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FAMILY AND COMMUNITY MEDICINE IN COSTA RICA: WHERE PROFESSIONALIZATION MEETS DEVELOPMENT

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ABSTRACT

Family and Community Medicine was introduced to Costa Rica through the McGill - CENDEISSS Project of 1989 - 1994. The development of this new speciality is interpreted as a "professionalization" drive, which, while appropriating the discourse of the international primary health care movement, in fact places more importance, as a social movement, on negotiating for and expanding its own jurisdictional space. Two bodies of literature are called upon to provide theoretical guidance, namely, writing on "professionalization" and ethnographic interpretations of "development" in the so-called Third World. The phenomenon of Family and Community Medicine in Costa Rica is described as an international, national, and local movement. The town of Puerto Viejo de Sarapiqui is the focus of an ethnographic description of the speciality's local-level implementation.

SOMMAIRE

La médecine familiale et communautaire a été introduite au Costa Rica grâce au programme McGill - CENDEISSS, 1989 - 1994. Le développement de cette nouvelle spécialité médicale est interprétée comme une tendance vers la "spécialisation". Tout en s'appropriant le discours du mouvement international des soins de santé primaires, cette tendance vers la spécialisation, en tant que mouvement social, vise d'abord et avant tout a établir son propre espace juridictionnel. Le cadre théorique est fourni par deux courants doctrinaires, d'un côté les écrits portant sur la "professionnalisation" et de l'autre l'interprétation ethnographique du "developpemnt" au "Tiers Monde". Le phénomène de la médecine familiale et communautaire est décrit comme un mouvement international, national et local. La ville de Puerto Viejo de Sarapiqui sert de point de mire a une description ethnographique de l'implémentation de cette spécialité à l'echelle locale.

ACKNOWLEDGMENTS

Although this thesis is signed by only one author, the work represents the efforts and encouragement of many. For without the constant and prolonged moral, intellectual, and financial support of a number of people and institutions, the writing of this work could not have been made possible. However, the responsibility for the words on these pages, including any and all mistakes or misinterpretations, remains mine entirely and solely.

First and foremost, I must express a sincere appreciation to the Costa Rican health officials, family and community physicians, and the McGill-CENDEISSS project participants who agreed to lengthy interviews and answered pestering questions. Particularly, I would like to thank the people of Puerto Viejo de Sarapiqui, for their warmth and kindness even on the wettest days of the rainy season; to the health personnel at the clinics in the village, especially Alberto Castillo and Martha Lopez, for welcoming me into their establishment and their homes with open arms. Uli Locher, on sabbatical in Costa Rica during my research period, provided me much needed advice, encouragement, and guidance on this, my very first research experience "in the field," and did not hesitate to employ me as a research assistant while there. Uli and his spouse, Silvia Bellfort, gave me shelter, delicious food, and an occasional trip to the beach on the weekends I took away from my work. Douglas and Sandra Montero shared their home and their family life with me for my first ten days in San José, provided insights into the culture and morays of Costa Ricans, and gave me a first-hand appreciation of the work and the home life of a family and community physician.

My project could never have got off the ground without the assistance and en couragement of Dr. Liliane Filion-Laporte at McGill's Department of Family Medicine. Dr. Laporte played a key support role from the outset of my research initiative: she was instrumental in obtaining funds for my initial one-week trip to Costa Rica in February 1994, introduced me to many of the key players in the project, and helped me to secure financial support for my fieldwork.

The entire experience would have remained but a two-page proposal had it not been for the financial support of the Canadian Society for International Health's International Health Education Program. Ted Hermary is to be thanked for his timely constructive criticism, and Holly Buchanan for her tireless editorial and logistical support in Montreal, especially while I

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INTRODUCTION

In September 1994, a five-year collaboration between McGill University's Department of Family Medicine and Costa Rica's CENDEISSS,[1] the National Centre for Strategic Development and Information in Health and Social Security, officially came to an end. The McGill-CENDEISSS Training Project in Family and Community Medicine, a development initiative funded by CIDA, the Canadian International Development Agency had, according to McGill Family Medicine officials, been successful in establishing an autonomous department of Family and Community Medicine in Costa Rica.

As a student of Medical Sociology, this project interested me for a number of reasons: first, the discipline of Family Medicine appealed to my sensibilities because it represented a movement within the medical paradigm that challenged the traditional, biologistic, mechanistic model, and thus merited a look from a sociological perspective; second, it was a project conceived as a "development" effort in Central America, a theme and a region that are at once dear and challenging to me.

When Professor Uli Locher of McGill's department of Sociology introduced this project to me in the Fall of 1993 as a possible area of research for my Master's thesis, I immediately felt a strong pull to the topic. I contacted Dr. Liliane Filion-Laporte at McGill's department of Family Medicine, and told her of my interest. She kindly provided logistical support, and assisted me in securing funds to cover the period of my fieldwork. In February of 1994, I took an initial one-week trip to Costa Rica to meet with people involved in the project there, to carry out preliminary interviews, and to determine a site for my community study. By June, I was back in Costa Rica, as prepared as possible for the three months of fieldwork I was about to carry out. From my own

[1]CENDEISSS is the Centro Nacional de Desarrollo Estratégico e Información en Salud y Seguridad Social This institution is in charge of specialty training for all post-graduate health professionals and technicians in Costa Rica.

process of discovery, and the large body of data that grew from it, came what is synthesized, in what I hope is a coherent manner, in the following pages.

This thesis presents an ethnographic, qualitative analysis of the development of family and community medicine in Costa Rica. This topic was chosen in part because, from a Medical Sociology point of view, the development of medical specialties and professions is a central issue, as shown by the large body of literature on the processes of "professionalization." The thesis also deals with the institution of medicine in the "Third World," and raises questions surrounding "development" and the transfer of medical practices from "developed" to "developing" countries. The originality of the present work lies, therefore, in its attempt to connect two distinct trends in the literature, namely "professionalization" and "development."

What follows in the next chapters is, first, an overview of some of the important secondary literature on "professionalization" and on "development," along with suggestions on how the two topics can be connected. Chapter 2 presents an overview of the situation of health care in Costa Rica and introduces the McGill/CENDEISSS project for training in family and community medicine, within the Costa Rican context. Chapter 3 approaches the development of family and community medicine in Costa Rica from a macro perspective, looking at the specialty as a national movement, but also pointing out international pressures and constraints. Chapter 4 provides an integrated ethnographic view on the practice of family and community medicine. More specifically, it looks at the practice of rural health care at the local level, with the intention of connecting themes elaborated in the macro section to the local-level practices of graduates of the Training Program in Family and Community Medicine. Finally, chapter 5 presents a selection of themes that run through the discourse and the practice of family and community medicine at the local, national, and international levels, and that complement the analytical frameworks established. A concluding section makes suggestions for further research.

CHAPTER ONE — THEORETICAL PERSPECTIVES

The development of Family and Community Medicine as a distinct approach to health care delivery, and thus as a new medical specialty, as well as an emerging profession in Costa Rica will be analyzed in this thesis from two perspectives. I will examine the development of the discipline in Costa Rica from a "professionalization" perspective, using analytical frameworks put forward by Abbott (1988), Freidson (1970, 1973, 1986), and Bucher and Strauss (1961). These provide useful insights into the dynamic processes of jurisdiction-building, segmentation, and power accumulation, as well as the discursive strategies that inform the processes that are taking place in the course of the establishment of the Family and Community Medicine model in Costa Rica.

One drawback to this literature, however, is that it examines professionalization only in the "developed" world, principally in the US and UK. The link between "professionalization" and "development" has been left virtually untouched. It becomes the task of this thesis, therefore, to examine and attempt to elaborate upon this unexplored domain. To this end, a critical examination of the official discourse of Family and Community Medicine, the health reform movement in general, and the concepts of "community participation," "political will," and "integration" in particular, can be juxtaposed with evidence of local-level dynamics in order to illustrate the gap between what Family and Community Medicine and Primary Health Care theory say, and what its practitioners actually do. Morgan's (1993) investigation into the political economy of "community participation" in health in Costa Rica provides an important background against which our analysis will be developed. Ferguson's (1994) study of what he calls the "development machine" provides useful insights into the gap between the discourse of development and its impact at the local level. As I can assume that the literature on development is well known, a general literature review will not be undertaken. Rather, I will focus more narrowly on issues of development in Costa Rica, using Morgan as our principal source, and borrowing from Ferguson to complement my analysis.

PROFESSIONALIZATION

Freidson and Abbott have written extensively on the processes of professionalization in North America and the UK. Although they have not examined professions in the developing world, some of the notions they put forward can tentatively be applied to the case of family and community medicine in Costa Rica.

Freidson was instrumental in deepening the discussion on professionalization to factor the actual work of professions into the equation. Previously, most writers in the field tended to view professionalization structurally, as a linear, somewhat generalizable process that had more to do with the creation of rules, regulations, and jurisdictional space than the establishment of work patterns that defined power differentials. For Freidson (1986), profession is the human link between knowledge and power, and any analysis of professionalization must have its terms of reference grounded in human activities, or work. Freidson distinguishes between formal knowledge (i.e., the official discourse of the professions, including academic and bureaucratic-institutional voices) and work, and seeks to describe the interface of the two as the domain of the professional practitioner. For Freidson, it is up to the professional to translate knowledge into action, and thus to use formal knowledge as power over his or her clients.

Abbott's approach to professionalization is a more comprehensive one; his "system model" has three fundamental postulates: "(1) that the essence of a profession is its work not its organization; (2) that many variables affect the content and control of that work; and (3) that professions exist in an interrelated system. Change in professions can therefore be analyzed by specifying forces that affect the content and control of work and by investigating how disturbances in that content and control propagate through the system of professions and jurisdictions. The proper unit of analysis is the jurisdiction, or more generally, the larger task area" (1988: 112).

This jurisdiction, for Abbott, is the link between a profession and its work. "To analyze professional development is to analyze how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions

themselves" (1988: 20). The development of any one profession or specialty must therefore be examined historically and contextually, bearing in mind political, economic, social, and cultural influences on the processes of jurisdictional claims.

In Abbott's analysis, these claims play themselves out in three arenas: the legal system, public opinion, and the workplace. The legal system is loosely perceived as the set of institutions that can confer formal control of work to the professions (the legislature, courts, and the administrative or planning structure); public opinion is, in the USA at least, the primary audience for professional jurisdictional claims, and public jurisdiction is "a claim of both social and cultural authority" (1988: 60); in the workplace, "jurisdiction is a simple claim to control certain kinds of work" (1988: 64). In the case of Costa Rica, and of developing countries in general, one could add a fourth, *international*, arena in which jurisdictional claims are made: international organizations such as the World Bank and the World Health Organization as well as aid agencies in so-called developed countries play not only an important administrative and financial role in the development of new programs in developing countries, but are also a critical audience to which professional movements such as family and community medicine must make overtures.

Family and community medicine can be seen as an emerging profession, or specialty within a profession, that is attempting to gain power through the invocation of special skills and formal knowledge. We can take family and community physicians as an emerging force in what Ehrenreich and Ehrenreich (1977) call the "Professional-Managerial Class," or Gouldner's "New Class" of intellectuals and technical intelligentsia (Freidson 1970, 1973, 1986). Occupations in this class are "organized as professions that claim commitment to public service and the possession of an esoteric body of specialized formal knowledge and that seek freedom from evaluation and control by others" (Freidson 1970: 46). These professions, in order to survive and thrive, must develop a "coherent organization that effectively undertakes a 'market project' that succeeds in carving out a labor-market shelter, a social closure, or a sinecure for its members in the labor market" (Freidson: 1986, 59).

Granted, professions tend to belong to a similar "class," yet this class is far from monolithic; indeed, Bucher and Strauss (1961) noted a certain segmentation within élite occupations such as medicine. They "emphasized—in contrast to sociological perspectives that stressed a homogeneous professional 'community'—that occupations like medicine could be thought of as a coalition of interest-groups and specialisms. Each segment identified itself, in contradistinction to other segments, in terms of its distinctive mission, its knowledge-base and its characteristic approach to work" (Atkinson 1995: 88).

Freidson, on the other hand, indicates that medicine comes very close to complete social closure; certainly, from an "outsider's" perspective, it does. However, I agree with Bucher and Strauss, and suggest that there is significant segmentation within the profession itself. Indeed, if we look at professions as processes, then one of the mechanisms that maintains professional life is segmentation. Family and community medicine can be seen as just one segment within the profession of medicine. For analytical purposes, we can interpret the institution of medicine as being composed of a number of established and emergent specialties that act very much as independent professions, each vying for its own institutional space. Thus, in keeping with Freidson, I will be examining the specialty of family and community medicine as an emerging profession unto itself, with a distinct mission, knowledge base, and work orientation. I will also describe the specialty in terms of the inner work of medicine, as a continually evolving "segment" or "social movement" within what Bucher and Strauss call the "body professional" (1961: 332).

Abbott suggests that, "in claiming jurisdiction, a profession asks society to recognize its cognitive structure through exclusive rights; jurisdiction has not only a culture, but also a social structure . . . . To understand the actual claims, then, it is less important to analyze their particular content than their location, their general form, and the social structure of the claiming professions themselves" (1988: 59). I would suggest that, to make a strict distinction between "content" and "location" would not be a straightforward exercise: one inevitably overlaps and meshes with the other. Accordingly, it is at this vague and indeterminate juncture, where jurisdictional claims meet the structure and

embeddedness of work and institutional culture, hierarchies and social worlds, that we can introduce the notion of "boundary work" (Gieryn 1995, Star 1989). To paraphrase Gieryn, in the present case boundary work will be defined as a process whereby certain characteristics are attributed to an institution, to its practitioners, values, methods, and work organization, in order to construct social boundaries that distinguish the institution or specialty from other specialties, or, in fact, from other forms of health care provision.

For Gieryn, boundary-work "occurs as people contend for, legitimate, or challenge the cognitive authority of science—and the credibility, prestige, power, and material resources that attend such a privileged position" (1995: 405). In our case, we can substitute "primary health care" or "public health" for "science," focusing on a extended version of Abbott's "arenas" in which jurisdictional contests are fought.

To summarize, the professionalizing jurisdictional claims of family and community medicine in Costa Rica, and indeed, beyond this country's borders, can be perceived as a clear example of "boundary-work." This work and the claims made in carrying it out can also be interpreted from a "development" analytical framework, where the key dependent variables are not necessarily the existence or the growth of a profession, but the social distribution of resources, and, in this case, the equitable provision of health care services.

WHERE PROFESSIONALIZATION MEETS DEVELOPMENT

Morgan (1993) engages in what she calls a "political-economic ethnography of health policy," emphasizing "the social and historical roots of disease and health care, with particular attention to the existence of stratified social relations within a world economic system" (1993: 2). She suggests that political economic analyses of international health have focused on the "global penetration of capitalism" to the detriment of a consideration for "the crucial role of the state" in directing social policy as well as "the dynamic participation of subordinated peoples in resisting domination" (1993: 3). Her view of development in health is succinct and challenging to all stakeholders in the health development trade: "For those who view health as more than the absence of disease, who believe that health is the outcome not just of universal access to medicine but of adequate

sanitation, access to gainful employment, positive working conditions, and freedom from institutionalized injustice, then the health of the poor improves as people resist the forces that perpetuate inequality" (1993: 166). The interaction among the various forces that resist and perpetuate inequality in health takes place in a context that is defined by interrelated institutional and symbolic processes. Already, we have pointed to professionalization as the institutional process on which this thesis will focus. As far as symbolic processes are concerned, Morgan identifies a number of "political symbols" of health in Costa Rica, including "political will" and "community participation." Over the course of my fieldwork, these terms—to which I would add another important rhetorical claim, namely "integration"—emerged time and again as central rhetorical features of the primary health care movement, which have also been appropriated by family and community medicine.

"Participation," for Morgan, is a "socially constructed amalgam of ideas, defined and refined through time" (1993: 4). For example, current World Bank rhetoric calls the "essence" of participation "exercising voice and choice" (Narayan 1995: 7). A relatively new concept in international development, it was sold by development agencies as a panacea for rural projects in the 1970s, yet, according to Morgan, without considering "the relevance of citizen-state relations in a given country or its prior history of citizen participation" (1993: 4). Morgan sees much of the international health literature on "community participation" as ahistorical, assuming that most impediments to participation are to be found at the community level, "for example in the psychological characteristics or charismatic appeal of individuals, the organizational or leadership structure of specific communities, the existence or persistence of traditional beliefs regarding disease etiology, or some other intra-community variables" (1993: 3).

