The birth of a Ministry of Public Health in Colombia, 1946-1953: Cold War, invisible government and asymmetrical interdependence

El nacimiento de un Ministerio de Salud Pública en Colombia, 1946-1953: Guerra Fría, gobierno invisible e interdependencia asimétrica

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Abstract

This article studies the shift from a Ministry of Hygiene in Colombia to a Ministry of Public Health, from 1946 to 1953. This was not only a new name for the ministry, but a transitional process from government policies based on European public hygiene towards institutionalizing the North American model of public health. The process involved negotiations between local government representatives and the Currie Mission, which was sent to Colombia by the Inter-American Bank for Reconstruction and Development and the Inter-American Cooperative Health Service. These negotiations took place via asymmetrical relationships of interdependence, within the framework of the "invisible government" implemented by the United States in Latin America during the Cold War.

Keywords: Colombia; Cold War; invisible government; Ministry of Health; history.

Resumen

Este artículo estudia el cambio de un Ministerio de Higiene en Colombia a un Ministerio de Salud Pública, de 1946 a 1953. Este no fue solo un nuevo nombre para el ministerio sino un proceso de transición de políticas gubernamentales basadas en la higiene pública europea hacia la institucionalización del modelo norteamericano de salud pública. El proceso involucró negociaciones entre representantes del gobierno local y la Misión Currie, que fue enviada a Colombia por el Banco Interamericano de Reconstrucción y Desarrollo y el Servicio Cooperativo Interamericano de Salud. Estas negociaciones se dieron a través de relaciones asimétricas de interdependencia, en el marco del "gobierno invisible" implementado por Estados Unidos en América Latina durante la Guerra Fría.

Palabras clave: Colombia; Guerra Fría; gobierno invisible; Ministerio de Salud; historia.

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This study explains the historical transition from a Ministry of Hygiene to a Ministry of Public Health in Colombia during the Cold War, between 1946 and 1953. Our interest stems from the lack of knowledge on the emergence of this institution, despite its important influence on health in the country and its longer existence than its predecessor, the Ministry of Hygiene. Indeed, knowledge on the emergence of the Ministry of Public Health is scarce since historians have mainly focused on the Ministry of Hygiene, since it was the first autonomous institution for public hygiene in Colombia. This was the fruit of a long process that began in 1886 with the creation of the Central Health Board, which evolved into the Superior Sanitary Council (1913), the National Health Direction (1920), and the National Department of Health (1931), all dependents of one state institution or another. The process continued with the integration of Hygiene into the Ministry of Labor, Hygiene, and Social Security (1938), and ended with the creation of the Ministry of Hygiene and its excision from the Ministry of Labor (1946) (Hernández, 2000).

In fact, the importance of the Ministry of Hygiene as the culmination of this process is why it captures the attention of Colombian historians of public health. It is interesting that the emergence of the Ministry of Public Health has not been similarly engaging; this new ministry successfully improved health indicators and remained at the head of the health sector for much longer than its predecessor (which disappeared only six years after its creation). The present article intends to fill this gap.

During our research process, the initial argument was that endogenous and exogenous forces might have driven institutional change, according to the Institutionalization and Identity Construction Process, an analytical model developed by the Public Management and Organizations research group at the Escuela Superior de Administración Pública (ESAP) (Barrera, Rodríguez, Bedoya, 2007, 2008).

However, as our analysis deepened, this model was seen to be narrow, since it is based on a positivist and structural-functionalist social theory that understands society as a body in permanent homeostatic balance. This theoretical framework did not provide afull awareness of the social conflicts and power asymmetries that were in motion during the institutional evolution of the ministry. In fact, a literature review of the top ten Latin American journals published during the last 15 years (2000-2014) in the Web of Science or Scopus databases by Gonzáles-Miranda et al. (2018, p.103) shows a "clear tendency of researchers to conduct organizational studies from a functional-positivist perspective. This demonstrates the limited presence of a comprehensive view to study social phenomena within organizations."

These authors identified three theoretical perspectives: administrative theory, organizational theory (OT), and organizational studies (OS). The latter proposes new critical understandings from constructivist stances that take into account the social phenomena within organizations. This theory is intended to explain the particular characteristics of the context in which these organizations are embedded, especially in Latin America. The current proliferation of publications in the field of OS shows growing interest in and concern with organizational social analysis. However, this growth in different and contradictory tendencies and networks that is proliferating in this new field and ultimately leads to a "functional pragmatism" intended to negotiate positivist and constructivist views did not

provide a clear understanding of the constant political conflict between sociopolitical actors, both inside and outside the institutions (Gonzáles-Miranda et al., 2018, p.93).

For this reason, we decided to enrich our analysis with a socio-political approach linked to a historical neo-institutionalism that brought the actions of government and other socio-political actors back to the center of explanations for the process of institutional change in the ministry. This approach provides an understanding of the State not only as an organization, but also as an arena where socio-political actors, insiders as well as outsiders, struggle to impose their political perspectives and interest (Skocpol, 1985). This required analysis of not only the institutional changes, but also the socio-political role of government officials and international advisors (Belmartino, Bloch, 1994; Hernández, 2002).

The analysis examined the conflicts and interests behind endogenous as well as exogenous forces. The endogenous point of view required investigation into the technical and professional development interests of ministry officers seeking social recognition for their new professional practice (Eslava, 2004). At the same time, President Laureano Gómez and his officers sought to ensure firm control over government decisions and institutional arrangements, including in the Ministry of Health.

