prior to firing, compensation for years of service, employer-paid life insurance for employees with four or more years service, and employer-paid disability insurance (Parker 1998: 105).

20. APRA, now legalized, was banned from running its own presidential candidate and thus threw its support behind Bustamante.

21. Mesa-Lago 1978 provides different figures for contributions (138). Roemer's statistics are cited here, as they are more reliable. These percentages increased over time; the most recent rate, since 1996, requires the employee-worker to make the entire contribution, 9 percent of her or his salary, which is deposited by the employer with the Social Security Health System (known as *ESSALUD*, formerly *IPSS*).

22. Interview by author with Roger Guerra García, interview by author, Lima, 11 September 1998. See also Bravo 1980.

23. I do not have specific data on informal sector employment for 1981. However, in 1970, 31.6 percent of Lima's workforce was employed in the informal sector and another 9.8 percent as domestic laborers. In 1990, between 40.7 and 46.8 percent of Lima's workforce was employed in the informal sector and 5.1 percent was employed as domestic laborers (Sheahan 1999: 98).

24. Numbers provided by the Ministry of Health.

25. Between 1984 and 1993, females comprised between 88 and 99 percent of domestic workers (Gárate and Ferrer 1994: 75-76).

26. For specific data on women in Peru's informal and formal workforce from 1980 to 1993, see Gárate and Ferrer 1994, esp. 73-76. I say "effectively" excluded because informal-sector workers could voluntarily join the social-security system, but the majority opted not to due to the cost. In 1987 only 12.1 percent of the nonsalaried workforce was covered by social security (Verdera 1997: 30).

27. Mesa-Lago 1989 points out that Peru was particularly restrictive in its social-security dependent coverage among Latin American countries.

28. Figure from the website for the Ministry of Health, "Ministry of Health Website, Seguro Integral de Salud Program Page," accessed 15 February 2006.

29. See Gootenberg's essay in this volume.