Morgan's response to these assumptions is to assert a need to analyze development initiatives "dialectically, as consequences of the relations among international, domestic, and local groups who act in response to changing economic and political priorities" (1993: 4). In her broad-ranging analysis, she acknowledges a United Nations typology of

participation as either "spontaneous," "induced," or "coerced."[2] Ultimately, however, she prefers not to follow these categories, instead interpreting participation as

> a political symbol, by nature amorphous, flexible, and adaptable. Unraveling what participation symbolizes to different people and groups at various historical periods offers insights into the relations of domination and subordination operating within and between societies. . . . Participation is always constrained at the state level by partisanship, funding limitations, the whims of international agencies, and the resistance of local and national interest groups, including professionals and bureaucrats. And at the local level, participation waxes and wanes with the felt needs of the populace and the state's ability to respond effectively to them. (1993: 5-6)

Morgan gives the reader an important critique of the official discourse (akin to Freidson's "formal knowledge") that surrounds participation, interpreting it as more a strategy of social control than a genuinely fundamental value of Costa Ricans.[3] Morgan sees a deep-rooted tradition of state paternalism in this country, and despite official slogans equating participation with democracy, participation (in health, politics, or "development") nonetheless has not occurred spontaneously at the community level in general. Instead, the state, as a "benevolent" giver of good health, has had to create or "induce" participation of the poor and the marginalized.

International agencies such as the World Health Organization (and its subsidiary, the Pan-American Health Organization), the World Bank, and others, have incorporated the jargon of participation and democratization into their official mandates, and in the process have made compliance at the national level a prerequisite for receiving technical or financial assistance. According to Morgan, these mandates are filtered through the

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[2]"Spontaneous" participation is "voluntary, base-up, without external support," or "informal, bottom-up, community supportive". "Induced" participation is "sponsored, mandated, and officially endorsed"; the "coerced" form is "compulsory, manipulated, and contrived" (Morgan 1993: 5).

[3]Abbott discusses jurisdictional claims in terms of social and cultural control. "The cultural control arises in work with the task and is legitimated by formal knowledge that is rooted in fundamental values. The social control arises in active claims put forth in the public, legal, and workplace arenas" (1988: 83). We would argue that participation is put forth as a form of social, not cultural control by the health authorities, since participation as such is not, according to Morgan, a fundamental value in "Tico" (i.e., Costa Rican) society.

state, down through various levels of government, in a highly politicized process of mediation and negotiation. "The local manifestations of international health programs must therefore be regarded as a consequence of the interactions among global, national, and local forces" (1993: 10). Such an interpretation is not dissimilar to Abbott's call for popular, juridical, and political levels of analysis.[4]

In the end, for Morgan, "community participation" is a component of international health jargon, a strategy for jurisdiction-building and the manipulation of resources at a number of locations: from grant proposal-writing in the international forum, to policy dictates at the national level, to the allocation of funding and professional positions at the local level. Whether "community participation" actually takes place in community health initiatives, or further, whether "community participation" can be defined in any generic way, is another issue altogether. A central organizing principle of Primary Health Care, itself a low-cost health strategy, "community participation" is a process whereby individuals and families are meant to come to view health not only as a right but also a responsibility; however, missing is the principle that the right to health should be guaranteed by the state.

James Ferguson (1994), in a poignant analysis of "development discourse," points out the incongruity between bureaucratic "development" knowledge and local "aboriginal" (as well as academic) knowledge and the effects the production and application of the former can have on structural (i.e., socioeconomic) change. In a manner similar to Abbott's interpretation of the role of knowledge claims in professional jurisdiction-building, Ferguson's "vivisection of a conceptual apparatus" (1994: *xvi*) looks at the generation, the application, and the practical consequences of specific, bureaucratic, ideas about development. His analysis is anthropological, thus "decentered", and locates "the intelligibility of a series of events and transformations not in the intentions guiding the actions of one or more animating subjects, but in the systematic nature of the social reality which results from these actions" (1994: 18). Thus, in comparison with Abbott,

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[4]For an interesting case study of health development institutions and processes in Nepal, their interactions at the local, national, and international levels, and their relationship to culture, see Justice (1986).

who analyzes knowledge claims as a "process" (here called "professionalization"), Ferguson goes further, focusing on the "results" of knowledge claims, or the "conceptual apparatus" called "development."

According to Ferguson, the development trade seeks technical solutions for what it perceives to be technical problems. He argues that these "problems" are not technical at all, but political, social, and cultural. In his Lesotho case study,

> isolation, lack of markets, lack of credit, . . ., lack of education, . . . are exaggerated or invented to take the place of things like unemployment, low wages, . . ., political subjugation . . . and entrenched bureaucratic élites; then an institutional apparatus is unleashed to combat these largely illusory technical problems (1994: 87-88).

To follow his argument, one could point out a number of similar "problems," such as a lack of education and a lack of community participation, that have been identified in Costa Rica by health planners, bureaucrats, and practitioners.

I would disagree with Ferguson, however, and contend that the development trade does indeed perceive the political nature of structural "problems" such as poverty and oppression, and that plans are made in cognizance of these. It must be remembered that the net "result" of development initiatives rarely, if ever, point to an eradication of inequality or disenfranchisement, and will virtually always "fail," when compared to planned-for outcomes. It must also be noted that the terms he uses, such as "unemployment" and "low wages," are constructs of political economy, just as are "lack of markets" and "lack of credit," the "technical" terms he criticizes.

What is useful about Ferguson is that he points out convincingly that notions such as "development" must not be taken for granted. Whether his Foucauldian analysis is in fact "correct," and whether development projects indeed do consistently "fail" to meet planned outcomes, is not the point. "Success" and "failure" are relative concepts that mean different things to different people. Rather, his insight comes in his suggestion that what needs to be studied is not the people, but the apparatus, or the institutions, that do the developing.

In order to decipher why the "development" discourse takes the form it does, Ferguson tells us it is necessary to "uncover the institutional and ideological constraints and imperatives that structure the discourse" (1994: 28). By contrasting "development" discourse with "academic discourse", he attempts to prove their mutual incompatibility. He deconstructs a World Bank text and shows most of its claims to be either false or fraught with ideological assumptions couched in neutral terms, thereby illustrating the institutional character and thus the academic inadmissibility of the text. Again, whether the World Bank is "right" or "wrong" is not the point here; what is interesting for us is that many notions of development, such as "community participation" and "integration" are indeed bureaucratic constructs, and it is these concepts that are borrowed by family and community medicine in their professionalization drive.

Ferguson's characterization of "development" as a "machine" that tends to standardize development interventions, discourse, and program elements, and to homogenize "expertise," makes the important point that there is very little overall instrumentality involved in the process. In other words, there is not any kind of conspiracy on behalf of a state, an international organization, or a "ruling class" that "possesses" power. Rather, Ferguson claims, a state, a development agency, a "machine" should be looked at as points of "coordination and multiplication of power relations, . . . , a kind of knotting or congealing of power" (1994: 272-273). One could extend this view, and apply it to the domain of professionalization.

Ferguson then poses an important question: given that "development" outcomes are rarely congruent with plans, what is their relationship? His complex, or confusing, answer is really but a simple metaphor: that we must see the "structured discourse of planning . . . only as part of a larger 'machine,' an anonymous set of interrelations that only ends up having a kind of retrospective coherence. . . . Planners' conceptions are not the blueprint for the machine; they are *parts* of the machine" (1994: 275-276). Thus, plans tend to "fail" to change the world according to their prescriptions. Similarly, the discourse of family and community medicine, seen as "plans," will likely fail to change the world. However, they will serve in the discipline's struggle for legitimacy and social space.

SYNTHESIS

The people who claim to take responsibility for the health development of poor Costa Ricans also believe in the need to establish themselves as professionals. On the one hand, they espouse an inclusionary discourse. On the other hand, they engage in the exclusionary erection of jurisdictional walls. Although this might seem contradictory, it is in fact a strategy inherent to the process of professionalization. As Freidson (1970) points out, "the profession's service orientation is a public imputation it has successfully won in a process by which its leaders have persuaded society to grant and support its autonomy" (1970: 82). Thus, "service" to communities and to development comes on the condition that a certain social space be guaranteed by "society," which, following Abbott, I have broken down into "arenas"—the international health institutions, the legal system, public opinion, and the workplace. The mechanisms by which these guarantees are sought by the profession in question include rhetorical strategies that invoke political symbols such as "integration," "community participation," and "political will," as pointed out by Morgan. These symbols are emergent components of Ferguson's development "machine" that, in our discussion, become instrumental in the negotiation of power relations.

Two distinct sets of literature have been drawn upon to form a theoretical basis for this thesis. Although theory surrounding "professionalization" and that on "development" might seem at first to have little in common, in fact, they complement one another and have common points that are useful for our analysis. Both sets of sources take official "discourses" (i.e., "jurisdictional claims," "development plans," "community participation") and subject them to scrutiny, distinguishing and elaborating upon what is "said" and what "gets done."

Together, these approaches inform the present analysis on the process of the development of a new profession, family and community medicine. At the same time, they will be used to explain the relationship between this new profession and socioeconomic development in health in Costa Rica.

METHODOLOGY

Research was carried out in two phases, which I will call "pre-departure" and "fieldwork." The first phase consisted in establishing contact with the Department of Family Medicine at McGill University in Montreal, collecting and analyzing the available documentation on the McGill-CENDEISSS project, interviewing a number of key actors involved in the project, and reviewing literature on health, development, professionalization, ethnographic methodology, and Costa Rica. I made an initial one-week trip to Costa Rica in February, 1994, in order to meet with key informants and collaborators, to investigate potential field sites, and to give myself a preliminary exposure to the sociopolitical, cultural, and working context of family and community physicians. Upon return to Montreal from this brief visit, I concentrated on developing a methodological and conceptual plan of action for the second, "fieldwork" phase.

This phase, during which the empirical material at the core of the study was collected, was undertaken between June and September 1994 in Costa Rica. During this time, I used four different methodological strategies: I conducted interviews, collected and analyzed documents, engaged in participant-observation, and designed and administered a survey.

A) INTERVIEWS

I interviewed health authorities at the national level, from the Ministry of Health (Ministerio de Salud, or MS) and the Social Security Fund (Caja Costarricense de Seguro Social, the CCSS or "Caja"), and at the regional level (Region Central Norte of the Caja, and Heredia of the MS). I also interviewed representatives of the Pan-American Health Organization, the National Centre for Strategic Development and Information in Health and Social Security (Centro Nacional de Desarrollo Estratégico e Información en Salud y Seguridad Social, CENDEISSS), and McGill University representatives in Costa Rica. Of course, I interviewed, both formally and informally, graduates of the McGill-CENDEISSS training program in family and community medicine. I also conducted

interviews with health workers and community members of Puerto Viejo de Sarapiquí and outlying areas, where I traveled with the MS's Mobile Medical Unit. A significant portion of my data was collected during impromptu discussions with health workers and officials, community members, and during conferences on family and community medicine.

B) DOCUMENTS

I was given unrestricted access to the National Library of Health and Social Security (Biblioteca Nacional de Salud y Seguridad Social, BINASSS), the Pan-American Health Organization's documentation centre, and to the libraries of the Universidad de Costa Rica (UCR) and the Universidad de Heredia. Dr. William Vargas of the UCR's department of Public Health arranged for my access to electronic mail and the Internet.

C) PARTICIPANT-OBSERVATION:

Puerto Viejo de Sarapiquí is a small town of 6,500 inhabitants (1993 figures) in Heredia Province, 80 km North-East of San José. It was chosen as the community to be studied for several reasons. The first had to do with access: from my conversations with the people involved in the McGill-CENDEISSS project, I decided that it would be important to study a clinic that was "typical," which might be representative of the health service delivery situation in most of the country, and that had an "average" family and community physician as its director. I could have studied the clinic in Barranca, which has become a model for the entire country, but the clinic and its charismatic director (a young, extremely energetic family and community physician very keen on promoting the family and community medicine "model") seemed too exceptional to be copied to any extent elsewhere. MD, one of the project participants, was of the opinion that the Puerto Viejo clinic was not exceptional, and that its director, AC, would be willing to collaborate with my project. Upon contacting him and explaining my intentions, AC agreed to take part. Thus, my access was gained easily, and without undue loss of time.

A second factor that influenced my choice of Puerto Viejo as a case study was its location. It is in a part of the country that has undergone drastic demographic changes in the last eight years. A tremendous in-migration of plantation workers has taken place, as about twenty-five new banana fincas have come into production. Also, a highway, only recently built, has reduced travel time to the capital from over eight hours to just under one and a half hours. Thus, it remains a primarily rural area, yet not at a great distance from San José. Logistically, this was convenient for me, as I expected to be returning to the capital on a regular basis. Only in San José would I have access to libraries, public officials, and those people involved in family medicine.

A third factor was that the public health care system in Puerto Viejo was making efforts not only to accommodate the demographic changes in the area, but also to reflect the national reform underway in the government health sector. Since 1984 the government has been in the process of integrating the two health bureaucracies in order to streamline and consolidate the structures. In Puerto Viejo, the two clinics were beginning to merge administratively in 1994, and the construction of a new, "integrated" clinic was begun in August 1994.

Over the course of my stay in Puerto Viejo, it became clear that in order to understand the conditions in isolated rural areas, I had to travel with the mobile medical unit on its community rounds. I thus spent many days traveling by four wheel drive, by boat, and by horse to the outlying communities of Sarapiquí county, sometimes staying overnight in the health posts. There, I observed interactions between the health team and their patients, and spoke at length with the team and with community members.

To summarize: Puerto Viejo was chosen for reasons of privileged, rapid access; its location, which was both convenient and interesting; a manifestation of the national reform process; and because it was "typical" example of the challenges faced by family and community physicians.

As a limited comparison to the clinics in Puerto Viejo, I spent one day at the Los Sauces clinic close to Tres Rios, 15 km east of San José, and two days at the Clinica Sotomayor in Barranca, 11 km inland from Puntarenas, Costa Rica's major Pacific coastal city. In order to understand the collegial dynamics of the family and community

medicine movement, I observed their goings-on as a delegate to two conferences on their emerging specialty. The first, the "pre-Congreso," was held in June 1994. The second, from September 1-3, 1994, was the three-day "First Annual Conference on Family and Community Medicine."

D) SURVEY METHODS

As an observer in the two clinics (CCSS and Ministry of Health) in Puerto Viejo de Sarapiquí, I devised a simple interview schedule to be administered to patients (see Appendix) in order to determine demographic trends and health care services use in Puerto Viejo. With two assistants, Y and S, we interviewed a total of 758 patients that generated a secondary sample of 3,352. (Locher and Scyner).

CHAPTER TWO — COSTA RICAN HEALTH CARE: CONTEXTUALIZING THE INTRODUCTION OF FAMILY AND COMMUNITY MEDICINE

In order to understand the development of family medicine in Costa Rica, the institutional context must be elaborated. Although health care coverage is "universal" in Costa Rica, the delivery of health care is fragmented among various institutions which have been assigned distinct, yet overlapping responsibilities, and which have developed their own particular bureaucratic cultures.

TECHNOCRACY VS. MYSTIQUE — THE TWO FACES OF THE COSTA RICAN HEALTH BUREAUCRACY

The Ministry of Health was founded in the 1920s, after a series of government offices were put in charge of public health and the control of communicable diseases. Since then, its functions have varied; from being provider of all curative care and administrator of the country's hospitals, it has now been reduced (on paper, but so far not in practice) to the role of "ente rectora," or rectory body. In the current scheme, the Ministry of Health is to give up its role as service-provider, and remain only a policy-making institution. The Costa Rican Security Fund (CCSS) is to be in charge of all health services rendered.

The CCSS, established in 1941, began its operations in 1943 to provide sickness and maternity coverage as well as pensions for urban salaried workers. Initially, it was limited geographically to San José and the provincial capitals, and demographically to the insured and their dependent spouses and children, and pensioners. Coverage included general and specialist care, surgery, maternity care, hospitalization, laboratory services, dental care, limited optometry services, and medicine; sick-leave and maternity leave were paid for. Health benefits were extensive, however, much of the population was left uncovered.

In 1961, the government passed a law mandating the expansion of social insurance coverage to the entire population within a ten-year period. However, due to a lack of infrastructure, the implementation of the law was delayed almost a decade. In 1971, a

new law ordered that the CCSS proceed with the 'universalization' of coverage. In 1973, as a result, all hospitals were transferred from the Ministry of Health to the CCSS (called "el traspaso"), and the CCSS was charged with providing free health care to the poor. The same law gave the responsibility for curative measures to the CCSS, while the Ministry of Health was to focus on prevention. Mandatory coverage was extended to "domestic servants and employees of micro enterprises and their dependent relatives," as well as to indigents and their dependent families. Voluntary coverage was offered to "the self-employed, unpaid family workers and employers, and their dependent families" (Mesa-Lago 1992: 85).

The National Health Plan of the 1970s gave the Ministry of Health the responsibility for extending Primary Health Care to all rural populations and to the urban poor. Health posts were established in isolated rural "health areas" for every 3000 or so people. Paramedical personnel (Primary Health Care technicians, or TAPs - Técnicos de Asistencia Primaria) would visit the population in their homes, recording health statistics, giving primary care, and testing for malaria, dengue, and other communicable diseases. "Mobile units," teams of physicians, dentists, and TAPs, would provide general medical and dental care at health posts (or other non-residential buildings, where a health post did not exist) in isolated communities, usually on a quarterly basis.

In 1976, the Ministry of Health's urban community program began, "geared to the urban population in shantytowns, which basically consisted of rural migrants" (Mesa-Lago 1992: 85). Health posts and health centres, similar to those in rural areas, were established.