Meanwhile, exogenous factors included the political interests of the members of the Currie Mission[1] and Inter-American Cooperative Health Service (IACHS),[2] which involved establishing an "invisible government" in Colombia, as the United States had done in other third world countries during the Cold War (Wise, Ross, 1964). This different approach focusing not only on endogenous and exogenous forces, but also assessing society as a conflicted aggregate of social fields involving constant power struggles among socio-political actors to hegemonize the material and symbolic capitals in motion within these fields (Bourdieu, 1990), reveals the power asymmetries behind the agency of the local and international actors engaged in this institutional change.

The historical research on health institutions in Colombia reveals that most scholars looked at very long periods of time, hindering closer investigation. Some studies mentioned the creation of the ministry, while others described the normativity of how government health institutions were organized (Aguilar, Silva, 1979; Eslava, 2004; Restrepo, Villa, 1980), and still others viewed the historical event as an opening or closing date of the period studied (Chávez, 1981; Gutiérrez, 2010; Quevedo et al., 2004).

This review of the Latin American literature found growing interest in the interactions between public health, international support, and the State during this period (Cueto, 2013; Cueto, Palmer, 2015; Palmer, 2005; Pardo, 2014; Quevedo et al., 2004).

According to Amy Whitfield and Howard Waitzkin (2009, p.216-217), most of this literature emphasizes that "public health policies in the Americas have focused on the economic benefits of preventing and eradicating disease. International health agencies originated in large part from the need to create a system to stop the spread of disease, which was hindering trade." Marcos Cueto (2004) also describes the creation of the Pan American Health Organization (PAHO) and its role in using health policies to advance trade and economic benefits.

Cueto, Anne-Emanuelle Birn, and Armando Solórzano have described how the Rockefeller and Kellogg Foundations played an important role in creating such policies

in the Americas (Birn, 2006; Birn, Solórzano, 1999; Cueto, 1997). As noted by Howard Waitzkin (2013), these foundations focused their work on eradicating illnesses that impeded commerce, promoting economic development in developing countries or reducing medical expenditures.

Similarly, Steven Palmer describes the extraordinary influence of American corporations (particularly the United Fruit Company), government institutions (such as the Army), and philanthropic foundations (most notably, the Rockefeller Foundation) in configuring public health services in Central American countries, determining that both internal and external factors influenced the formation and deformation of public health systems and state medicine. Nevertheless, despite the strong presence of external actors in Central American health, this author concludes that the strongest influences were internal (Palmer, 2005, 2010).

In contrast, Cueto (2013) stresses the important role of exogenous forces such asthe Rockefeller Foundation, PAHO, IDB, and United States government in the development of Latin American health policies during the Cold War, encouraging modernization and dependency as a political strategy against communism.

According to Whitfield and Waitzkin (2009, p.220),

> Cueto shows in *Value of health*, [that] US schools of public health exert a large impact on Americanizing Latin America, beginning in the 1920s and 1930s. The Rockefeller Foundation and the US Office of the Coordinator of Inter-American Affairs provided many scholarships and fellowships to Latin American medical leaders to attend US schools of public health. These leaders returned to their countries steeped in ideologies and methods advocated by the United States.

These statements show current scholastic interest in understanding the roles played by endogenous and exogenous forces in the shaping of health policies and institutions in Latin American countries. This is what David Wise and Thomas B. Ross (1964, p.3-7) have more directly called the "invisible government" of the United States in the Third World, and resembles what Kwame Nkrumah (1965, p.239) has dubbed "neo-colonialism."

The Colombian economist Salomón Kalmanovitz (1983, p.37) understands these kinds of processes to be asymmetrical interdependences, as a feature of the "development of late capitalism." This perspective makes it possible to comprehend the role of domestic and international actors and their negotiations in the development of public health institutions and policies, and to explain the asymmetrical results of these processes.

Colombian researchers have been also interested in how international agencies and philanthropic organizations helped implement health policies in the country (Hernández, 1995; Hernández et al., 2002; Quevedo et al., 2004). For instance, the Colombian historian Camilo Quintero Toro (2006) revisited the concepts of imperialism and the history of sciences described in the compilation edited by Marcos Cueto (1994), *Missionaries of science: the Rockefeller Foundation in Latin America*, noting that the different contributions in this collection agree that

> [on one hand], the Foundation helped Americans guarantee their investments and properties in Latin America, as well as the good health of their American workers in

> these countries. And, on the other hand, it helped Latin Americans construct medical and scientific infrastructure, eradicate diseases, and increase agricultural production (Quintero Toro, 2006, p.160).

Nevertheless, none of these foreign and Colombian studies examined the role played by endogenous and exogenous forces and socio-political actors in the emergence of Colombia's Ministry of Public Health, although Mario Hernández (2002) used the socio-political approach to look at the creation of the Ministry of Hygiene.

Transition from European hygiene to public health in Colombia

The change from a Ministry of Hygiene to a Ministry of Public Health in Colombia is closely related to the transition from European public hygiene to the institutionalization of tropical medicine and public health in the country during the first half of the twentieth century. Although a tradition borrowed from the old medicine of "warm climates" existed in Colombia from the first half of the nineteenth century (García, 2006, p.46-57), French bacteriology and British tropical medicine became an important influence in the late nineteenth and early twentieth centuries. Similarly, US Army physicians applied military strategies to tropical medicine – eradication campaigns following Ronald Ross's tropical hygiene practices in Africa (Worboys, 1988) – as they fought yellow fever and tropical anemia (hookworm disease) in the American South and Latin America (Cuba, Dominican Republic, Haiti, Panama, Texas and Puerto Rico). These campaigns in countries where the US had political, military, and economic interests surpassed the limits of the traditional hygienist scope inherited from mid-nineteenth century Europe (Ashford, 1946; Espinosa, 2009; Ettling, 1981; Farley, 1991; Quevedo et al., 2004). Such experiences opened the door to tropical medicine, not only in Colombia, but also in Latin America's other tropical countries (Quevedo et al., 2004).