The Ministry of Health's other functions were, previous to 1994, to provide "general service to the entire population, such as epidemiological control, environmental sanitation, immunization, nutrition, health education, and family planning" (Mesa-Lago 1992: 85). It also operated "education and nutrition centres" (CEN) and "integral care centres" (CINAI). The former, similar to kindergartens, "provide milk and nutritional supplements and education to children and pregnant women"; the latter are "day-care centers that supply three daily meals to children under the age of 6, as well as other services" (ibid). It is not unusual to see CEN/CINAI attached to a clinic.

Two other public institutions provide some health care or parallel services. They are the Institute of Water Supply and Sewage (Instituto Costarricense de Acueductos y Alcantarillados, or ICAA), which has ensured the provision of potable water supplies and waste disposal to 93% and 97% of the population, respectively (1989 figures in Jaramillo 1993: 146); and the National Institute of Insurances (Instituto Nacional de Seguros, or INS), which covers employment injury. Non-workers are excluded from INS coverage.

Much overlap was (and still is) occurring between the institutions. For example, in every town or city, one is likely to find a CCSS clinic, a Ministry of Health health centre, and even an INS clinic, all of which offer outpatient services to theoretically distinct clienteles: the "insured," or the majority, would go to the CCSS, the "uninsured" (for example, the indigent and illegal immigrants) and those requiring "preventive measures" (mostly pregnant women and babies) are seen at the Ministry of Health; only those whose complaints are work-related (and formally documented as such) can see an INS physician. As a result of the fragmentation and overlap, in 1979 the concept of a national health system was introduced into law, accompanied by more clearly defined functions for all three institutions. Yet, it was not for another decade that concrete action would be taken on these measures. In the meantime, the 1982-1986 National Development Plan and the 1983 National Health Plan were drawn up, that

> launched advances in integration, primarily between CCSS and the Ministry, that included the following: a National Health Council was established under the direction of the Ministry of Health and charged with the development of the National Health System; functions were separated and coordination was enhanced, as was uniformity in terms of health regions; if only one institution served a given location, it was determined that it would assume full responsibility for health care; and, in newly built facilities, all programs were integrated and housed together (Mesa-Lago 1992: 86).

However, most of these plans have still to be carried out:

> less than half of the health facilities have been integrated; both institutions basically continue to function with their own top authorities, bureaucracies, and budgets; and most services are not functionally unified. Integration has been partly achieved at the local level, but not at the top, and

problems of overlapping, inefficient use of resources, inadequate coordination, and flaws in the quality of services persist (Mesa-Lago 1992: 86).

Interviewees argued that one of the factors that blocked integration at the top level is a very tangible institutional culture that has contributed to very different mind-sets, and thus to resistance, amongst the powerful health bureaucrats. Ministry of Health officials spoke of the "mística," or the mystique of their organization. For example, the director of health services for the Central Norte region commented:

> We care for our population, and are willing to work hard, at lower pay, for long-term goals. Health education, promotion, and prevention don't give any tangible results, but that's our mandate, and that's our mystique. The CCSS, on the other hand, doesn't have the same culture. They are bureaucrats interested in results, now, without a real humanist vision of the future; rather, their vision is based on cost-benefit analyses. Many of them don't ever leave San José to meet with community members, to understand the human side to their abstract models. (interview, 94-08-30)

On the other hand, a middle-level planner at the CCSS remarked that people at the Ministry are lazy, that "those people who work for the government have a very low level of culture."

These post-hoc legitimations (or rhetorical strategies to maintain institutional or professional jurisdiction or boundaries) reflect a certain uneasiness about the proposed integration, and thus a resistance to it. Afraid of being gobbled up by the CCSS technocracy, and thereby losing the "mystique," the Ministry of Health bureaucracy has become further entrenched. Considering that the Ministry's budget is much smaller than that of the Caja, and that its workers and officials earn substantially less than their Caja counterparts, it is perhaps not surprising that, combined with their preventive mandate, Ministry personnel have developed such a "mystique." They must do more with less, and carry out long-term projects that do not bear "tangible" or immediate "results."

Another top official at the Ministry of Health, after being asked why there was such resistance to integration, argued that "we are a democracy here. We cannot do things as

brusquely as if we were in a military dictatorship. In a democracy, changes like these must be discussed and agreed upon, and that takes time." It seemed that he was willing to discuss the reform for as long as he had to.

Schematically, we can see the health care delivery system as a five-tiered pyramid. The first, or primary level of care is provided by the Ministry of Health's prevention and Primary Health Care services to the entire population and to targeted groups through health posts (home visits, vaccinations, infant-maternal health care, control of contagious diseases), mobile units (medical and dental teams who diagnose and give first aid), dental clinics, and the CEN-CINAI. The secondary level combines preventive and curative services provided at both Ministry health centres and rural assistance centres as well as CCSS clinics. The Ministry centres deal with prevention, outpatient consultation, emergency, obstetrics, pediatrics, and general medicine, along with hospitalization for child delivery; the CCSS clinics and hospitals provide more extensive outpatient services as well as minor surgery (Mesa-Lago 1992: 86).

The third and fourth levels "are the curative services provided by CCSS peripheric, regional, and national (specialized) hospitals" (ibid). Jaramillo (1993: 316-319) gives us a similar schema, but with six levels: the home, the health post, health centres and outpatient clinics, peripheric hospitals, regional hospitals, and, finally, national teaching hospitals. The hierarchical form of the health system is clear, and the ostensible aim of the new "reforma" is to flatten it.

Yet one of the functions of the "democratizing" or "egalitarian" discourse — a reflection of the rhetoric of international health organizations — is not necessarily the flattening of hierarchies, but the creation and reinforcing of "boundaries" that legitimize and protect the health institution. Claims to foster "community participation," "intersectoriality," and a "patient-centred," "bio-psycho-social" or "comprehensive" approach to care are aimed principally at an audience far removed from the community level. By espousing goals and using rhetoric similar to that of international health organizations, officials in Costa Rica make themselves attractive to national and international health funding agencies. Morgan (1993) tells us that Costa Rica's health care agenda is heavily influenced by international agencies and their ideologies, and that

it depends on "developed" countries for health models and medical materiel. To be sure, then, giving a good impression to donors, lending agencies, and other influential international actors is seen as important, and Costa Rican health institutions see a need to be perceived from the outside to be doing the "right thing." This implies that a specific political vision is shared by international and national officials. However, it does not ensure that the vision will be pursued outside these circles, for example, at the local level, in spite of its being the alleged target of these discourses.

THE "REFORMA" OF THE HEALTH SECTOR

Despite its bureaucratic complexities and the unnecessary duplication of many services, Costa Rica still has one of the most comprehensive and inclusive national health systems in the developing world. Coverage is almost universal, most citizens contribute to its financing, and there is a reasonable degree of equity: only about 16 per cent of health care visits are to private practitioners (World Bank Report 1993), and every individual who seeks medical help has a right to treatment.

In the 1970s and 1980s, the Primary Health Care strategy, focusing on care based on prevention, reducing risk factors, and extending coverage to rural and urban marginal areas, succeeded in transforming the country's health profile to resemble that of a developed nation. "Salud sin riqueza," or "health without wealth," was a success, at least in the eyes of international health experts (see Morgan 1989 for a discussion of Costa Rica's "successes"). With the economic downturn of the 1980s, there was a need for increased efficiency and efficacy of health programs, a reduction in the duplication of services by the CCSS and Ministry of Health, and a re-thinking of a model of health care that would reflect and accommodate the new economic and social realities of the end-of-century. Given the debt situation, and the need to comply with World Bank guidelines for structural adjustment, new solutions had to be invented. State reform was needed, increased efficiency, productivity, and competitivity of the public and private sectors was being demanded, and a changing, aging, demographic structure required new and

different health services. The "modernizing" epidemiological profile, or a replacement of acute parasitic and infectious diseases by chronic cardiovasular diseases, cancer, and accidents as the principal causes of morbidity (Sáenz 1989: 1) required more expensive, technology-intensive treatments, or better, more effective preventive and educational measures.

To sum up, he history of health care reform in Costa Rica is extensive, from the "traspaso," or transfer, of the hospitals from the Ministry of Health to the CCSS in 1973 (a process that took twelve years to complete) to the "Integracion de Servicios de Salud en Costa Rica" proposed by the Arias government in 1985, to the "Reforma Sector Salud" proposed in 1993. The latter two reforms called for the integration of curative and preventive services under the auspices of one government body, as opposed to the provision of both services by distinct agencies. Previously, preventive health care had been delegated to the Ministry of Health, whereas the CCSS was charged with curative services. In my research in Costa Rica, I often found it difficult to distinguish clearly between the two. In a typical example of the functioning of the system, a Ministry of Health official explained to me that a physician from a Ministry of Health clinic would follow a woman's pregnancy to term, and in so doing would provide all necessary "preventive" measures; the process of childbirth, however, is under the Caja's aegis. Concordant with the "biomedical model," childbirth is classified as a health "problem" that requires a "curative" intervention. If there are complications, a CCSS physician deals with them. If there are none, a Ministry of Health physician takes over the care of the woman and the newborn. In theory, the "integration" of institutions would allow for a continuity of care by providing one physician who would follow the woman's entire pregnancy process, thus eliminating the complexities and confusion that accompany the fragmented approach. In reality, however, the "integration" of the two institutions has only been carried forward to a minimal degree, and continuity of care seems to be a reality only in private clinics where families can choose (and pay for) their own physician.

THE "NEW MODEL" OF HEALTH CARE

As for the current (i.e., the one to be replaced) "model" of treatment, health authorities believe that it is predominantly biologistic, "where disease has been the object not only for the organization and delivery of services, but also for the development of human resources and for budget allocations. We thus have a focus for care that is highly specialized, organized in all its structure by disciplines" (Proyecto Reforma Sector Salud 1993: 11, my translation).

This model, according to the document, does not take into account patients' family and work context, or even their social-psychological perspective. It is highly centralized, tends to neglect local conditions or particularities, and has not considered the individual, the family, and the community as the protagonists of their own health processes. Rather, they are seen as passive actors. With a "new social dynamic, the model of attention does not adequately respond to today's health needs, and neither, we believe, will it respond to future needs. In conclusion, it can be claimed that organizationally, functionally, and conceptually, our medical model does not provide an adequate answer for the health needs of the country" (ibid: 11, my translation).

The new model proposes to remedy these concerns by introducing a "biopsychosocial" approach to viewing the process of health and illness. This means giving comprehensive, continuous care, focusing on the family, the community, and on the environment. In theory, planning will be based on local needs; health care teams will be responsible for families, thus eliminating discontinuities and fragmentation of care; and all training will be given based on the principles of Family and Community Medicine.

Patients will be given more freedom to choose their General Practitioner or Family Physician as well as specialists, and will even be given the choice of where to go for health care services. "Community participation" is expected to enhance the model, and vice versa, as "the new model will *propitiate a change of attitude in society*, with respect to health, where health is no longer an eminently individual problem, but instead becomes a collective situation, with everybody becoming responsible for maintaining, preserving,

and improving it" (Proyecto Reforma Sector Salud 1993: 15, my translation, italics added).

The new model proposes that a quality control system be put into place, as well as an improved health information system; the planning process will be participative, and involve "all social actors and all administrative levels" (ibid: 16). Of course, we are told, planning must be flexible and adaptable to local conditions, thus an important administrative decentralization will take place. Finally, twelve priority areas have been identified (pregnancy and childbirth, acute respiratory infections, intestinal infections, etc.), as well as five special programs: comprehensive care of children, adolescents, women, adults, and seniors (ibid: 18).

Although the new model is described in far greater detail than the above schema, it is still based on the same three basic principles (equity, solidarity, and universality) as the old model. Furthermore, a number of changes being decreed at the policy level are just that — policy. One might question how more efficiency is going to be eked out of a system that is already strained financially, with a shortage of personnel, especially in rural areas. Moreover, concepts such as 'community participation' are nebulous and intangible, certainly difficult to plan for, and whose impact is even more difficult to measure. Communities are to be "encouraged" to participate; "all significant social actors" are to be involved in the decision-making process; and Family and Community Physicians are expected to coordinate communities' illness and health-seeking processes.

If the rhetoric of the new Family and Community Physicians, in their quest for legitimacy and institutional space at local, national, and international levels, has any grounding in practice, they have taken upon a formidable task indeed. To "induce" participation in health in communities where community dynamics have never been conducive to such participation; to spare the time needed for veritable continuity of care; to integrate into communities isolated from San José; to understand the "bio-psycho-social" contextuality of fifty patients per day, all seem to be exceptional goals. These themes, and others, will be explored in the next chapters, in a look at the dynamics of this emerging specialty in Costa Rica. First, however, a brief history of the introduction of the family and community medicine model to Costa Rica would be in order.

THE MCGILL/CENDEISS PROJECT: THE BIRTH OF FAMILY AND COMMUNITY MEDICINE IN COSTA RICA

The McGill/CENDEISSS Project, "Training in Family and Community Medicine", began on July 1, 1989, the result of a request by Costa Rican health authorities submitted to McGill University's department of Family Medicine to help develop an academic teaching program for the training of Family and Community Medicine physicians and teachers. McGill Family Medicine agreed to collaborate on this project "because we felt that McGill had expertise in faculty development, and it was felt that it would be of great benefit to our department to collaborate with Costa Rica because of the need in our country to explore ways and means to develop the community orientation of the practice of Family Medicine" (McGill Final Project Report 1994: 1). According to the head of Family and Community Medicine training in Costa Rica, McGill was the only university among about twenty approached in North America by CENDEISSS that showed an interest in the proposed project. According to the final report, the project

> was designed as one means of improving the delivery of community-oriented primary health care (or COPC) to the population of Costa Rica. The principles of Family and Community Medicine formed the foundation for the integration of preventive and curative care delivered in the context of an effective doctor-patient and doctor-community relationship. The general objective of the project was to establish a self-sufficient academic department of Family and Community Medicine within CENDEISSS (ibid.: 1).

As we have seen, it was in the context of the severe debt crisis of the early 1980s that policy makers in Costa Rica decided to seek out cheaper and more comprehensive approaches to health care delivery. It was becoming clear that a health system based increasingly upon tertiary care facilities and university teaching hospitals was not meeting the needs of the general population. Physicians were specializing and sub-specializing, in accordance with their own ambitions, and mirroring existing patterns of professionalization in North America. Yet in so doing, they created a need for expensive, capital-intensive, technology-oriented tertiary care. Primary care, prevention, and health education seemed to be of lesser importance in this climate. The economic downturn

forced the government to adopt tight fiscal policies, and thus to search out more cost-effective health measures. With international health agencies such as the World Health Organization and the Pan-American Health Organization keen on "Primary Health Care" after the Alma-Ata declaration of 1978,[5] the stage was set for the revamping of the Primary Health Care system in Costa Rica. The stage was set also for the creation of a new specialty, Family and Community Medicine, that would be a main player in the new politics of Primary Health Care. Without the credentials, the recognition, the "specialized knowledge" and the status of "specialists," physicians, according to interview respondents, would opt for the more traditional, lucrative specialties such as gynecology or internal medicine.

The creation of this new specialty that was to "improve" the health care delivery system, and hence the health profile of the population, can be characterized, in sociological terms, as a process of "professionalization" (see Freidson 1970, 1973, 1986, and Abbott 1988). Indeed, the segmentation this might be perceived to create within the profession of medicine itself is in fact, in Bucher and Strauss's (1961) terms, a standard occurence. Specialism, then, is not an untypical component of the process of professionalization, and attests to the dynamic form of professions.

Although Costa Rica had long been committed to Primary Health Care as a national policy, since the early 1980s the health system was uncoordinated and ill-structured to be able to deliver comprehensive Primary Health Care to the entire population. As already noted, preventive and public health services were the responsibility of the Ministry of Health; curative services were offered by the Caja Costarricense de Seguro Social (the "Caja" or the CCSS). According to the McGill report, the division of service provision along these institutional lines led to "duplication of some services and inadequate coverage of others, high referral rates to the secondary levels of care, and growing dissatisfaction on all fronts" (McGill Final Report 1994: 2).

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[5]The Alma Ata WHO/UNICEF summit in 1978 declared Health For All by the Year 2000 (or HFA-2000) as a universally attainable goal, to be achieved through Primary Health Care. See below for a discussion.

In 1985, the Arias government approved the policy document called "La Integración de Servicios de Salud en Costa Rica," which, according to McGill documents, "called for the integration of curative and preventive services by professional and ancillary health personnel at the level of general primary care in community health clinics. This *created a need for a medical professional* who would role-model and coordinate the integration of care" (ibid.: 2, italics added). From the Canadian family medicine perspective, a "need," or a jurisdictional void, obviously existed, as the specialty, already well established in North America, simply did not exist in Costa Rica. A new, "integrated clinic" at Coronado, a suburb of the capital, San José, was built as a prototype for the "integrated services", and an opening for Family and Community Medicine as a specialty was created.

In 1986, CENDEISSS charged RCG with investigating Family and Community Medicine as a "professional model" for the practice of integrated care.[6] Although the term "professional" is not defined in the McGill-CENDEISSS documents, it is important to note that the need for such a model is clearly spelled out in the text. Relevant actors in Canada and Costa Rica interpreted the model as one that prescribed that physicians (i.e., not "non-professionals" such as nurses or health promoters) be charged with the "responsibility" for primary care, a position that would require several years' post-graduate training. RCG "found that the development of Family Medicine was an important movement for the renewal and improvement of health care services in all Central and South American countries, and that Costa Rica offered an appropriate environment for its implementation" (ibid.: 2). He created a residency training program, and had ten physicians ready to begin their training in February 1987. "[W]ith few resources and no direct experience, collaboration with an experienced academic institution was imperative" (ibid.: 2).

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[6]RCG, a urologist, worked at the same teaching hospital as GM, the newly invested president of the CCSS. GM appointed RCG to investigate the possibility of incorporating family medicine into Costa Rica's ambulatory services. Both men were associated with the "left"-leaning PLN (Partido Liberación Nacional) that had won the elections in February, and that formed the government in May of 1986. By July 1986, RCG was researching family medicine in Brazil, and by February 1987, the residency was inaugurated. RCG was appointed the specialty's first director.

As previously mentioned, in February of 1987, CENDEISSS requested the collaboration of McGill's Department of Family Medicine, after having approached a number of North American universities. The proposal consisted of three components: the acceptance of Costa Rican medical residents in Family Medicine at McGill; the training of Costa Rican medical professors in Family Medicine in Canada; and consultations by McGill Family Medicine professors in Costa Rica to advise in the field of Family Medicine (ibid.: 2).

On the Canadian side, McGill Family Medicine decided that a joint project would be of benefit to both partners, and that Costa Ricans could help Canadians learn to integrate skills of Community Medicine into the practice of Family Medicine. In particular, McGill "believed that the expertise in faculty development present in our department and our experience with the McGill Kellogg Center for Advanced Studies in Primary Care would be a solid contribution to the training of Costa Rican teachers and to the development of the Family and Community Medicine program in that country. The Project was initiated in July 1989" (ibid: 3).

In 1990, a new government came into power, headed by Rafael Angel Calderón Fournier and the PUSC,[7] and concomitant changes were made in the top positions in the health care bureaucracy. The new director of CENDEISSS lent his support to the continued development of Family and Community Medicine, keeping in mind his top two priorities: first, that of developing multidisciplinary teams, or EBAIS (Equipos Básicos de Atención Integral de Salud, consisting of a nurse's aid, a social worker, a primary health care technician or TAP, and, resources allowing, a general practitioner), as the basic unit of care provision, and second, that of developing "the mechanism to involve the community in the definition and analysis of health needs, and in the planning and evaluation of services" (ibid.: 3). In short, then, the new model was to be teamwork-based and involve "community participation." There was to be more emphasis on

[7] The Partido Unidad Social Cristiana, or the Social Christian party is also known as Unidad, or "Calderonistas" after former presidents Rafael Angel Calderón Fournier and his father Rafael Angel Calderón Guardia, the party's founder. The PUSC is the more "right"-leaning of the two major parties.

developing "community-oriented skills" in the Family and Community Physicians who each were to serve as coordinators of up to 20 EBAIS.

This emphasis was accentuated in April 1993 by the proposed total reform of the health care system, in keeping with the guidelines exacted by the World Bank for structural adjustment. "The objective of the reform was to enhance the efficiency and effectiveness of existing health structures to respond to a new profile of pathologies characterized by an increased prevalence of chronic illnesses and *social pathologies* " (ibid: 4, italics added). Again, the McGill document does not specify what it means by the "social pathologies" family and community physicians are to be able to treat.

The proposed reform would not only integrate curative and preventive services under the auspices of one institution, the CCSS, but would amalgamate the personnel and services of the Ministry of Health and the CCSS under a single CCSS administrative structure. According to the World Bank, which plays a key role in financing the reform process, significant decentralization of "management and operational, programming, and budgeting functions to the regional level" (World Bank Report 1993: *vi*)[8] would take place, and a "Redefined Primary Health Care Model" would be established and put into practice. World Bank policy states that this new model, or "Nuevo Modelo de Atención," would create a series of EBAIS within a "local systems framework." Each of the 700 EBAIS in 74 designated health areas would provide comprehensive Primary Health Care for approximately 3000 people. A coordinating team, with a Family and Community Physician at its head, would be responsible for between 40,000 and 60,000 people, or 13 to 20 EBAIS. According to the World Bank, "Integrated health care delivery packages would be introduced, including comprehensive preventive and curative care to children, adolescents, women and families. Features of this new model include continuity of service providers (particularly of family doctors), epidemiological surveillance,

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[8]This is a "Staff Appraisal Report," a restricted document that details the World Bank's evaluation of the Costa Rican health sector and its project and loan policy. The "Health Sector Reform - Social Security System Project" would provide a loan of $22 million to "support the Government's effort in the implementation of critical policy, institutional and operational reforms which aim at improving efficiency, effectiveness, and quality of the delivery of CCSS health care services and upgrading the quality control and surveillance system in the health sector" (1993:*v*).

delegation by CCSS of decision-making and budget control functions to the regions, introduction of incentives to enforce referrals, encouragement of support from community organizations and local users, and the rendering of more efficient services at lower levels" (World Bank Report 1993: *vi*).

Two processes were at work here in tandem: the creation of a new specialty on the one hand, and the restructuring of the health institutions on the other. Pressures at the national and international levels encouraged the creation of new bureaucratic structures. These pressures likely were also influential in creating a "need" or an opening for importing Family Medicine to Costa Rica. Whether Family Medicine could have been created in the absence of the proposed and actual (albeit at a snail's pace) institutional reform, remains a hypothetical question.

It is one thing to argue that government and World Bank policy created an opening for Family and Community Medicine in the slowly reforming health system. It is another thing to determine whether this project will be successful. According to the specialty's proponents, it was, and remains, only a question of time and of "political will" until the reform is put into practice and the specialty is given full institutional space. The most formidable obstacles to change, they say, are bureaucratic inertia and institutional rigidity, two aspects of the health care system that are likely not to disappear.

CHAPTER THREE - FAMILY AND COMMUNITY MEDICINE IN THEORY AND IN COSTA RICA

> The family doctor is a leader in the community, not just a kind of health technician. And he's not just a public health official. He is a political advocate, and does a more encompassing job, that takes in all aspects of the environment, not just public health per se. He has a vision, a vision of community health and of primary care. He is a community leader, and a team leader, who can keep a health care team motivated and enthusiastic about their work.
>
> ——WV, professor of Public Health, University of Costa Rica.

WV makes it clear that family and community medicine is not just a sub-specialty of medicine. Rather, he shows that its proponents and practitioners see the discipline as an essential and integral component of health care in Costa Rica, and indeed, in the world. As such, we can interpret and analyze the specialty as a profession in process, and thus as a social movement. This chapter will trace the theoretical and historical roots of this movement.

OVERVIEW

From the McGill-CENDEISSS program's inception in 1989 to 1994, approximately ten family and community physicians per year have graduated from the three-year residency. Additional quantitative data for the full period are difficult to access, as they are contained in confidential documents not made available to the researcher. In speaking to project participants, exact figures could not be ascertained.

McGill's involvement ended in the fall of 1994, at which time the McGill participants considered that their goal, to establish a self-sufficient academic department of Family and Community Medicine within CENDEISSS, had been achieved. However, the specialty was still struggling to create a social and professional space for itself, and thus not meeting the expectations of its Costa Rican proponents. The number of applicants was down, and the program's participants seemed uncertain about their future. WV, the

head of the department of Public Health at the University of Costa Rica was of the opinion that

> the ideal number of graduates would be 20 per year, but this year [1994], there are only seven or eight in the first year of the residency. I would hope that that would increase, but I get the feeling that we will have to wait for the Reforma to pass. Once we have our Reforma, the program will be strengthened, and we will be able to push forward with a new vision of community health. What the country really needs are doctors with a real community vision.

The origins of this "community vision" lie in the ideals and principles of the discipline of family and community medicine in Costa Rica, which, in turn, are based primarily on the precepts of Family Medicine as it has evolved in North America.

FAMILY MEDICINE

As described by Ian McWhinney (1989), a renowned Canadian family medicine scholar and professor at the University of Western Ontario, family medicine is a new model of health care delivery, evolved from general practice, that is qualitatively distinct from its predecessor, the "biomedical model." Treating illness as more than a disease entity, the patient as more than an individual, biological "case," and causal entities as more than just identifiable pathogens, Family Medicine, now in its twenty-seventh year as a recognized specialty in the United States, is very much a product of the social and intellectual trends of the second half of the twentieth century. "Contextuality," "self-knowledge," a "patient-centered approach" are common refrains of theorists; "continuity of care," "health education," and the patient's "bio-psycho-social reality" those of practitioners (BINASSS document 1993; Geyman 1985; McWhinney 1981, 1989; Rakel 1977; Slater 1989).

For McWhinney, it is important to make a distinction between family medicine and family practice. The latter, he tells us, is what family physicians "do"; the former is the "body of knowledge about the problems encountered by family physicians" (1989: 12). McWhinney admits that this distinction is "tautological," yet, he claims, "so are the

descriptions of all applied subjects." The principles-versus-practice debate in medicine, and indeed in most of science, is a common one: what is theorized in principle is often far different from what is carried out in practice. Yet as Mol and Berg (1994) point out, there need not be a tension between these seemingly contradictory aspects of science. In fact, they rest on two or more "logics" that occupy different spaces, both literally and figuratively, yet which refer to and reinforce one another.

In the present discussion on Family Medicine, two logics, the theoretical (or bio-psycho-social) and the practical (or clinical), are clearly at play. The former is used by teachers to explain phenomena and describe the principles. The latter is used by clinicians on a daily basis, and is informed not only by theory but by the symptoms and complaints of patients. The logics are employed in different places literally (teaching settings vs. the clinic), as well as figuratively (theoretical logic is supposed to tell the "truth" about an object or category; clinical logic is used to "handle" it). The apparent tension between principles and practice (which are often widely divergent) can thus be seen as the interplay between logics, and that what often separates the logics can also serve to link them.[9] For now, we will briefly address the "principles" that guide what family practitioners "do."

THE PRINCIPLES OF FAMILY MEDICINE

McWhinney (1989: 12-16) has identified nine basic principles of Family Practice. These are not necessarily exemplified by all family practitioners, nor are they unique to the discipline of Family Medicine. However, taken together, "they do represent a distinctive world view—a system of values and an approach to problems—that is

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[9]Mol and Berg argue that "the logic called 'principles' is presented as *underlying* what is done in 'practice'. Medicine thus appears to be a solid whole. Not a heterogenous assemblage of bits and pieces with frictions between them, but something with practices founded on principles. At the same time, the status of the two logics is not symmetrical. One logic, by calling it a principle, is granted the truth. The other, by being put into practice, gains the world" (1994: 260).

identifiably different from that of other disciplines" (1989: 12). The principles are summarized as follows.

First, claims McWhinney, the obligation of the Family Physician is more with the person than with a body of organic knowledge, with a nosological entity, or with a special technique. In other words, the patient, and not the doctor, defines what the problem is, and the physician's commitment is open-ended and long-term, not limited to simply curing the sickness, carrying through a treatment regime, or declaring the condition incurable. The doctor-patient relationship, ideally, is to be a life-long one, and contact is expected between the two on a regular basis, whether the patient is in good or bad health. "Illnesses that have little intrinsic interest for a clinician become interesting because they are experienced by a person who is known" (1989: 13).

The Family Physician seeks to understand the "bio-psycho-social" context of the illness. The physician, in addition to searching for diagnostic categories, contextualizes the patient's experience within his or her biological, personal, family, and social environments. McWhinney compares a patient's illness to a piece of a jigsaw puzzle: "We often come across a piece whose pattern does not make sense, however we look at it. Then we put it in its place — in the context of the whole picture — and immediately its meaning becomes clear" (1989: 13).

The Family Physician keeps an ongoing relationship with the patient and the patient's family, and sees every contact with patients as an opportunity for prevention or health education. Family Physicians view their practice as treating a population at risk, thinking of patients not only as individual entities, but also as population groups, and making a commitment to maintain patients' health whether or not they are attending the office.

To do this effectively, the Family Physician must be a resource-management specialist who acts as part of a community-wide network of supportive and health-care agencies, and who mobilizes community resources, whether formal or informal, for the benefit of patients. Furthermore, Family Physicians would ideally live in the community where they work, to be visible, involved in and understanding of the neighbourhood, and to be accessible to its residents.

Accessibility implies that the Family Physician is willing to see patients at the office, in their homes and in the hospital. It is important that the Family Physician be able to follow patients across boundaries and between contexts to create a continuity of care. The Family Physician must be involved "intensely" in the patient's illness process, and follow closely the patient's progress. This often means giving credence to the "subjective aspects of medicine," being sensitive to patients' feelings and understanding oneself: "family physicians understand that their own values, attitudes, and feelings are important determinants of how they practice medicine" (McWhinney 1989: 14).

It must be remembered that these are theoretical principles, guidelines to the practice of Family Medicine under ideal conditions. McWhinney's intention is not to describe Family Medicine as it is practiced, but as it *ought to be* practiced. As such, much of the language he uses serves more of a rhetorical or didactic than a descriptive function. For example, in his puzzle analogy, he describes how a piece of the puzzle takes on meaning when seen in the context of the "whole picture." Here, he seems to have comprehended the need for a certain anthropological "contextuality," yet he gives no hints as to how a Family Physician is to go about comprehending the "whole picture." Certainly, the representation of other contextual variables as distinct entities, as pieces of a puzzle, is problematic. Inherent to the analogy is the notion that the variables in fact "fit" with one another, and that an overall understanding, as a limited entity, can be developed about a patient, a family, or a community. In fact, several of the physicians I met in Costa Rica were convinced that the "entire" context could be elaborated, if only the particular variables could be measured or quantified. Although a desire to learn more about the patients' context is manifested, there seem to be few concrete steps taken in the direction of elaborating the nature and the mutability of the possible contextual variables. To be sure, many talk about understanding the "big picture," yet few can actually describe it. It would seem, then, that this talk is an example of the "boundary work" (Gieryn 1995) that family and community physicians do to distinguish themselves from other specialists who might see only a "limited picture."

Secondly, the notion of a wide-ranging "responsibility" for a "population at risk" has been discussed critically and at length by Armstrong (1984, 1987). In the post-WWII

period, biomedicine has come to redefine patienthood as the person "at risk." As the use of the epidemiological survey became more widespread, the old distinction between ill and healthy bodies was replaced by the notion that all people are potentially "at risk," and thus all people were potential patients, defined as members of ill or healthy populations. The medicalization of the spaces between bodies (which contained vectors, or were potential places for transmission of "at riskness") as well as the definition of illness along a continuum (or as a behaviour pattern rather than a lesion), allowed medicine, especially those disciplines focusing on the "bio-psycho-social" contextualities of patients, a new form of social control over populations. One is reminded here of the "social pathologies" that family and community practitioners are meant to treat, as mentioned in the previously cited McGill document (McGill Final Report 1994: 4). Implied in the new definition of the "at risk" patient is the notion of the physician's "responsibility" for the "at riskness." Again, this rhetorical strategy serves to increase jurisdictional space for the profession, and potentially to give the physician a heightened sense of social worth or status in his or her community.

Similarly, the notion that family physicians are to be a "visible presence in the neighborhood [and that] the fact that they often are not should be a source of concern" (McWhinney 1989: 14) exemplifies biomedicine's extension of its gaze into the spaces between bodies. By "integrating" fully into the community, theory tells us that a Family Physician's work will be more effective, as she will come to understand the community and its members, and therefore their health needs and concerns, more fully. It is assumed that, by being removed from the community, the physician is also deprived of an important source of contextuality, which, as we are told, is "necessary" for the good practice of Family Medicine. Certainly, this speaks to the sentimental notion of community as *Gemeinschaft* (see Tönnies 1957), where human relationships are "intimate" rather than "contractual." It also seems to indicate a romantic urge to regain the "community as a moral infrastructure" (Etzioni 1993: 142), yet in no way helps us (whether family physicians, sociologists, "community" leaders, or whoever) to determine what this "community" in fact *is*. Hence the problem in determining what in fact would be the process of a physician integrating into or being a part of a "community."

For McWhinney, it is important that the Family Physician be able to follow patients across boundaries and between contexts. This, according the literature and to practitioners, is integral to our understanding of the principle of continuity of care. The Family Physician must be involved "intensely" in the patient's illness process, and maintain an "unbroken responsibility to be available for any health problem through to the end" (McGill Introduction to Clinical Medicine n.d.: 5). This precept seems to place the family physician in a state of uninterrupted availability to patients, as well as give him or her responsibilities far beyond what is humanly achievable. The vague notion of "continuity of care" once again serves more as a tool for "boundary work" than as a practicable guideline for everyday action.