This approach was included in the concept of public health shaped by the Rockefeller Foundation since 1916 (Welch, Rose, 1916), when this institution sponsored the creation of the Johns Hopkins School of Hygiene and Public Health and the development of this new medical specialty, which contrasted with the classic European concepts of public hygiene and social medicine. Specialists taught in this program were fully dedicated to managing collective diseases, in contrast with clinical physicians who focused on individual management of disease. Although public health existed prior to this time in English, it was used to mean Hygiène Publique, based on miasmic/environmentalist theory. In contrast, the Rockefeller Foundation merged the German bacteriological research tradition in infectious and contagious diseases and British experience administering health programs to design a new professional profile in public health instead of the classic public hygiene officer. This new specialist would be a researcher (able to recognize predominant diseases/etiologies and health events in a community) as well as a health administrator (able to implement and conduct sanitary eradication campaigns). This specialist's array of knowledge included bacteriology, epidemiology and immunology, along with environmental sanitation, statistics, and public health administration (Fee, 1987; Welch, Rose, 1916).

But according to Juan Carlos Eslava (2004), the institutionalization of the Rockefeller Foundation's version of public health in Colombia took several years, since these new practices took time to be established and adapted progressively to local conditions amid the construction of a new sanitary field.

Transition from a Ministry of Hygiene to a Ministry of Public Health

The Ministry of Public Health emerged during the Cold War and implementation of development programs to construct welfare states (Esping-Andersen, 1990), when economic and social planning was first introduced within the framework of what regulation theory has called the Keynes/Ford regime of capital accumulation (Neffa, 2006). In order to promote these programs in less developed countries, some international institutions like the Inter-American Bank for Reconstruction and Development (IBRD), World Bank, and Inter-American Cooperative Health Service sent economists and health experts to Colombia to diagnose the situation and design a development program. These institutions had a decisive influence on the design of organizational structures that national governments adapted with little criticism (Roth, 2006).

The transitional process of institutionalization was further consolidated in Colombia against this backdrop, as all the conservative presidents elected since 1946 and during the entire following decade declared themselves against communism and clearly brought their governmental policies into line with the profile demanded by the IBRD in order to receive financial aid (Henderson, 2006).

For example, President Mariano Ospina Pérez (1946-1950) was in office during the IBRD's Currie Mission, organized by the IBRD to formulate the economic basis for a development program (López, 2011). The mission arrived in Colombia in 1949, led by the Canadian economist Lauchlin Currie, who studied at the London School of Economics and served as an advisor to Franklin D. Roosevelt in 1933 to develop the New Deal. As his career grew Currie won Roosevelt's trust, and in 1939 he was the first White House economist, wielding significant influence (Garrido, undated). This indicates the power Currie may have had in designing and implementing interventionist politics and persuasion tactics in other countries. Likewise, his close contact with the foreign policies of the New Deal made him aware of the importance of health to ensure mutual security.

The mission delivered its final report in June 1950. The Colombian government referenced this report in requesting technical and financial support from the World Bank to establish the development program it recommended; this allowed the government to improve its capacity to design and implement its economic policies, a trend that continued during the administration of the subsequentpresident, Laureano Gómez Castro, who was elected on November 27, 1949 (Guío, 1995; Henderson, 2006).

Gómez Castro was a radical conservative, anti-liberal, and anti-communist leader attempting to implement constitutional reform intended to create a confessional and corporative State that would be ruled in association with enterprise, coffee producers, and Catholic ecclesiastical hierarchies. He also wished to promote economic development that considered private interests while keeping economic public policies stable. As such,

Gómez Castro realized that the Currie Mission's program could legitimize his economic and political plans; he was already aware that sanitary reforms would be fundamental for integrated development, and also understood these reforms as measures to promote welfare, hoping to make the population less likely to choose the path to communism (Guío, 1995; Henderson, 2006; Pardo Mota, 2008).

Along these lines, he issued Decree 2838 of September 1950, creating an Economic Development Committee with six experts in economics and finance and the permanent assistance of Currie (Guío, 1995). But Currie's participation in this Committee and the mission report not only influenced economic aspects: there were wide implications for the field of health. The recommendations in the report involved bilateral guidelines ensuring mechanisms to modernize health in Colombia and propel the development of a healthy society; in other words, a productive, rather than contagious, population that could assure secure commercial processes (Quevedo et al., 2004).

In Currie's (1950, p.232) own words:

> Health is the main component of the standard of living and, at the same time, one of its greatest determinants. The deficient health conditions mean not only an impossibility to achieve maximum productivity, but a direct drainage of wealth and resources. The low levels of health cause a lot of direct and indirect costs and deviate funds and facilities that could be used to strengthen and increase the economy. Deficient health is expensive.[3]

Gómez Castro also took into account the Currie Mission's recommendation to reorganize the executive branch of the government. This was very important, since the president was on the way to creating a strong centralist and corporative State, while the mission's report highlighted that the president's ability to manage Colombia was weak. Currie (1950, p.449) indicated two main reasons:

> The first one is that the President has a very small group of employees, which makes virtually impossible for him to follow the activities of all of the official dependencies, or to have a direct vigilance of their activities. The second one is the high number of governmental dependencies which have generated confusion, authority and responsibility conflicts, and low coordination within the executive branch. As a consequence of all these causes, the Government has turned diffuse.