MCGILL'S VERSION OF FAMILY MEDICINE

Costa Ricans were introduced to family medicine primarily by McGill teachers and practitioners. It would be relevant, then, to ask to what extent McGill's model reflects the one described by McWhinney. In effect, McGill Family Medicine documents and principles are informed by McWhinney's model as well as that of the College of Family Physicians of Canada, which has four stated "integrated principles of family medicine." These are first, that the patient-physician relationship is central to family medicine; second, the family physician is a skilled clinician; third, family medicine is community-based; and fourth, the family physician is a resource to a defined practice population (McGill Family Medicine: Introduction to Clinical Medicine n.d.: 2). The "mission statement" defines the general goals of the Family Medicine training program in terms of four learning sources: patient encounters, curricular or theoretical material, supervisors, and a research project. A variety of distinct skills are to be acquired from each of these. Students on the two-year rotation receive training in "all major sub-specialties," (namely, general ward medicine, rural medicine, internal medicine, geriatrics / palliative care, perinatology, psychiatry, paediatrics, surgery, and emergency).in addition to maintaining "their own patients and their own practice. Residents return to the Centre for educational instruction, and for one to two half-days a week to see their patients, exclusive of block

rotations in the Family Medicine Centre" (Postgraduate Training Program in Family Medicine n.d.: 7). The programs vary slightly between teaching centres. Students have the option to work in a number of settings, urban and rural, in Quebec and in the Northwest Territories.

Apart from the program's goals, objectives, and theoretical stance, little has been written on McGill's approach to Family Medicine, and that of its teaching hospitals. Learning and teaching of the specialty are practice-based and tailored to the needs and circumstances of the teaching hospital or clinic. It was with a similar approach that McGill teachers undertook to train family physicians in Costa Rica. As we will see below, an important component to the Costa Rican aproach to family medicine (aptly renamed family *and community* medicine) that is less present in McGill's model is the notion of Primary Health Care.

FAMILY MEDICINE AS A UNIVERSAL MODEL OF HEALTH CARE

Most proponents of the Family Medicine model claim that it is universally applicable. For Stephen Spann, Director of Family Medicine at the University of Texas, Galveston, "Family Medicine is a universal movement, with universal principles that can be applied locally; I can work anywhere as a Family Physician - in Kenya, Uruguay, or Texas" (presentation to the First Annual Congress in Family and Community Medicine in Costa Rica, San José, September 1, 1994). For McWhinney (1989: 25), if the elaborated principles of Family Medicine

> have an enduring value, they should be applicable to all cultures and all social groups. . . Elementary public health measures are still the first need in many societies. But they are not the only need. Other problems will only yield to the personal, family-centered approach. . . . I believe that these principles have universal application. How they are applied, however, will vary according to the circumstances.

This argument reveals an epistemological tension between so-called "universal" principles and their "context-specific" applicability. Yet, rather than being contradictory,

these two aspects of the family medicine model are potentially mutually reinforcing; indeed, McWhinney and Spann seem to imply that this tension is almost constitutive of the specialty. We would add that such tensions tend to be characteristic of professions in general. Adapting Star and Griesemer's (1989) approach to professionalization, we can look at family medicine's principles as "boundary objects" that are "simultaneously concrete and abstract, specific and general, conventionalized and customized"(1989: 408). Boundary objects are

> both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual-site use. These objects may be abstract or concrete. They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds (1989: 393).

Thus family medicine, in Costa Rica and elsewhere, by creating and managing its "principles," maintains its coherence and contends for a certain social space over which it acquires "cognitive authority." This process Gieryn (1995: 405) calls "boundary work," a process that can be seen, in the Costa Rican case, as the attribution of certain characteristics to the institution of Family and Community Medicine, to its practitioners, values, methods, and work organization, in order to construct social boundaries that distinguish the specialty from other medical specialties, or, in fact, from other forms of health care provision.

The universalizing "principles" and corollaries used by family and community medicine in Costa Rica, as well as the practices and discourses of its teachers and practitioners, constitute boundary objects used to justify and promote jurisdictional expansion at both local and "universal," or international, sites. For example, the claim that Family Medicine has universal applicability and recognition is used to give the specialty credence at the local level. Similarly, the notion promulgated in Costa Rica that Family and Community Medicine is an ideal solution to local-level health problems lends

favour to the specialty in the eyes of health planners at the national and international levels.

To summarize, the claims to universality and contextuality as practical and practicable "principles" can, and ought to, be reformulated as boundary objects used by the profession and directed at ministries of health, international health agencies, and the World Bank to create a social (as well as economic, political, and cultural) space for a new medical specialty. To be sure, if the importance of "contextuality" is in actuality recognized by Family Medicine at the local level, then the modification of its principles to fit the context of non-western cultures would surely make the specialty difficult to interpret from "our" point of view. What is interesting about Costa Rica is that it is at once quite "western" and "non-western" at the same time, considering its status as a somewhat developed "developing" country.

Indeed, for the powerful actors at the national and international levels, the Costa Rican setting seems to be fertile ground for the implantation of their "universal" model. Costa Rica is a bridge between the "industrialized world" and the "Third World," a modernizing country the vast majority of whose population is of European descent. With a burgeoning middle class that keeps an envious eye on all things North American and consumerist, and with a health profile resembling more North than Central America's, it is the ideal laboratory for family medicine in the developing world. Certainly, Costa Ricans claim to have adapted and shaped the discipline to their own needs and, in the words of McWhinney and Spann, to their own context.

For example, Family Medicine and Community Medicine are two distinct specialties in North America, but Costa Ricans have combined them into one. This amalgamation is important, as it ties into the primary health care mandates and more general development policies of WHO and other international health organizations.

Another adaptation comes in the Costa Rican version of a Canadian discourse on family medicine. A Costa Rican document on the main principles of family and community medicine is virtually a direct translation of McWhinney, but with a number of additional stipulations. According to Alfaro (1994: 12), the Costa Rican family and community physician must "introduce the patient to the national health system, yet his

responsibility must not end once the patient has been referred to tertiary care. In fact, once the patient has left hospital care, the Family Physician must maintain a close follow-up, and integrate the patient back into a productive role in the community." Alfaro continues: the family and community physician must be available, on a constant basis, for any and all forms of health problems, regardless of the illness's causes, course, or prognosis.

This image of the family physician might seem unrealistic. Yet, despite the discipline's insistence that the family physician is not to be a "heroic figure," it goes on to portray the family physician in heroic terms. In Costa Rica, the family physician must be "available 24 hours a day, 365 days a year, and a ready counselor to his or her patients, available at all times" (BINASSS document 1993: 15, my translation). Yet in only a small number of cases, family physicians have become community activists, are available on call, and are willing to help their patients at virtually all hours; these individuals, however, are the exception and not the rule. Yet it is their comportment that is praised and their behaviour that is given as an example for other family physicians to follow.

This is further reinforced by the view in Costa Rica that there are significant differences between the family physician and the General Practitioner.

FAMILY MEDICINE AND GENERAL PRACTICE

For McWhinney, family medicine is the logical extension of, or successor to, general practice. The Family Physician has more training, and thus more "vision" and "contextual skills," than does the General Practitioner.

A publication entitled "El Medico Familiar y Comunitario en Costa Rica" (1993: 5), contrasts the two physician-types in seven ways. They are the following: a) The General Practitioner approaches problems with a curative intention. The Family and Community Physician gives preventive, curative, rehabilitative, and health promotion services; b) The General Practitioner loses control of his patients, transferring responsibility to specialists, due to the shortcomings of his training. The Family and Community Physician is able to resolve more than 80 per cent of problems presented and manages inter consultations and

references, but never loses responsibility for the case; c) After medical school, the General Practitioner must become self-taught in order to keep up with new medical knowledge. The Family and Community Physician participates in programs of continuing education; d) The General Practitioner confronts psychological problems in an empirical way, using common sense. The Family and Community Physician is trained in the behavioral sciences; e) The General Practitioner works on his or her own, without supervision. The Family and Community Physician works in a team and serves as coordinator for the different levels of care; f) Research forms a part of the Family and Community Physician's activities, as a means for improving the quality of care. For the General Practitioner, this is an unknown activity; g) The General Practitioner usually has his or her only training in medical school. The Family and Community Physician is trained in a structured and rigorous three-year program of post-graduate university studies, after which s/he obtains the title of specialist. These categories form a clear example of the "boundary work" that allows a profession or specialty to distinguish itself from other specialties or professions. It must be remembered that many of the claims presented above are based on the "ideal-type" for family and community medicine. In practice, most family and community Physicians in Costa Rica do not have access to the resources necessary to be able to conform to the above-mentioned categories. Certainly, in order to give curative, rehabilitative, and health promotion services, a family physician requires not only sufficient time for consultations with patients, but also a scheduling capacity for follow-up, and sufficient resources and personnel to be able to closely follow patients' progress.

One could argue, and indeed many actors in the Costa Rican health setting do argue, that many perceptual and social skills (and thus insights into patients' contextuality) come not with theoretical training in the behavioral sciences, but rather with maturity, openness, and a certain predisposition toward others and towards working for the community.[10] This reflects the struggle for cultural authority that occurs in the

[10]For example, VC, the Ministry of Health official in charge of health services for the Central Norte region believes that "it's not because one is a Family Physician that one is going to change one's way of thinking. I believe that it's something that comes in one's life experiences ["formacion pre-experiencias,

legitimation process of the profession, and a further tension between proponents of the model and its critics. These same critics might imply that the relative allocation of work within family and community medicine tilts in favour of professional development, to the detriment of actual health problem-solving at the ground level. Yet to oppose professional development to health problem-solving (actual or theoretical) would be to engage in a kind of deconstruction work that misses the essential link between the two. As Bourdieu (1975) pointed out in the case of the scientific field, technical capacity and social power, taken together, define scientific authority, as "a particular agent's socially recognized capacity to speak and act legitimately (i.e., in an authorised and authoritative way) in scientific matters" (Bourdieu 1975, quoted in Cambrosio and Keating 1983). In other words, strategies for developing a profession do not necessarily preclude getting the job (in this case, addressing and solving patients' complaints and families' and communities' health problems) done. Indeed, if we remember Abbott's arenas where jurisdictional claims play themselves out, we will also recognize that the struggle for social power is conducted in the process of work as as well as in "higher" social spheres. Thus, some instruments that Family and Community Physicians use to differentiate themselves from General Practitioners may seem more "attitudinal" than "skill-based," yet both seem to serve as tools for boundary work to justify the specialty as well as to intervene in community health issues. In the sociological literature on the professions and professionalization discussed in Chapter two, similar arguments are advanced by professional groups in order to validate and maintain their social position (see Abbott 1988, Foster 1987, Friedson 1970, 1973, 1986, Justice 1986, Star 1989, Stevens, 1971).

Fundamentally, then, we can interpret the difference between General Practitioner and Family Physician as one of status, or of standing in the relatively strict occupational (and

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pre-edad"] that makes it such that a person really has these aptitudes, these abilities for community work, for comprehensive care . . . University doesn't help to open up the mentality to the importance of working for the community, to the importance of promoting health, of doing prevention. Thus some people might intuit, obtain, or learn from a teacher who tells them, who motivates them, but the rest of the [medical] training doesn't motivate towards that, but instead towards being the best cardiovascular surgeon, doing the most sophisticated transplant, using the most high-tech mechanisms -- this is what it is to be a good doctor, so that's also the way the trend goes." (VC interview, 94-08-30).

thus social) hierarchy established in the health professions. The General Practitioner is just that, a general practitioner, an "undifferentiated physician," on the bottom rung of doctors. The Family Physician, on the other hand, somehow has superior endowments. S/he is a specialist (and ironically, a specialist of generality!) — one to rival specialists in other fields, to compete with them for recognition, status, and, of course, money. A Family and Community Physician, specialist in Primary Health Care delivery, family and community health management, participatory decision-making, a new, "holistic" or "comprehensive" (as opposed to biologistic or reductionist) diagnostic capacity, becomes indispensable to the country's health needs; a General Practitioner does not. This is not to say that all Family Physicians maintain this attitude; however, the institutional framework at the national and international levels encourages it.

PRIMARY CARE AND THE FAMILY PHYSICIAN'S ROLE

The movement to a new paradigm of Primary Health Care has taken on new force in the world, and especially in Latin America since the deep economic crisis of the early 1980s. The goal set out in the 1978 WHO/UNICEF Alma Ata conference, of "Health for All by the Year 2000" (HFA 2000),[11] has required a new and specific "universal" health care strategy, distinct from previous strategies. This strategy has been called Primary Health Care (or PHC), and must not be confused with the primary level of care, or with basic health services. The latter can be considered to be the lowest rung or the entry point into the health care hierarchy, at which point problems are generally referred to and solved by biomedical specialists, without the input of individuals or communities. PHC,

[11]The WHO has defined "health" as "a state of complete physical, mental, and social well-being, and not just the absence of disease" (from Jaramillo Antillón 1993: 26). HFA 2000 is defined ideally as a minimal level of health that permits all citizens of the world to work productively and to participate actively in the social life of their community, and pragmatically as a series of quantifiable goals. For the Americas, the minimum health goals established by the WHO and PAHO are the following: Life expectancy of at least 70 years; infant mortality at less than 30 per thousand; child mortality (1-4 years) at less than 2.4 per thousand; vaccination services to 100 per cent of children under the age of one, and to 100 per cent of pregnant women; drinking water and human waste disposal coverage at 100 per cent; and health services coverage of 100 per cent of the population (Kroeger and Luna 1992: 6).

on the other hand, is an approach that attempts to solve or prevent most health problems at a local level, while involving the community in its own health processes.

Primary Health Care, the new panacea that promises to help achieve HFA 2000, has been defined as "essential health services, based in practical methods and technologies, scientifically based and socially acceptable, put within the reach of all individuals and families of the community, engaging their participation, and at a cost that the community and the country can support during each and every stage of its development, with a spirit of responsibility and self-determination" (Kroeger and Luna 1992: 5, my translation). Primary Health Care is conceptualized as the nucleus of national health care systems, as well as an important component of community social and economic development. It is the first level of contact between individuals, families, and communities with the national health system, and brings health care as close as possible to homes and to the workplace.

The important elements are universal access, health promotion and prevention, combined with adequate treatment and rehabilitation, universality, equity, and continuity; satisfaction of priority health needs such as mother-child health, and vaccinations; and, of course, "community participation" (CP). As we have seen, CP is a concept fraught with political and moral connotations, yet is used in a relatively neutral and positive way by health theorists.

Family Medicine and Primary Health Care are intimately related in Costa Rica and in the developing world: in theory, the role of the Family Physician is to provide Primary Health Care, either directly or indirectly, to his or her community. Where resources and the supply of Family Physicians are limited, the Family Physician is expected to play a coordinating role within the existing health care team, which likely consists of nurses, social workers, psychologists, administrators, primary health care workers ("técnicos de asistencia primaria," or TAPs), and CHVs (community health volunteers).

The Family Physician's role, thus, is that of administrator, teacher, provider of health care, and the locus around which revolves the delivery of all non-hospital based and "non-traditional" (in the sense that the "old, biomedical model" is "traditional") health services. He or she is the purveyor of good health to the community, engaging the

population in responsible and healthy activities, and acting as a key player in the social and economic development of the community.

FAMILY AND COMMUNITY MEDICINE AS AN EMERGING MOVEMENT

In 1994, family and community medicine was attempting to combine principles of traditional curative biomedicine with those of traditional preventive public health, and to embody those principles in the person of the family and community physician, at once a health professional, a community leader, an expert on disease and cure, yet a practitioner of prevention. As a movement, family and community medicine in Costa Rica was only beginning to establish itself and its "esoteric" body of knowledge, and was relying heavily on a certain "political will" in order to entrench itself institutionally. Although all health institutions ostensibly endorsed the prerogative of family and community medicine as the new community-based primary health care manager in the reformed system, it was up to the senior health officials to authorize the creation of posts specifically for family and community physicians. At the time of the study, this did not seem to be happening; rather, many newly trained family and community physicians were obliged to opt for positions allocated to GPs. Hence, many family and community physicians felt that they were qualified specialists, but unable to obtain work in their field.

The creation of a "labor-market shelter" (Freidson1986: 59) was a slow and frustrating process, and family and community physicians were feeling hampered in their efforts to legitimate their profession. Not only official recognition of their training, but a well-defined social and institutional space in which they were to work seemed to be the most important requisites for family and community medicine to flourish in Costa Rica.

These notions were reinforced at the First Annual Conference on Family and Community Medicine, held September 1-3, 1994, in San José, which was well attended not only by family and community practitioners, but also by other physicians and health workers such as nurses, social workers, psychologists, and public health researchers and professors. Notably, the three most important health officials in Costa Rica (the Minister of Health, the President of the CCSS, and the Pan-American Health Organization's

mission chief) attended the opening ceremonies, and a letter from Costa Rica's president was read to the assembly. From this show of officialdom, one could assume a wholesale official support for the specialty from the government and its health representatives. However, family and community physicians still perceived there to be a lack of resources and a lack of real political commitment to their cause, and to be allowed to lead the health teams, or EBAIS, that were planned for in the health care reform.

Indeed, at the "Jornadas Pre-Congreso," or pre-conference meetings, held at the club of the College of Physicians and Surgeons of Costa Rica on June 16-17, 1994, documents were drawn up that identified the relevant actors (individuals and institutions) to the processes of "developing the practice of family and community health" and of "developing continuing education in family and community health." From the President of the Republic, down through the health bureaucracies, universities, health workers' unions and practitioners, the intentions, capacities, needs, alliances and conflicts of all actors deemed relevant to the family and community medicine project were identified. For example, under the rubric of the "development of continued education in family and community health," the University of Costa Rica's Department of Public Health was deemed a strong ally, with a "major interest" in the project. In comparison, the Minister of Health was identified as having a "formal, political interest," the director of the School of Medicine had a "relative interest," and the director of the Puntarenas Health Centre was "against" the project.

According to DM, family and community medicine in Costa Rica was facing a number of threats. These were lack of time for health planning; lack of impact measurement; lack of family physicians and of resources; lack of administrative independence; and difficulty in integrating community participation in health. These, he juxtaposed with the "strengths" of the specialty, or rather, the potential for strength: that health planning can lead to measurable results; impact measurement requires and encourages democratization and participation; an increase of preventive care would have a significant impact and reduce the cost of health care; health education and continuity in practice are important components of the specialty's mandate. The "threats" seem to be

tangible problems or frustrations the specialty faces; the "strengths" seem to be less tangible, more of a wish list.

DM identified "political will" as the principal avenue for progress, to overcome the frustrations, and to fulfill the wish list. As an example of "political will" he mentioned the fact that GA, one of the first graduates of the specialty, was now a regional health director. The insertion of colleagues into positions of power in the health bureaucracy was perceived to be a sign of progress, and an indication of the presence of a "political will" that would promote the cause of family and community medicine.

POLITICAL WILL, OR "VOLUNTAD POLITICA"

All interview respondents noted independently, and without prompting, that institutional change and the implementation of the "reforma" required a certain political will ("voluntad politica"). Yet this political will seemed to come from somewhere "above," in a typically Costa Rican fashion. The paternalistic state is generally perceived to provide resources, directives, and guidance to its subjects; this attitude is not absent from the realm of health care. AC identified the minister of health and the executive president of the CCSS as the ultimate purveyors of health policy, and those capable of engendering and effecting change. There was little perception that change could occur outside of official dictates from above.

For example, most family and community physicians claimed that the "real" implementation of family and community medicine in Costa Rica depended, ultimately, on the political will of the MS and the CCSS to recognize, fund, and make institutional space for the specialty. Similarly, patients at the clinic in Puerto Viejo recognized that the quality of health services would not improve until there was the "political will" to provide additional funds and staff.

Representatives from "above," however, seemed to be non-committal to the family medicine specialty. Although they made themselves present at the first annual conference on family and community medicine, they made few promises of funding or institutional aperture for the new specialists. Many family and community physicians were looking to

ambitious colleagues who were fast climbing the bureaucratic ladder in the Caja or the Ministry, to provide the necessary "political will," given their newly acquired institutional clout. Yet, for the specialty as a whole, there seemed not to be a concerted strategy for cultivating this political will. In the words of EJ, one of the first graduates of the program and now a senior bureaucrat in the CCSS,

> The problem with family physicians is that they have chosen responsibilities but they have not demanded the "logistics," as they call it in war. . . . As the system didn't absorb the family physician, each one has applied what I call the "law of alleluia." Each person to himself. And so, there is no systematization. And it' a problem. . . . There are regions where a family physician has conceptualized health care in one way, and others in another way. And others in yet another way. . . . And family physicians don't know what to do, because they don't have a clear conception of their role within the health system. And that's the threat. . . . What we need are FCDs who have the capacity to lead, to be leaders.

FAMILY AND COMMUNITY MEDICINE AND SUSTAINABILITY

Understandably, many family and community physicians were frustrated at a perceived lack of institutional space for them. The new specialty still was not popular amongst recent medical graduates, and, despite the lip service paid to primary health care and family medicine in official discourse, little official, tangible support for the specialty was evident. Yet, amongst the professional classes, change comes but slowly. As Freidson tells us, the major characteristic of the medical profession is a certain preeminence of prestige and expert authority. Medicine requires a "general public belief in the consulting occupation's competence, in the value of its professed knowledge and skill" (1970: 10-11). Furthermore, the professional group's success is less dependent on training than on "the evaluation of such involved observers as legislators, the public, and representatives of other occupations . . . , and the criteria used by each of these may differ from the other's" (1970: 80). Thus, a clear indication that a specialty is actually "successful" comes only once recognition is obtained in these fora. RCG, the first person

in charge of family and community medicine in Costa Rica, stated to the first annual conference:

> Remember that we live in a political environment . . . as politics is so important in CR, we must have at least one foot in the political door. If our friends in high places ["compañeros en la politica," e.g. GA] keep to their principles, we can surely have an impact. The model and its results still cannot be measured. The impact will be felt over the long term, in ten years. But we must keep applying ourselves, infiltrating the system, in order to maintain the changes. And up until now, there have been big changes, although we haven't seen them directly. What we must do is keep on with the residency, and to assure ourselves that the program doesn't die. The health administrative bodies talk about nothing else but the principles of family and community medicine, even though they won't name it as such, or admit to it. Be optimists, but be patient. Your biggest work will be with the communities. The impact will be there, permanently, even when the Caja administration changes every four years.

It seems, then, that what family and community medicine was looking for, in addition to its altruistic goals of streamlining and improving the approach to health care, and, by extension, the overall health of Costa Ricans, was a certain institutional, political, and popular recognition as the new, improved purveyor of "Health for All." In particular, there was a need to be recognized by other specialties, and thus to other audiences within medicine, that often viewed family medicine as a glorified general medicine, a specialty to which turned principally those physicians who were not "good enough" to get accepted into specialties such as surgery, pediatrics, and gynecology.

The practical reality for family and community medicine in Costa Rica was that it was still but an emerging specialty, and it needed, in order for its practitioners to approach their ideal type, to assure for itself a certain position in the institutional hierarchy. This meant assuring funding for family and community medicine programs and positions; ensuring that there is political support amongst the important decision-makers to facilitate the development and growth of the profession; promoting the specialty as a viable one for recently graduated GPs to enter into; and lobbying in local, national, and international communities to convince people involved in health care that the family and community

medicine model is the best guarantee of an efficient, affordable, and improved health care for the future.

In discourse surrounding the family and community physician in Costa Rica, the "ideal" version of the practitioner seems to dominate, and the "real life" version is mentioned only in passing, often tinged with disappointment. For example, according to AC, the physician in Puerto Viejo de Sarapiquí, the role of the family and community physician is to

> attend to, in a comprehensive manner, a population group. By attending to the group in all its aspects. Not only in the curative aspects, as is normal here, but also in matters of education, prevention, rehabilitation, training . . .. Also it is the physician's role to incorporate him or herself into the community, in researching and determining problems, by identifying with the people's needs, and by collaborating in the mechanisms for solving problems in sanitation, or basic needs of the population. Not necessarily medical services. Other services may also contribute to improving health: potable water, communications, transportation, roads: these also are matters that I believe the physician must deal with, and not only the direct attention of health problems as such . . .

Of course, he and most other newly-trained family and community physicians in Costa Rica cannot and do not live up to the expectations they set out for themselves. AC was not able to apply his perceived principles of family and community medicine, for a number of reasons:

> for my particular situation as a director. . . . the real conditions are not given, due to the low supply we have of services and the high demand for care, both curative and preventive. In other words, we are limited and a great part of my time is not now oriented towards treating patients. . . [rather] much time goes towards administration, which I am in charge of. . . . At this moment, I have not dealt with families, and the situation is very difficult because of the lack of personnel, and we have a high demand for services, mostly curative ones . . .

This contrasts with the image of Barranca painted by GA, the clinic director there. According to him, he already had conducted community consultations, and came up with and prioritized health concerns of community representatives. It appeared, however, that these consultations were done on his initiative; by the end of the research period, GA had

been posted to the position of regional director of the CCSS, and was no longer in charge of the clinic.

DM, one of the more "successful" graduates of the family and community medicine program,[12] identified by McGill's department of Family Medicine as a top performer, perceived an institutional shortcoming in the provision of health care:

> In Coronado, RB [an ambitious family physician] organized the EBAIS; he's a great administrator, and knows the principles of how to make it all work. But we haven't given enough weight to the implementation of community medicine. For example, we could do work with schools or with housewives. But up to now, we only have promotional activities, without clear goals of what the programs really want to accomplish. We still haven't thought how to evaluate these. . . . We must carry out this evaluation in a very scientific way, not as we have done in the past. Up until now, we seem to have been just thinking up programs, carrying them out, and then that's it. There is no follow-up at all. We have no idea what kind of impact we're having. Which means that there is not much continuity of care.

His discourse seems to indicate that health problems and their alleviation simply required better technical capacity on the institutions' behalf, and better tools to effect and evaluate behavioural change in the community. However, DM was well aware of structural and social "problems," but did not have an adequate solution for them. Similarly, AC noted: "another problem is the low socioeconomic level, but what can we do about it? Not much, I don't think." This comment speaks to macro political and economic conditions that the "model" does not or cannot challenge. Morgan and Ferguson criticize international development agencies for precisely this: that they provide "technical" solutions to what they perceive to be "technical" problems, without addressing the structural causes of inequality, subordination, and poverty.

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[12]In terms of "professional achievement," DM ranked among the highest of the specialty's graduates. In 1994, he was a teacher of the family and community medicine in Coronado. In 1995, he was working as a consultant for PAHO and the CCSS, where, he felt that "with the position that I have [i.e. not practicing family medicine full-time], I can develop as a complete professional." DM's ambition is to become Minister of Health.

DM, AC, and others wanted to see the "impact" of preventive measures and community interventions quantified, and find that, given the less "technical" nature of the work done by family physicians, it is more difficult to quantify their actions for purposes of impact evaluation. The desire for "measurable results" are a principal theme that ran through the discourse, that seemed essential to the legitimation of the work of the family and community physicians. AC, however, had a clear understanding that this level of discourse had to be espoused so that health planners would understand his needs and those of his patient population:

> I believe that we would need to quantify, in some form, the preventive work or the preventive tasks that the family physicians carry out. Because in the present circumstances, in current statistics that are used by the Caja, this cannot be quantified. One cannot put a number on how many preventive activities a physician has done; the statistics sheets that the Caja have are nothing but how many patients have been seen. This is how they see the yield ["rendimiento"]. . . . So, it's also necessary . . . to give an importance to preventive activities, quantify them, and make use of statistics.

The target audience for this discourse clearly were the health institutions, where the specialty perceived it had to apply pressure in order to be able to grow. On the other hand, family physicians appeared to be resigned to the notion that the impact of their work at the local level was necessarily limited. An analytical description of the local clinical reality and health care conditions in one community follows in the next chapter.

CHAPTER FOUR — MICRO STUDY: PUERTO VIEJO DE SARAPIQUI

INTRODUCTION

Puerto Viejo de Sarapiquí as a site for field research was at once exceptional and typical. On the one hand, massive recent in-migration of banana plantation workers put great strains on public services such as health care. On the other hand, conditions at the clinic there did not appear to differ to a great extent from those in other clinics across the country. Although an extensive comparison with other towns or villages was not an option for the researcher, it was apparent, through discussions with health care workers from various locations, that Puerto Viejo was not untypical. Many health workers came to the conclusion that publicly-funded health care in Costa Rica as a whole suffered from a lack of resources.

Data obtained in Puerto Viejo can by no means be said to be representative. However, they are useful in illustrating not only the state of health care at the level of service delivery, but also in illustrating the distance that separates theory from practice, as well as the challenges that lay in front of the proponents of the new model of health care. Tensions between professionalizing claims of family and community physicians, on the one hand, and local-level needs and prerogatives, on the other, become evident from an understanding of the conditions in Puerto Viejo de Sarapiquí.

This chapter will explore the local-level health care dynamic in a descriptive fashion, following the themes evoked in previous chapters. Where possible, a comparative approach will be used, taking examples from other communities and clinics visited during the course of the research period, such as Barranca, Coronado, and Los Sauces. Barranca is a poor urban community 11 km inland from Puntarenas, Costa Rica's major Pacific coastal city, which boasts one of the most "successful" family and community medicine programs; Coronado's new "integrated" clinic in a northern suburb of the capital San José is also a teaching hospital for family and community physicians in training; Los Sauces is a squatter settlement of 3200 residents outside the town of Tres Rios, about 15 km east of

San José, whose community clinic is run by one of the first graduates of the family medicine program.

DEMOGRAPHICS

Puerto Viejo de Sarapiquí is essentially a frontier town, the main economic activities of which are the banana, timber, and cattle-raising industries. In the late 1980s, a number of banana companies introduced operations to the area, and proceeded, over subsequent years, to buy up land from the government and from local landowners, to raze the existing crops or forest, and to replace them with huge plantations. A new highway had been completed in 1990 that reduced the travel time to San José from seven hours to ninety minutes. Although few data are available on the extent of the plantations, their impact on local demographics and economics nonetheless has been significant. The massive in-migration of people seeking work is reflected in data we collected on patients at the CCSS clinic, 28 per cent of whom had moved to the district in the previous two years. Fully 55 per cent of respondents were not residents of Sarapiquí county in 1989. Furthermore, 60 per cent of patients who worked outside the home were employed by banana plantations (Locher and Scyner, 1994).[13]

Figures from the Ministry of Economy, Industry, and Commerce put the county's population at 26,432 in July 1993, whereas Ministry of Health figures were significantly higher (VC, the head of medical services for the Ministry of Health in Heredia province, claimed that the population had gone from 8000 in 1990 to 48,000 in 1994).[14] The disparity between these figures is significant for projecting health care needs for the

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[13]The results of this survey pertain only to patients of the CCSS clinic. However, it can be assumed that figures obtained at the clinic are representative of the population as a whole. 60 per cent of patients claimed to be "housewives."

[14]JVP, in charge of the civil registry in Puerto Viejo, estimated the population at 25,000, not including "immigrants" (Nicaraguans). His electoral list contained 9000 registered voters in 1990 and 13,000 in 1994. 60 per cent of Costa Rican migrant workers resident in the canton were not on his list, as they voted in another district. (interview 94-07-01)

population. Although at the time of the study, the construction of a new, larger, integrated clinic was being planned, according to VC, the health demands of the population already exceeded the projected supply. This was contradicted by MLP, a CCSS official, who indicated that population growth was actually slower than expected, thus the new clinic could be smaller than what plans called for.[15]

Economically, Puerto Viejo was better off in 1994 than it was prior to the arrival of the banana companies. According to JVP, the local civil registry official, "there is work here for everyone who wants it. Nobody can say that they can't find a job." Yet most of the work available was long and arduous, and many residents, whose primary motive for living in the county was to make money, seemed little interested in civic responsibilities. Macho plantation culture fostered alienation and violence, and any potential for change through collective action was mitigated by a rigid and hierarchical division of labour. Workers' frustrations often manifested in the form of violent assaults against fellow workers or supervisors; machete wounds were a common sight at the clinic, and stories circulated about murders and disappearances. A substantial number of workers were Nicas (Nicaraguans), who had fled a country where civil war had made collective or political action a perilous activity. Many Tico internal migrants would prefer to be with their families "back home." For HV, the head of the Pan-American Health Organization in Costa Rica, these

> communities . . . had a strong migratory movement, . . . are recently constituted, 10, no more than 15 years ago, . . basically from Nicaragua. And the individual and collective psychology of those migratory individuals where there are very few unifying factors . . . [makes it] such that each individual lives in a rather isolated way, . . . there is indifference in the face of collective problems; each person does his own thing, trying to earn a resource, money, to be able to return to his roots.

Whether this observation has sociological or practical significance is difficult to say. However, it is likely a fair characterization of the "banana culture" of Puerto Viejo. According to many longtime town residents, Puerto Viejo had undergone a radical transformation since the banana companies had moved to the region. The impact of the decisions of multinational conglomerates such as the United Fruit Company cannot be

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[15]Quick and abundant population growth, and the changes it entails, were not unique to Puerto Viejo. The popoulation of Barranca, in comparison, was 7, 056 in 1981, 15,882 in 1984, and 21,122 in 1993 for a growth of 200 per cent in 13 years (from González Pantaleón 1995: 66).

underestimated; the strain placed on health services in the area by massive population growth due to a demand for plantation workers has been significant.

SUPPLY AND DEMAND OF HEALTH SERVICES: PREVENTION VS. CURE, and DO PATIENTS CARE ABOUT THE DIFFERENCE BETWEEN THE TWO?

Health care in Puerto Viejo de Sarapiquí in many ways reflects the broader, macro, structural trends in Costa Rica, discussed in the previous chapter. At the time of this study, health resources in Puerto Viejo included two publicly funded clinics as well as two private practices. As in most of the rest of the country, "curative" care was provided at the CCSS clinic, and the Ministry health post, only a five-minute walk away, was in charge of "preventive" services. On average, three physicians worked in the CCSS clinic, two out of the ministry's health post (one of whom went on community visits), and two worked privately, for a total of seven. During the course of the three months, however, one private practitioner left, seeking greener pastures, and one of the physicians at the Ministry health post finished his contract. One nurse worked at the CCSS clinic, and several TAPs and malaria prevention workers, as well as a mobile dental team that did school visits, were based at the Ministry health post. The town boasted one private dentist's office, two privately-run pharmacies, and the government-run pharmacy at the CCSS clinic, where prescriptions were filled free of charge for patients covered by social security.