Considering these recommendations, the president decided to appoint a second Currie Mission, which came to the country between June 1950 and March 1951. This time, the American mission focused on public administration, studying the organization and administrative structure of the Colombian government and proposing a set of recommendations to the president for improvement. The final proposals were presented in *Reorganization of the Colombian government's executive branch: a mission's report,* which complemented the suggestions from the first mission. This time they focused on the organization of the president's office and the most directly significant ministries, including the Ministry of Hygiene (Currie, 1952).

In terms of health problems, this second report opened with a diagnosis of Colombian public health conditions, summarizing the needs and objectives to be pursued. Finally, it

pointed out potential improvements and how the new organization should work (Currie, 1952). One of the most notable proposals was the creation of a Ministry of Public Health to replace of the old Ministry of Hygiene.

The report stated: "Within the proposed modifications, there is one that must be mentioned from the beginning: the change from the name of the Ministry of Hygiene to the larger and more descriptive of Ministry of Public Health and Social Assistance" (Currie, 1952, p.260).

The two Currie Missions are a typical illustration of how US government interests in Colombian economic and health public policies operated, an example of what Wise and Ross (1964) have called the invisible government of the United States in the Third World.

In the words of these authors:

> There are two governments in the United States today. One is visible. The other is invisible.
>
> The first is the government that citizens read about in their newspapers and children study about in their civic books. The second is the interlocking hidden machinery that carries out the policies of the United States in the Cold War.
>
> The second, invisible government, gathers intelligence, conducts espionage, and plans and executes secret operations all over the globe.
>
> The Invisible Government is not a formal body. It is a loose, amorphous grouping of individuals and agencies drawn from many parts of the visible government (Wise, Ross, 1964, p.3).

These authors also emphasize: "The Invisible Government includes, also, many other units and agencies, as well as individuals, that appear outwardly to be a normal part of the conventional government. It even encompasses business firms and institutions that are seemingly private" (Wise, Ross, 1964, p.4). And they conclude: "This Invisible Government is a relatively new institution. It came into being as a result of two related factors: the rise of the United States after the Second World War to a position of pre-eminent world power and the challenge to that power by Soviet Communism" (p.4).

According to Nkrumah (1965), all these elements appear as part of a new political tactic that consists of providing more independence for former subjects, followed by technical and financial "aid" for their development. This is a new way of perpetuating colonialism while simultaneously talking about freedom was implemented with methodical thoroughness after the Second World War and "has come to be known as 'Neo-colonialism'" (p.239).

But this notion of neo-colonialism implies a one-way movement, from the metropolis toward backward countries. As Salomón Kalmanovitz states, this is why such characterizations do not help us fully understand the problem of economic and political relationships between nation-States that differ in economic and political power, and help overshadow the substantial differences between colonialist conditions and a truly independent State. This same author adds that in these cases, what actually exists is a kind of asymmetrical interdependence in which local socio-political and economic actors interact with international agendas, struggling to assure their own economic and political interests (Kalmanovitz, 1983; Quevedo et al., 2018).

The Currie Mission's proposal for a new ministry

The name change was not the only modification suggested in the Currie Mission's report; it also proposed a reorganization of the ministry, which is illustrated in Table 1. Overall, it establishes a top-down organization that is centralized technically but decentralized in administrative terms. It includes central normative agencies to establish lines of authority with officers who delegate functions, establish priorities, and monitor activities in a harmonious effort with the minister at its center. With regard to centralization of power, the minister would directly deal with the heads of seven dependencies (rather than the twenty that existed when the report was written). The post of deputy minister was also established to ensure more effective management, reinforcing the minister in general coordination (Currie, 1952).

This organization shows the relationships between the mission's recommendations and the trend that was being promoted by the IACHS in Latin American countries (República del Ecuador, 2 feb. 1943; Campos, 2006). The IACHS emerged as part of an international strategy designed in the United States by the Institute of Inter-American Affairs (IIAA), which was first led by the American entrepreneur Nelson Rockefeller, and its Health and Sanitation Division, both created in August 1940 (Campos, 1998).[4]

This organization and its different schemes served as instruments for Roosevelt's policy during the Second World War, and his comprehensive economic cooperation program for the hemisphere, the Good Neighbor Policy, intended to counteract the effects of Nazi propaganda in Latin America. It was also complemented with "vigorous educational and cultural programs" (Zepeda, 2010, p.283). As such, from the 1940s American foreign policy was concentrated in defense and cooperation in the hemisphere (Campos, 1998). Thus, the Office of the Coordinator of Inter-American Affairs (CIAA) "was determined to conquer the hearts and minds of Latin Americans in order to win their backing for the United States' interests before and during the war" (Zepeda, 2010, p.283).

According to Campos (1998, p.524-525):

> the CIAA's interest in the field of health and sanitation began in 1941, when the coordinator became aware of negotiations to establish North American military bases in Latin America. Rockefeller relied on advice from the staff of the Rockefeller Foundation, which had been working on public health in Latin America and consequently realized that conditions at some of the areas proposed for these bases were unhealthful.