The distinction between "curative" and "preventive" care is very important one in Costa Rica; health institutions and practitioners have traditionally divided up their work along these two parameters. Although "cure" and "prevention" are difficult to separate in practice, the institutions charged with their execution are quite distinct. Despite national and international policy calling for the integration of institutions and approaches to care, a clear separation still existed at the local level.

The manifestation of the institutional division of labour in Puerto Viejo was easily observed: the CCSS clinic, in its role as "curer" of sickness, was normally full of patients seeking medical care. The Ministry health post, in its "preventive" capacity, often

seemed idle, without patients. Of course, much of the Ministry's work was done in the communities by TAPs and the mobile medical unit, and as such, was not visible to the observer in Puerto Viejo. However, the contrast between the levels of activity at both clinics was still striking. This was evident also in Barranca, where the CCSS clinic was mostly teeming with patients, and the Ministry clinic in nearby Puntarenas appeared to function well below capacity. GA, the director of the Barranca clinic quipped, on an impromptu visit to the Ministry clinic in Puntarenas, "You'll likely find the director in his office reading the newspaper." As it turned out, the director was not to be found at all.

To link "prevention" to an "empty" clinic, and thus to imply that the Ministry was not doing its job, would be problematic. Certainly, the image of the empty Ministry clinic was a recurrent one during discussions with health officials, especially from the CCSS. Some even accused Ministry workers of being lazy and uncultured. Yet in theory, if prevention were effective, then there would be a reduced need for visits to the clinic. Furthermore, demand for curative-type care is much higher and more visible than that for prevention, hence the long queues outside CCSS clinics.

THE CCSS's "CURATIVE" CARE

The CCSS clinic was located on the town's main street, enclosed in a fenced-off compound that was kept locked at night. The buildings included the clinic itself, with a small area for a reception desk and patients' files, three examining rooms, a small office for the administrator and the clerk (whose role was to issue social security cards), a small air-conditioned pharmacy, and a small waiting area with a capacity for seating no more than twenty people. Adjoining the clinic were the offices of the "sucursal," or the fiscal branch of the CCSS which collected social security fees, and three small housing units, occupied by AC, GM, the young doctor on social service, as well as JM, the head of the "sucursal." All three, and indeed, all physicians at the clinic had their permanent residence elsewhere, for the most part in San José. AC was a fairly low key person, who made few excursions into the community of Puerto Viejo. He spent his weekends and some evenings at home in San José with his family.

Demand for "curative" health services in Puerto Viejo far outstripped supply, as evidenced by long queues outside the CCSS clinic in the morning before opening time. This is not unusual, however; indeed it is commonplace at clinics across the country. The waiting room in Barranca was usually full; in Coronado, most wickets giving appointments with physicians were closed by noon. Patients in Puerto Viejo, and elsewhere, were often turned away from the clinic, as there was no time to accommodate them. In a given day, the limited number of appointments depended on the number (one to three) and availability of doctors, as well as the number of patients they were able to see. CCSS regulations stipulate a maximum of 35 patients per doctor per day, yet this number could be as high as 50 or more. Patients were given a number when the doors opened in the morning, then had to wait, sometimes hours, until their number was called. Often, patients would be turned away, or would be refused an appointment if they arrived after the day's quota was filled. This did not bode well for people who had to travel a significant distance (from a community downriver, for example), and whose only means of transport would bring them to Puerto Viejo too late in the morning to be able to make an appointment. This is not to say that emergency cases were not looked after; these would generally be attended to, or sent by ambulance to a hospital in San José or Guápiles.

Patients were well aware of the limitations of the clinic, and they often planned their visits accordingly. If they lived in a distant community, they might, for example, do their shopping while waiting for their appointment. Although many patients expressed dissatisfaction with the services rendered, just as many claimed to be satisfied.[16] Patients attributed their dissatisfaction not to a lack of goodwill on the physicians' part, but to a shortage of personnel or resources. Furthermore, it seemed that those least likely to display dissatisfaction were also those at the lower end of the socioeconomic scale.

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[16]Although many patients might have had reservations about stating open criticism of the clinic, a survey conducted in the clinic found that 51 per cent of respondents thought the treatment they received was "good," 41 per cent indicated "regular," (translation: "OK" or "not bad") and 7 per cent said "bad." Interestingly, 62 per cent of respondents who were foreign-born (all Nicaraguans), answered "good," compared to only 40 per cent of respondents born in Sarapiquí county.

Discrimination against residents of isolated or distant communities, in terms of access to "curative" care, was a notable structural limitation of the clinic's service delivery. The rural character of Sarapiquí county ensured that a large number of its residents had to travel a significant distance and sacrifice valuable work time in order to reach the clinic. In comparison, the small clinic at Los Sauces, a squatter settlement about 30 km east of San José, served a distinct population who all lived in the community, a 10-minute walk from the clinic. According to GW, the director of the Los Sauces clinic, access to care was easy, and patients could show up at virtually any time and receive treatment. Similarly, in Barranca, a mostly urbanized community, service tended to be provided to all patients who came to the clinic. According to the clinic's statistician, no patients were turned away: "If there are patients at the end of the day, after 3 o'clock, the director [GA] will always see them. The director will always see patients."

In terms of personnel, the supply of "curative" services in Puerto Viejo was often sporadic. First, characteristic of the country's overall shortage of nursing staff (due, in AC's opinion, to unattractive salaries and schedules), there was only one nurse, despite budget provisions for two. A lifetime resident of Puerto Viejo, the nurse, RA, had been employed at the CCSS clinic for twelve years, and had no plans to leave.

In theory, RA could not be replaced in the case of illness or accident. In practice, ML, the clinic's administrator, would take over nursing duties, such as taking patients' signs or administering vaccines, in RA's absence. This reflects a certain occupational flexibility in practice, or, in Abbott's terms, a blurring of disciplinary jurisdictional boundaries. Although the division of labour in the clinic was strictly defined by rules of professional jurisdiction, the "boundaries of actual professional jurisdiction change[d] to accomodate organizational imperatives" (Abbott 1988: 65). Abbott claims that in overworked worksites, these boundaries disappear, and a certain transfer of knowledge, or "workplace assimilation" occurs. "Subordinates and others . . . learn on the job a craft version of given professions' knowledge systems" (1988: 66). Thus, the administrator would give injections; the receptionist would fill prescriptions; the pharmacy technician ("técnico de farmácia") would give medical advice.

This type of assimilation was acknowledged, and in fact encouraged in Barranca, where the director GA and his staff took "teamwork" seriously. While interviewing candidates for pharmacy technicians' positions in Barranca, GA made clear to the candidates that "this clinic doesn't work like the rest. Forget what you learned in your traditional clinics. We work as a team here, and team members go out of their way, beyond their job description, to make sure the clinic works for the community."

In Puerto Viejo, the physicians —those highest on the occupational totem pole, and thus with the most to lose by taking on "subordinate" tasks — would tend neither to engage in extra-jurisdictional activities, nor to allow others to engage in doctors' activities. In this way, they made themselves indispensable to the delivery of medical services, such that when no doctor was available, the clinic simply ceased to function. This can be illustrated by fieldnotes I took on June 27, 1994:

I arrive at the clinic at noon. A person is being taken out on a stretcher, to be delivered by ambulance to the hospital in Guápiles. Already this morning, a 13-year-old girl was rushed to the Calderón Guardia hospital in San José, to have her crushed arm amputated. Her school bus lost its brakes and pinned her arm against a wall. A third ambulance exit had to be made for a woman in labour — she gave birth in transit.

The clinic is virtually empty. All appointments were cancelled today, due to the emergencies in the morning. Two of the doctors had to leave in the ambulances, and the nurse is on holiday. A replacement nurse hasn't shown up.

FG, the young doctora doing her year's social service after medical school, is agitated. She has just returned from accompanying the girl in the ambulance, and is shaken up. GM, the other young GP doing social service seems unperturbed, saying the required "too bad", engrossed in the newspaper.

Although the day's work is over by noon, everyone exclaims that there are not enough personnel to carry on the functions of a clinic here. Clearly, this is not a typical day. However, if the clinic has to shut down or turn away patients every time an emergency comes in, something is amiss. Staff claim also that to do the night shift is virtually impossible, as there is no security guard, and night-time cases tend to be dangerous drunks.

Only days after this entry, AC decided to eliminate emergency night-time services for "security reasons." AC wanted more than just a doctor available after regular closing

hours, considering that late-night patients were potentially inebriated or violent. He wrote to CCSS head office in San Carlos asking for funds to cover wages for a nurse, a pharmacy attendant, and a cleaner, to accompany the physician. In so doing, he seemed to be demanding that his superiors grace his clinic with a certain "political will." In a sense, AC was asserting his jurisdiction by defining the boundaries of the services his clinic was going to provide. In practice, this created tension at the local level by putting extra pressure on the Red Cross, which, with two sparsely equipped vehicles manned by volunteers, was in charge of ambulance and some first-aid services. Patients in need of emergency care after 4:00 p.m. had to go either to one of the two private practitioners, or to the Red Cross for ambulance transport to the hospital in Guápiles or San José. By the end of the study, two months hence, emergency night-time services still had not been restored.

"PREVENTIVE" CARE AT THE MINISTRY'S HEALTH POST

The situation was much different in the Ministry of Health clinic down the road. Much of the time it laid empty, apart from a few workers hanging about. Most of its employees were on the road, on community visits. The four or five TAPs (técnicos de atención primaria, or primary care technicians) generally would leave by 7 a.m. on their motorcycles to outlying communities, as would the mobile medical unit, comprised of one doctor (JCC), a driver who doubled as a pharmacist (Benito), despite having no training in pharmacy (another example of the blurring of occupational jurisdictions), and a TAP, whose duties were not unlike those of a prep nurse in North America. The Ministry of Health also provided a malaria prevention unit, as well as a mobile dental service, comprised of a dentist, a TAP, and a driver, who would service schools in the area.

Services provided by the Ministry of Health were of a "preventive" nature, in theory. Malaria workers would administer chloroquine and primaquine tablets to residents of homes within 200 m of a suspected (or real) malaria case, and would often fumigate where malaria-carrying mosquitoes were believed to breed. In certain cases, they would

show up at a suspected malaria site unannounced to community members (and hence without community input into the decision-making), and proceed to carry out their fumigation. Another "preventive" measure was milk distribution to poor mothers as nutritional supplements for their babies. In theory, mothers could come to the Ministry of Health on Fridays to pick up supplies. In practice, however, some of the Ministry's work, such as milk distribution, could not always be carried out.[17] Thus, although many Ministry employees and officials spoke of a "mística," or mystique, their grand ideals often did not translate into practice.

Another of the main functions of the Ministry of Health post was to deliver care to those who were not eligible for Caja coverage. One must be a salaried worker or a dependent thereof in order to be insured by Social Security and thus to have to right to comprehensive health coverage from the CCSS (Jaramillo 1993: 365). This implies that indigent people, the unemployed, many self-employed people, and employees of clandestine enterprises (who often ask employees to join the CCSS as "self-employed," in order to avoid the employer's contribution) are not necessarily covered under the national health insurance scheme.[18] The Ministry of Health preventive and primary health care services usually would reach these non-insured individuals, who either come to the Ministry of Health post for medical attention, or receive it if and when the mobile medical unit passes through their community. Of course, there was not always a physician on duty at the health post.

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[17]Such simple procedures as milk distribution at times turned out to be somewhat complicated. On Friday, July 1, I went to the MS health post at 7 a.m. to see how many women would be waiting for their milk. Only three women, babies in tow, were there. It turned out that the person in charge of the distribution got called to a meeting, and without notice, cancelled the milk distribution for that week. Nobody in the health post took over the task, and mothers went home empty-handed.

[18]For example, "Conejo," a "peasant" landowner in the community of La Aldea, a 5 hour, 180 km drive from Puerto Viejo (but 35 km as the crow flies), along a circuitous and treacherous route, claimed that he generally could not afford to pay his "cotisación" to the CCSS. Rather, he paid only when his wife was pregnant and the children were small, in order to receive CCSS coverage.

THE MOBILE MEDICAL UNIT

The Ministry of Health's "Unidad Móvil" serviced approximately thirty-two communities within the Puerto Viejo catchment area. Typically, the mobile team would leave Puerto Viejo between 7 and 8 o'clock, and would arrive in the community between 8 o'clock and noon. Transportation was either over land (in a Toyota four-wheel-drive donated by the Government of Japan) or by water (in an aluminum outboard-powered motorboat). Each community was scheduled for a visit once every five weeks or so. Some communities conducted the clinic in a schoolhouse or other public building, others had a recently-built two-room health post, designed and put up by the United Nations' High Commissioner for Refugees.[19] These buildings had modern wiring and plumbing, however, most communities visited had no electricity, and water generally came from a communal well.

The medical team brought with them several large boxes of standard medications, along with basic diagnostic and vaccination equipment. In general, following the prescribed division of labour, the TAP would take down patients' vital signs and personal information, the physician would then carry out an examination and make necessary prescriptions or referrals, and the driver/pharmacist would fill the prescriptions. They usually would see all the patients who showed up: on one occasion, the number was as high as 85; on another, only one.

All communities had either an individual or a health committee that publicized and organized for the mobile unit's visits, and collected a standard 100 colones (about $1 CDN in 1994) contribution from each patient towards clinic expenses and food for the medical team. Two of the ten outlying communities visited during the study appeared to have active health committees, however, the extent of their activities was difficult to

[19]The UNHCR had been active for several years in northern Costa Rica with refugees fleeing from civil war in neighbouring Nicaragua.

determine.[20] Morgan (1989) has indicated that the creation of rural health committees was carried out at the behest of the Ministry of Health, but suggests that these efforts were "designed to benefit the state by shifting some of the costs of the program to the rural citizenry" (1989: 235). Certainly, a 100 colon contribution was not an insubstantial fee, especially for individuals, such as subsistence farmers, who did not participate in the cash economy.

For example, Finca 10, a well-organized, unionized, plantation-worker community of about 1600, had a functional health committee that met on Fridays, and, once a month, carried out milk distribution. According to the woman in charge of the health post, the committee was made up of nine people from two communities, Finca 10 and Colonia Los Angeles. She indicated that a number of communities depend on the health post at Finca 10 for medical attention when the mobile unit of the Ministry of Health comes around once a month. Considering that she lived "about an hour" away, the health post's catchment area must have been fairly substantial. Ironically, a relatively modern CCSS clinic (built with money from banana companies), with laboratory facilities, a pharmacy, at least four doctors, and birthing rooms, was located only 5 km away in Río Frio. However, in order to get an appointment there, one had to show up before 8:00 a.m., and then spend much of the day waiting. Thus the Ministry personnel would travel more than 30 km over rough terrain from Puerto Viejo in order to give "preventive" care once a month in a run-down health post, while a modern CCSS clinic existed only 5 km from the post itself. As JCC, the mobile unit's physician, seemed to give traditional, biomedical

[20]The Ministry of Health has promoted, to a varying degree under different political administrations, the formation of rural health committees. Community Participation in Health was one of the main political platforms of the Carazo (PUSC) regime from 1978-82. Considering the highly partisan and politicized nature of "community participation," Carazo's program was dismantled by the Monge administration in 1985, and has not since been revitalized. Much rhetoric still surrounds the notion of "community participation in health," and the new Figueres administration seemed to want to promote more participation in health at the rural level. However, at the time of this study, it was too soon in the PLN's mandate to determine to what extent community participation was to become an important component of their rural health strategy. For further discussion on community participation, see Morgan (1989, 1993).

care and little or no preventive advice,[21] I was hard pressed to tell the difference between the service he offered and that offered by the Caja. A convenient explanation for patients' use of the Ministry services, given the existence of the Rio Frio clinic, was that they had not paid their "Seguros," or health insurance. One woman at the health post commented "the government doesn't give social security. So if you can't pay, if you don't have a job, then you don't get social security," and thus don't have access to the Caja clinic.

WHERE BUREAUCRATIC AND COMMUNITY DECISION-MAKING MEET

Although community members often expressed satisfaction with and respect for the mobile team (as no other services were provided), visits by the unit were sometimes unreliable, and were subject to last-minute cancellation by bureaucratic whim. For example, the scheduled visit in June was cancelled at the last minute to Fátima, a community of mostly Nicaraguans with no health committee, two hours downstream from Puerto Viejo (which, in turn, is three hours upstream from Fátima), across the San Juan river from Nicaragua. Benito, the driver/pharmacist explained to the residents during the July visit that "last month, the doctors were doing some kind of population analysis, so they couldn't come to the consulta." La Aldea, a circuitous 180 km, 5-hour drive from Puerto Viejo, also had its June visit cancelled, because, as JCC claimed, the health post workers were busy doing their budget ("presupuesto") for the year, which took about two weeks to complete.

Apparently, bureaucratic needs came before those of the community, as far as health workers were concerned. Certainly, the Ministry's discourse on prevention, or rather, the physician's role in prevention, was to be taken with a grain of salt. Interestingly, nobody came to the mobile unit's clinic in the village of Chirripozito, either because nobody had

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[21]I visited ten communities with the Ministry's mobile medical unit, and observed JCC, the physician, with thirty patients. Most of his remarks were cursory, and rarely did he ask questions that would lead to an understanding of patients' "bio-psycho-social" reality. His priority was to see all the patients at the health post, which would often require that he restrict his time with each patient to a few short minutes.

been informed of the visit, or because those who were informed forgot to let the rest of the community know. Evidently, the health committee was either non-functional or non-existent. JCC suggested that "We're going to have to send a TAP around to educate them about their responsibilities," then exclaimed to a villager, "the committee here is shit! We've been up since five in the morning so we could get here early! And nobody shows up! How difficult could it be to get the people to the health post?"