Nelson Rockefeller consequently suggested to the US War Department that the institute could organize public sanitation programs in these regions. A modest plan was initially approved, but the program was expanded after the Japanese seized primary territories for raw material production in Asia (particularly rubber). Now the program not only guaranteed the health of American soldiers in Latin America, but focused on protecting personnel working in the Amazon basin, a region that had become an alternative source for rubber and other raw materials required by the Allies' military forces (Campos, 1998).

The Inter-American Cooperative Health Service was created in 1942 and a Division of Health and Sanitation was organized within the IIAA to manage it, under the direction

of the military physician George C. Dunham. It was established in 16 Latin American countries: Ecuador, Brazil, Haiti, Paraguay, El Salvador, Honduras, Nicaragua, Costa Rica, Bolivia, Guatemala, Peru, Colombia, Panama, Venezuela, Chile, and Mexico. The IIAA openly stated that the objective of the program was "to improve the health conditions of around 25 millions of people … the various projects (852 projects) [where], in first place, centered in areas of high military relevance with the objective of safeguarding the lives and health of the armed forces of the other American republics" (EEUU, 1943, p.3-4).

As George C. Dunham (1944, p.817-818) also said:

> Public health work can serve not only to protect the people in other countries but is also of paramount importance for safeguarding our own population [the population of the United States]. The Inter-American Cooperative Health Services were organized to assist and implement the Good Neighbor Policy at a time when the threat of German conquest was most serious and every possible means had to be used to combat the powerful Axis influence in the Americas. The provision of medical and public health services for persons directly engaged in the war effort is an important function of the Cooperative Health Services.

Within the framework of this program, the IACHS was created in Colombia in October 1942 as the Servicio Cooperativo Interamericano de Salud Pública (SCISP) and regulated by Decree 41 of January 13, 1943. It functioned as an international advisory office under the Ministry of Labor, Hygiene, and Social Security, intended to act as an intermediary for technical cooperation in the field of health between the Colombian government and the US IIAA (República de Colombia, 13 Jan. 1943).

In fact, it began operating as an enclave for all these military, political, and sanitary needs and strategies in Colombia. The cooperation between Howard Shookhoff (future director of the Colombian SCISP) and John C. Bugher (Director of the Ministry of Labor, Hygiene, and Social Security in Colombia's Special Studies Section and the Rockefeller Foundation's official representative in Colombia) exemplifies relationships between the SCISP and the Rockefeller Foundation where the guidelines of the new public health model appear. Their interaction in Colombia began after Nelson Rockefeller's visit in September 1942. Soon afterward, in January 1943, Bugher funded George C. Dunham's trip to Colombia; Dunham was accompanied by Shookhoff to sign the agreements establishing the SCISP (Quevedo et al., 2004). Later, the Rockefeller Foundation funded activities by the Special Studies Section, as well as many SCISP projects (Quintero, 1949; República de Colombia, 1943).

But as Campos (2006) notes, after the Second World War ended and the threat of Nazi power disappeared, SCISP's interests in supporting the development of health services in Latin America and in Colombia continued during the Cold War as a three-pronged strategy involving an economic approach (ensuring worker health to guarantee Latin American economic development and markets for imported products), a sanitary approach (continuing the fight against epidemics that could threaten the health of America's population), and a political approach against communism, since as George Catlett Marshal has stated, an impoverished and unhealthy population is a very good breeding ground for communism to flourish.

When the proposal to establish the Ministry of Public Health was put forth, the SCISP was already carrying out activities and specific projects under the Ministry of Hygiene in six fields related to its international agenda: sanitary engineering, nutrition, malariology, education for health professionals, training Colombian personnel in public health, and creating pilot hygiene centers. These training programs were held not only in Colombia, but also in the United States (Quintero, 1949).

One of SCISP's major contributions was the progressive technical design and implementation of a top-down sanitary structure inside the Ministry of Labor, Hygiene, and Social Security, directed and administered by American technicians with cooperation from Colombian officers. From its creation, SCISP provided technical support to the Colombian government's sanitary campaigns (Quintero, 1949).

Later, in 1949, Minister of Hygiene Jorge E. Cavelier recommended a major national sanitary campaign focused on simultaneously carrying out preventive actions and providing medical care to the entire population (Cavelier, 1949b). Consequently, the programs that were being developed by the SCISP were nationalized and gathered into a single, new office called the Department of Sanitation (Quintero, 1951). Its health activities included anti-venereal campaigns, environmental sanitary programs, rural medical practitioner and traveling physician programs, epidemiological studies, and odontology, as well as port sanitation activities. According to Lauchlin Currie, since 1950 this department provided the means for the Ministry of Hygiene to implement central coordination for sanitary programs across the country. This was possible because public health functions were organized through a National Public Health Plan that made local health centers responsible for eradication campaigns and sanitary programs (República de Colombia, 1949).

At that time, the Ministry controlled this process at three main levels:

(1) Local public health services;

(2) Medical relief and treatment via hospitals, clinics, hygiene centers, day-care centers, etc.;

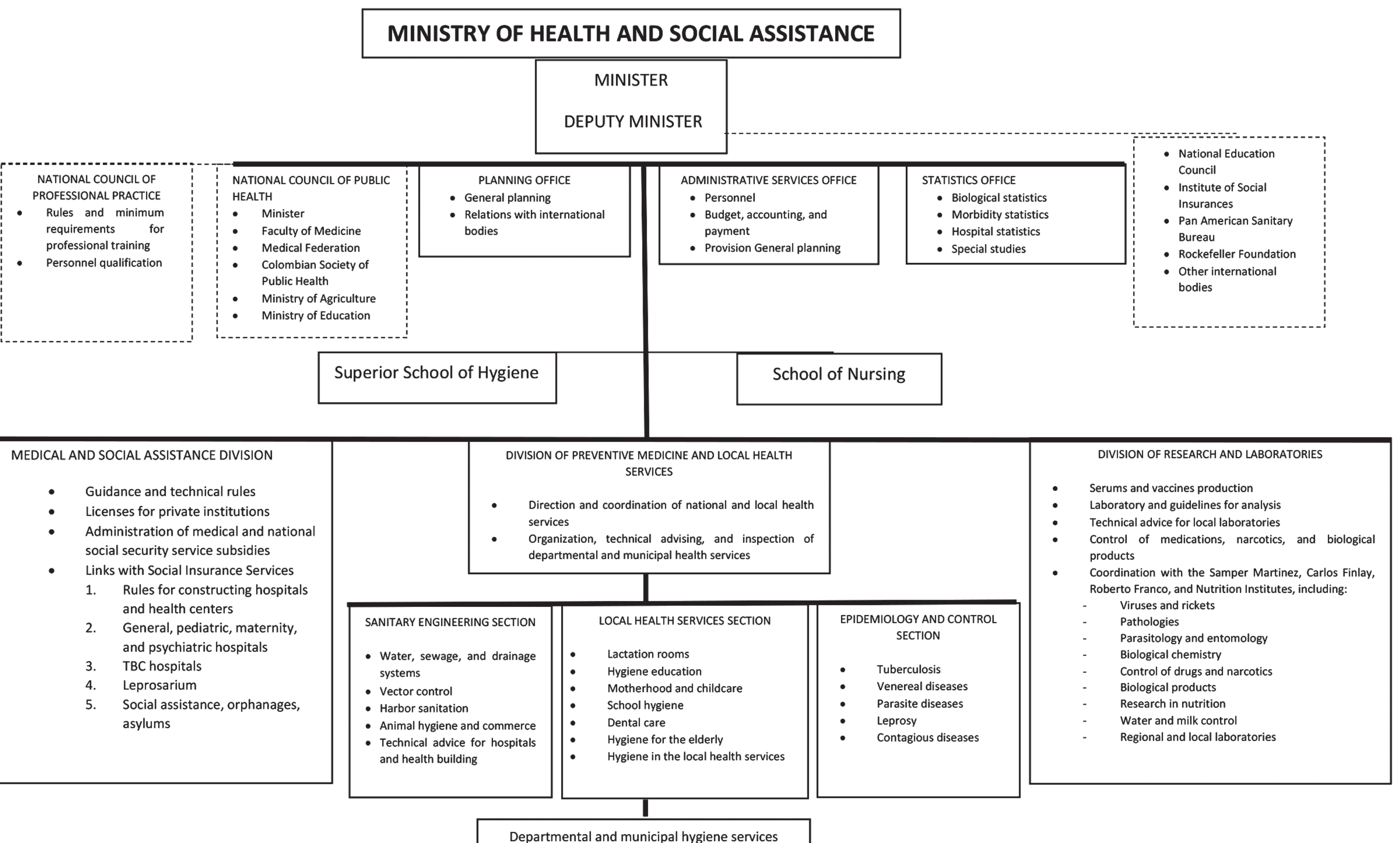
(3) Training and appointment of professional and scientific personnel to implement preventive health measures and provide medical care to patients (Currie, 1950, p.251).

Returning to the Second Currie Mission Report, we must stress that its members, along with some officers of the Ministry of Hygiene, proposed a new organization that created divisions which would assume the functions of the SCISP. This group of advisors and officers consequently intended to fully incorporate the SCISP and its public health model into the heart of the ministry. With this recommendation for the new role of the SCISP, the mission attempted to ensure direct intervention of US government interests in Colombian public health, as a way to implement the aforementioned "invisible government" (Wise, Ross, 1964).

No sooner said than done

Rene Lourauhas stated that institutional changes are caused by exogenous and endogenous determinants (Barrera, Rodríguez, Bedoya, 2008); this present study has identified both kinds of forces as promoters of the institutional changes in the Ministry

Table 1: Organization of the ministry proposed by the Currie Mission



Source: Currie (1952, p.270).

of Public Health. As Juan Carlos Eslava (2004) has noted, the endogenous forces included demands from Colombian public health workers to create an institutional niche permitting social recognition of the results of their new professional practice, based on the Rockefeller Foundation's public health model. In this sense, they progressively began to think of a government health institution that could be more compatible with this new approach.

These endogenous forces also included governmental dynamics intended to modify the poor health of the Colombian population, which some ministers of hygiene had noted in their memoirs that went to the Colombian National Congress (Carvajal, 1952; Cavelier, 1949a, 1949b; Jiménez, 1953). There were also the political and constitutional interests of president Gómez Castro, as mentioned previously (Pardo Mota, 2008).

Exogenous forces included the interests of the United States in improving health services in Latin American countries during the Cold War to protect the health of their inhabitants, thus assuring defense of the continent. This included various activities in sanitary, political, economic, and military fields. In this case, they materialized in the health guidelines developed by the Currie Mission and SCISP's advisers, both working on behalf of America's invisible government.

The mission's report also mentioned poor health conditions among the Colombian people (Currie, 1950), dedicating an entire chapter to hygiene and social security in the country. It described the most vulnerable sectors of the population, identified the causes of these poor conditions, presented sanitary statistics, and pointed out difficulties these services had had in addressing these conditions; finally, it addressed the facilities and resources needed to solve these problems.

The results of this diagnosis threatened the strategic visibility of the Ministry of Hygiene and demanded an institutional response with the implementation of a series of social practices that could improve these conditions, in order to neutralize criticism and avoid potential crisis. This transformation required an adjustment period to define the design and functions of the ministry.

During the process of transition (1946-1953), the responsibilities that had been assigned to the Ministry of Hygiene since its creation in the areas of directorship, epidemic surveillance, hygiene rules, and public assistance did not change. Nevertheless, functions related to the shift towards the new public health trends driven by the SCISP since its arrival to Colombia in 1942 and its allocation within the Ministry of Hygiene's Office of International Bodies were progressively incorporated into the intimate structure of the Ministry of Hygiene (Aguilar, Silva, 1979).

These new functions included training public health workers, regulating professional practice, redirecting national sanitation and organization of public assistance following American trends in implementing rural sanitation and health services, epidemiological surveillance of infectious transmissible diseases, and organizational and technological modernization of hospitals. The previous eradication campaigns managed by the SCISP now became structural sections of the institution (República de Colombia, 16 Apr. 1953).

Emiro Quintero Cañizares, the director of the National Sanitary Department, claimed in his 1952 report of activities that these changes finally were leading to better health

conditions in the country. This was corroborated by some sanitary indicators presented at that time (increases in life expectancy and decreased child mortality rates) compared to the data from the 1940s (Quintero, 1952). We should note that these new indicators were formulated and presented from the point of view of American public health standards, as recommended by the Currie Mission and the SCISP.

An institutional analysis of the changes that occurred during 1946-1953 shows that health officers appointed by the minister of Hygiene shaped its organization through recommendations that became presidential decrees. Specifically, several modified the structure of the institution to create, attach, or suppress different organizational units. In this way, the ministry's officers used legislative means to drive the process of professionalization for public health and to monopolize the field of health.

It is also worth noting that institutionalization is always a historical process. Changes had already been underway in the different units of the Ministry of Hygiene for several years, paving the way to a structural readjustment that was only fully achieved in 1953 with Decree 984 of April 16, renaming the Ministry of Public Health and altering its functional profile and structure (República de Colombia, 16 Apr. 1953). At this time, the recommendations of the Currie Mission's 1951 report with regard to organizing a new Ministry of Health were almost entirely fulfilled.

In fact, the SCISP became the heart of the ministry (following the Currie Mission's recommendations) as part of the Minister's Cabinet, composed of only five sections. This new position made it possible for SCISP advisors to directly advise the minister and orient staff activities in the different sections of the ministry. It also allowed SCISP officers to participate in "the weekly meetings held by the Ministry's Department of Sanitation to exchange information, better understand the programs, and conduct team planning" (Rogier, 1955, p.37-38).

This change also coincided with the Currie Mission's suggestion to broaden the minister's decision-making capacity and with it, governability of matters that had previously been beyond his immediate scope (Currie, 1952). It also affirmed President Laureano Gómez's wish to strengthen executive power and thus develop a strong centralized government.

The Currie Mission's recommendations were tied to a previous strategy; in fact, shifting the SCISP's projects into ministerial sections was clearly defined in the basic agreement between the IIAA and the Colombian government. This agreement stated that every project conducted by the SCISP should be carried out in four stages, the third of which involved integrating each project into the appropriate ministerial section. This was to be regulated by an agreement providing funding, trained personnel, and the presence of American technical advisors from the Division of Health and Sanitation of the United States Operations Mission to Colombia (USOM) and the SCISP (República de Colombia, 1956).

The new ministerial structure clearly reflected the institutionalization of a public health episteme designed in the US for foreign countries. The new ministerial structure eliminated all the institutional components related to public hygiene, such as the Superior Hygiene School, the International and National Hygiene Bodies, the Technical Division of Hygiene, and the Hygiene Coordination Department, replacing them with

a National Sanitary Department (in line with the SCISP's suggestions); the head of this department was to report directly to the minister. With this change, rural medicine and health organizations, environmental sanitation, epidemiology and infectious disease control, and a national public health training center came under the purview of this new department.

Besides the fact that the structure and functions of the SCISP were merged into the new ministerial structure, these changes showed how relocating this service granted it more control over institutional regulation, sanitary information, staff training and management, and the scientific development of public health in Colombia. This was possible because the SCISP was now at the same power level as the other sections, and enjoyed direct communication with these as well with as the minister. The other four sections were Legal advisors, Biostatistics, National professional practice council, and Research institutes.

In 1951, Gómez Castro had to step away from the presidency temporarily due to illness, and Interim President Roberto Urdaneta Arbeláez, Finance Minister Antonio Alvarez Restrepo, and Minister of Hygiene Alejandro Jiménez Arango made the final decision to create the Ministry of Public Health, all signing the decree. According to André Noël Roth (2006, p.75), who quotes Pierre Bourdieu, "This act, charged with symbolisms, constitutes itself as an act of 'legitimation' that attributes the new decision a particular 'force'."

A crucial facet of this development was the leadership of the Minister Alejandro Jiménez Arango, who trained as a neurosurgeon in Chile and the United States and also had thorough knowledge of American medical and sanitary models. He had already announced his intentions to follow the advice of the Currie Mission; some historians have credited him with changing the name of the institution to the Ministry of Public Health (Peña, 1999).

From a Eurocentric point of view, all the changes introduced by the SCISP could be attributed to the influence of the League of Nations Health Organization (LNHO) in America, as it had previously influenced Europe. However, we disagree with this interpretation, since the LNHO programs had little impact in Colombia between the two World Wars. As Iris Borowy (2009, p.236) states: "Latin American countries, as members of the League, saw themselves as part of the community of civilized nations. Contact with them suffered from distance and competition and fell far short of political hopes."

After joining the League as its Medical Director in October 1921, Ludwick Rajchman "articulated a view of international health co-operation that embodied the aspirations of the biomedical/public health episteme" (Dubin, 1995, p.67) that matched the visions of the Rockefeller Foundation. This explains why that Foundation funded the international health programs he implemented at the LNHO, at his request (Dubin, 1995). We should also note that the Rockefeller Foundation, which had been implementing a new approach in public health work in the southern United States and Latin America since 1908, also funded the SCISP (at least in part). These historical facts invalidate Eurocentric interpretations of the process of institutionalizing health processes in Colombia and Latin America, showing that the Rockefeller Foundation was intervening in the field of public health in Latin America and Colombia long before it did so in Europe (Cueto, 1995; Quevedo et al., 2004).

Final considerations

This analysis discusses the elements that were part of the historical process of transforming the Colombian Ministry of Hygiene into the Ministry of Public Health in 1953. One objective was to show that the new institution was the result of the definitive acceptance and institutionalization of the Rockefeller Foundation's public health model for developing countries and its practices in Colombia. The process, which was initially backed by the Foundation and then by the intervention of the SCISP, provided the new ministry with social recognition and legitimacy against the backdrop of the Cold War. Exogenous and endogenous forces promoted institutional change throughout the period of study (1946-1953), showing that both were involved during the negotiation process to improve health conditions in the country, although exogenous forces prevailed and imposed their own vision of how this was to be done. These outside forces catalyzed a process of internal change that was still incipient thanks to a lack of technical, financial, and organizational resources in the country. As Minister of Health Juan Pablo Llinás (1958, p.190) said in 1958 with reference to the financial situation, "[it was due] to those annual meager budgets that deficiencies and losses in ministerial functions to defend public health and provide healthcare to the Colombian people permanently failed."

Behind this international cooperation, there was also an effort to neutralize Nazi propaganda in Latin America during the Second World War. However, three more important war-related interests were also present. First, a strong and healthy Latin American population was required, for integration into the US Army in case of international military conflict. Second, there was an urgent need to ensure healthful local conditions for US Army soldiers, should they have to fight invading German or Japanese troops or other foreign armies in the jungles of Latin America (the Antimalarial Program was part of this second interest). Third, rubber and other raw materials were essential for the Allies, as a military strategy.

Once the Second World War ended, the SCISP's interests in supporting the development of health services in Colombia as well as other Latin American countries (such as Brazil) continued as a three-fold strategy during the Cold War. The first goal was to keep workers healthy, ensuring economic development in the region, the second was to continue the fight epidemics that could threaten the health of Americans, and the third was an anti-communist strategy, the central driver of the Cold War (Campos, 2006).

Within this context, the process of institutionalization left European public hygiene behind as it provided greater stability for the new sanitary order, making the ministry less vulnerable to the influence of forces from inside as well as outside the country. Social actors also played a remarkable role in this change by molding the structure of the new institution, in line with their own political interests.

Likewise, in Colombia acceptance of advice from international experts was vital to implementing the new organizational structure of the ministry that reinforced the interests of the national government, since it acted as a powerful institutional regulator. Other factors also promoted change, including exogenous forces such as integration with international processes like the Good Neighbor Policy, the Cold War, and the invisible government implemented by the United States. Endogenous forces were also at play, such

as internal interests in modernizing Colombia, negotiations of local socio-political actors, and to a significant extent, President Gómez Castro's interest in imposing a corporative, centralized, confessional, anti-liberal and anti-communist State and government, beyond mere institutional adjustment. We should add that two months after the change in the ministry, when the convalescent president returned to power, he was soon overthrown by Lieutenant General Gustavo Rojas Pinilla in a coup with the backing of moderate conservative and liberal politicians, on June 13, 1953. This put an end to all of Gómez Castro's constitutional dreams (Melo, 2017). But because the Congress had approved the new ministry two months earlier, it survived.

Finally, the United States had left responsibility for public health interventions and programs in Latin America in private hands from 1920 to 1940, through philanthropic foundations. But after 1942 the US government shifted its interventions in Latin American countries including Colombia, and itself assumed leadership on public health policies as part of the New Deal, the Good Neighbor Policy, and the Cold War, through direct funding and strategies such as the invisible government. This new style led to an enduring pathway currently understood as interdependence, and includes advisors of various types (Kalmanovitz, 1983; Quevedo et al., 2018). This analysis determined that this interdependence is asymmetrical, since ultimately the interests of the more powerful parties prevail in these relationships.

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NOTES

[1] The Inter-American Bank for Reconstruction and Development (IBRD) sent the Currie Mission to Colombia between 1949 and 1951.

[2] The Inter-American Cooperative Health Service began its activities in Colombia in 1942.

[3] In this and other citations of texts from non-English languages, a free translation has been provided.

[4] The IIAA, which was initially named the Office for the Coordination of Commercial and Cultural Relations between American Republics, was renamed the Office of the Coordinator of Inter-American Affairs (CIAA), in 1941. From March 1945 to its elimination in May 1946, it was again renamed the Institute of Inter-American Affairs (IIAA) (Campos, 1998, p.524).

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