How difficult, indeed. As previously discussed, community participation is a concept that is nebulous, certainly contested, and far from easy to describe in empirical terms. Having become established in international health circles as a main pillar of the Primary Health Care paradigm, one might expect that Costa Rican planners, highly influenced by international health trends, would make all efforts to promote participation at the village level. Certainly, in its "induced" form, participation by definition cannot remain unaffected by the actions and attitudes of government representatives. Yet considering the sporadic and somewhat perfunctory nature of the mobile unit's visits, its work seemed not to be done with the goal of fostering community participation. Granted, much of its work could be considered "preventive," in the absence of other forms of health care that reach outlying communities. Yet the role of the physician, considered by the medical establishment to be the key player in virtually all forms of care, was primarily a "curative" and interventionist one. It seemed that the health workers who were most involved in community work, health education and prevention, and thus more easily amenable to fostering participation and "integration" of health institutions and the people, were the Primary Care Technicians (TAPs).

"TAP"PING RESOURCES, WAITING FOR POLITICAL WILL

According to CB, the TAP assigned to Finca 10, preventive, continuous care was provided not by physicians, but by the rural health workers:

> It has been we, the TAPs, who have been responsible for maintaining the health indicators low in Costa Rica. We're the ones who do the work, but we don't get much recognition. The rural workers do all the work, but get very little recognition. There are no incentives, the government

never tells us what a great job we're doing. There aren't incentives, but yes, there are sanctions. I am certain that the people who maintain the health indicators are us. We go house to house every day of the year. We are the ones who maintain the contact with the people.

Yet, as with many rural health workers, CB was frustrated at the lack of resources available. Often, medications were in short supply or out of stock, TAPs' motorcycles were in bad condition and often in need of repair, salaries were often paid late, and per diems (or "viaticos" that TAPs are supposed to receive for their costs while in the field) often did not get paid at all. The last rural health campaign CB had worked on left him without pay or viaticos for six months, he claimed.

The biggest hurdle to implementing the integrated model of health care, for CB, was that health care in Costa Rica is fundamentally politicized: "Each time a new government comes in, they make lots of promises. They want us to work hard, but where are the benefits for us? There is really very little recognition of the work that we actually do." Costa Rican political rhetoric places health in a moral sphere "above" politics. Yet health care, according to Morgan, is highly contested politically by the two major parties, and is subject to much partisan activity. Each new minister of health claims to want to end political bickering over health, and to come to a "permanent" consensus about models of service delivery. Yet every new minister has a different agenda. This is well acknowledged by workers at the local level such as CB. As for his opinion on the proposed "integration," "I'm not certain how far it's going to go: the Ministry and the Caja want to integrate their services, based on this new model of family medicine. They talk so much about integration: supposedly, we now belong to the Caja, but none of us really knows how or why. I don't know just how far they'll motivate us: we just have to wait, wait for the government's promises to be fulfilled, for them to come through on their promises with respect to remuneration, transport, equipment".

Given this attitude, which seemed to prevail among Ministry employees, there seemed to be little incentive to carry out community participatory measures, mandated by new government policy. Furthermore, until the two institutions were "integrated" under one

roof in Puerto Viejo, a tangible sense of rivalry (somewhat the opposite of "integration") between employees of the CCSS and the Ministry was sure to remain.

INSTITUTIONAL FUNCTIONAL DIFFERENTIATION: WHERE INTEGRATION MEETS BUREAUCRATIC RESISTANCE.

According to AC, there was a difference in salaries between employees of the Caja and those of the Ministry of Health. The Ministry of Health paid substantially less for similar work. For AC, then, Ministry of Health physicians and other personnel harboured a certain resentment towards Caja employees, and consequently a resistance to working to their full capacity. "The biggest problem with the Ministry of Health doctors is that they are underutilized. . . The doctors at the Ministry of Health are all doing their social service, and most of them are working at about 10 or 25 per cent of capacity." In contrast, physicians at the CCSS clinic were "overworked."

To add to the uneven workload of the staff at the CCSS and Ministry of Health clinics, there was also a certain duplication of services. AC remarked that "for example, a pregnant woman can go one day to get checked in the Ministry clinic, and the next day, she'll go to the Caja." Or, if a person were to go to the Caja clinic with an expired insurance card, they would be referred to the Ministry of Health clinic. Thus, the Ministry of Health had a mandate to cover those people who, for whatever reason, could not get attended to in the CCSS clinic. The overlap between the two services is reflected in Mesa-Lago's statistic on coverage: in 1987, 137 per cent of Costa Ricans were covered by national health care, this "overlap being a result of the different services provided by each institution" (Mesa-Lago 1992: 87). One could easily interpret the overlap as a result of similar services being offered by both institutions.

In January of 1994, AC assumed the directorship of the Ministry of Health clinic in Puerto Viejo, charged with its "integration" with the CCSS clinic. He claimed that doctors at the Ministry of Health post resisted his appointment, as they "know that things work in the Caja, and not necessarily so in the Ministry." In other words, claimed AC, they saw the "integración" virtually as a hostile takeover of the Ministry of Health by the

Caja. He continued, "in the last six weeks, I've been trying to assume the directorship of the Ministry of Health post, but, of course, I can't be in two places at once." AC was thus faced with a daunting task: that of combining two bureaucracies and two very different institutional cultures. An example of his troubles lay in JCC's (the Ministry's mobile unit doctor, on his year's social service) resistance to take on any tasks outside his job description. As the mobile doctor, JCC refused to work in the clinic, especially considering that his salary was lower than GM's, the social service doctor contracted by the Caja.

"INTEGRATION" AT THE LOCAL LEVEL: POLITICAL WILL VS. REALPOLITIK

In practical terms, the "integración" consisted not only in combining services, but also combining infrastructure. A new clinic was to be built that would combine both health care agencies under one roof. Earth moving began in August, 1994, and the construction was to take approximately eight months. AC seemed to think that once the new clinic was built, the "new model" of health care, or Family and Community Medicine, would be implemented. "Political will" seemed to be forthcoming: President José María Figueres announced, on a visit to Puerto Viejo in August 1994, that a new "hospital materno-infantil" (a small hospital with birthing rooms) was to be built on the site. However, AC was quick to tell this researcher that there were no plans for a birthing unit in the new clinic. He chalked the president's promise up to political rhetoric, and cast doubt over the tangibility of the concept of "political will."

Meanwhile, "integrated care" (or "comprehensive care" in English) was not obviously being practiced in Puerto Viejo at the time of the study. With some of his patients, AC undertook to question them about matters extending beyond the nature of their complaint. For example, while treating a plantation worker for a knife wound, AC asked him about his marital status (he was single), whether he was sexually active, especially with prostitutes (he seemed to be), and if he or his colleagues had "caught" anything (to which there was mild acknowledgement). AC prescribed several boxes of condoms for the man

to share with his co-workers, and encouraged him to "be careful" and to return for more when he ran out.

For the most part, however, neither AC nor the other two physicians (who had no training in the principles of family medicine) had time to implement "atención integral." AC identified the major barriers to the implementation of "integrated" care as a lack of personnel and a lack of time to dedicate to patients. He commented:

I think that . . . the real conditions are not conducive [to family and community medicine] due to the limited services we can offer and the great demand for care placed upon us, both preventive and curative. That is to say that we are limited, and a great part of my own time is not at this moment oriented towards direct patient care. Much of it goes towards administrative matters that I am currently in charge of. . . In other words, in this case and at this time, I haven't been in charge of families, and the situation here is very difficult due to the lack of personnel, and we have a high demand for services, mostly of the curative type.

He proposed that institutional change allow physicians a greater time flexibility:

As for the doctor, he mustn't be limited, or be asked to see a minimum number of patients, or a minimum number of files . . . At this time it is perfectly defined that, for example, . . . they are five patients per hour. This does not guarantee good care . . . And there are patients who might need more time. Thus the doctor knows that he has many patients, and necessarily he will have to do things quickly in order to fulfil the task set out for him.

AC maintained that the lack of personnel made it difficult to carry out preventive or health education measures:

It is not possible, for example, to have two doctors with very large populations, and who have to be attending to everyone. They [doctors] cannot dedicate themselves to be doing work of the preventive and community type in the way they would like because they must attend to morbidity.

AC gave an explicit critique of the curative orientation of the Caja, and proposed a creative solution to this one-sided approach: that of quantifying preventive measures, in

order to provide tangible "results" in a language policy-makers at the national and international levels can understand:

> I think that it would be necessary to quantify in some manner the preventive work or the preventive tasks the family doctor does . . . to give importance to preventive activities, quantify them, use statistics. . . . Acute interventions ["Consulta que llega de choque"] and those that pertain to institutional conditions are those that get quantified. Thus there must be a modification also with respect to this. I think that if this can be fixed, much could be achieved.

With these remarks, AC identified a paradox: in order for family and community medicine to be implemented, the specialty and its practitioners must be made visible. However, in order to be made visible, the specialty's principles must have been successfully implemented. One got a sense that family and community physicians (as exemplified by AC) were caught in a bind, needing, but lacking a visibility at both the local and the national or international levels. AC's "quantifiable results" would make him, as a family and community physician, visible to national and international health authorities, and thus able to petition for more resources. Adequate time and personnel resources would allow him to increase local visibility and legitimacy, and allow him to adapt the "unversal" principles of family medicine as outlined by McWhinney.

Another "universal" variable that AC considered important, but lacking, and that policy makers spoke extensively about but had few ideas on how to "measure," was the concept of "community participation."

COMMUNITY PARTICIPATION

Little "community participation" of the type advocated by international health organizations was evident in government-provided health care. Puerto Viejo had no health committee, and the CCSS clinic's outreach efforts ended when a social worker who had been employed there left a year previous to the study. A meeting called in Puerto Viejo at the Red Cross office by the Ministry of Health regional director, to which school, health, agricultural, and community representatives were invited, managed to

elicit the interest of only one community representative, from Arbolitos, an hour's boat ride downriver. The Ministry of Health's regional director, regional medical coordinator, and regional nursing coordinator, along with the clinic's young doctor on social service duty were present, and clearly frustrated. VC, the regional director, claimed she was there to "explain to the community the process of integration of the Caja and the Ministerio, and also to get ideas from community members, associations, the Red Cross, etc. and to discuss what is important for them in the health field. To discuss what are the problems in the health services, and how to resolve the problems together." An excerpt from my fieldnotes reads as follows:

> The meeting is called to an end one hour after its scheduled start, over the protests of the representative from Arbolitos. He has what he perceives to be legitimate complaints about the poor medical service given to the community, his community's lack of finances to build a health post or to buy a water pump, the failure of the doctor on community rounds to show up on the prearranged day, and the inconvenience this causes patients who might have had to walk an entire day with a baby on their back to receive treatment. People often have to forego food for a day just to be able to afford the expected donation to the clinic for its maintenance and upkeep.
>
> The health officials reply: "There is no participation of the people! We want the community to look for its own solutions, with the help of the national institutions, but they don't even do this!"
>
> Alvaro, the Arbolitos representative, agrees: "in 8 years in this county, nobody has had the vision to do anything in health . . . we must organize the people here." VC's reply: "yes, as long as the people don't organize, there is not much that we, as institutions, can do."

Clearly, then, community participation was problematic in Puerto Viejo, if we are to take at face value the definition of participation promoted by international organizations.[22] Yet if our analysis goes beyond the walls of the meeting room, we will discover that while attempting to elicit community support and opinions, VC was in fact

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[22]A World Bank document on Community Participation in rural water supply projects defines participation as "a voluntary process by which people, including the disadvantaged (in income, gender, ethnicity, or education), influence or control the decisions that affect them. The essence of participation is exercising voice and choice"(Narayan 1995: 7). This is not to argue that all international organizations espouse World Bank definitions or policies. However, they can be useful.

catering to an audience that was not present at the meeting. By demonstrating that there was no real will in the community to participate in health measures, VC corroborated Morgan's (1993) claim that national and international health institutions tend to perceive the "problem" as residing in the community itself, thus diverting attention away from important social forces at the national and international levels.

AC, the director of the CCSS and Ministry of Health clinics, saw the "problem" as due to a lack of good planning and information sharing on the clinic's behalf, as well as an absence of community organization.

> I feel that one would have to give the most importance to educational and organizational issues . . . I believe that organization must begin by educating people. Education and information. And as well the real integration of public services in general, towards the population. . . . Education in the home, schools, high schools, with respect to health. Then there's organization . . . it's a question of finding, perhaps, people with the capacity to motivate or discuss or interest the people in their own problems. I think some sort of course or orientation could be done with people identified as leaders, or potential community leaders to inform them or interest them in organizational issues.

Of course, AC was speaking in hypothetical terms, and aiming his discourse, indirectly, at an institutional audience. Interestingly, AC did not envision planning or conducting such a "course or orientation" in the forseeable future, however. There seemed to be too many pressing issues to deal with in the here and now.

Given the lack of popular participation in health, whether "spontaneous" or "induced," can this be seen as problematic for the health institutions operating in Puerto Viejo? The two public clinics were functioning independently of community input, and little effort was made to assess the clinics' functional utility or the benefit the population derived from it. Standard epidemiological data such as birth and death rates, principal causes of mortality and disease prevalence, were collected by the Ministry of Health, and could be useful in determining and planning for general health (or disease / morbidity) trends, yet, according to AC, neither the community's perceived health needs nor the role of health institutions in the lives of individuals had been assessed.

Without significant perceived or real institutional flexibility, family and community medicine, especially in Puerto Viejo, was not going to be implemented. This "ideal" approach to health care for all Costa Ricans was to wait for "voluntad politica" in order to come into being. New positions had to be created and financed, personnel had to be recruited and given an incentive to stay in Puerto Viejo, and the construction of the new integrated clinic had to be completed. Change, it seemed, was not going to be motivated by movements or decisions at the grass-roots level, and the community would continue with the "traditional" model of health care service delivery.

By means of a comparison, the clinic in Barranca seemed to put into practice some of the principles of family and community medicine. Under the direction of GA, one of the first graduates of the McGill-CENDEISSS training program, this clinic purported to have a family and community medicine program on its feet and running. In 1994, three family and community physicians were working in Barranca, and GA was pressuring the local health authority to find financing for six more positions. GA claimed to have consulted with community leaders and had determined, with them, the community's health priorities. Together, they had established a garbage collection project as part of the dengue and malaria prevention program (stagnant water in bottles, tires, cans, and other receptacles is an ideal breeding ground for mosquitoes that harbour the dengue virus and malaria parasite).

GA had divided the community up into health districts, each to be serviced primarily by a health post to which a family and community physician would travel once or several times a week. Serious health cases would be referred to the clinic, and, if necessary, to the hospital in Puntarenas. GA claimed to have decreased references to specialists to a very low level, thus treating the vast majority of health complaints at the level of the family physician. Furthermore, his data revealed a decrease in the number of medications prescribed to patients, which, for him, signalled a rationalization of the prescription of drugs, or restraint on behalf of physicians. The prevailing perception was of a certain therapeutic value in the mere act of prescribing medications to patients. In the words of JCC, the physician on the mobile unit in Puerto Viejo, "if you give them something [i.e., a prescription], they go away satisfied." The decrease in prescription rates in Barranca

also reflected an explicit policy directive by GA to his medical team: less was better, and it cut down on expenses. As prescriptions in Costa Rica can be filled free of charge by individuals covered by social security at Caja pharmacies, patients often do not realize the cost of their medications.

GA engaged in extensive promotion of community health issues. Through the clinic, he was selling T-shirts with the clinic's logo on the front that read "Clinica Dr. Roberto Sotomayor G. [a prominent physician in the area, after whom the clinic was named], Programa de Medicina Familiar y Comunitaria, Atención Integral de la Salud Barranca-Puntarenas." On the back was a representation of a rowboat on clean beach, with seagulls flying overhead. In in bold characters, were the words "Yo Cuido Mi Puerto. No Tiro Basura. Y Usted . . . ?" ("I take care of my port. I don't throw out garbage. Do you . . . ?"). He also had a weekly program on the local community radio that dealt with health issues such as nutrition, cholera, malaria, and proper waste disposal. He had promoted a community clean-up campaign in Barranca, and was also involved in facilitating the development of women's cooperatives. GA lived five minute walk from the clinic, and was well known in Barranca, Puntarenas, and in other surrounding communities. His high energy level and outgoing personality made him ideal leadership material, and he was recognized by most people involved in the family medicine movement as an important resource in their struggle for recognition and support.

It would be presumptuous to attribute the "success" of family and community medicine in any community to a physician's personality. It is notable, however, that GA was making every attempt to implement the principles of his discipline in his community, despite a lack of resources. His energy seemed to be a major contributing factor to the perception, amongst health planners, officials, and academics, that indeed Barranca was a "success." AC, on the other hand, was not spending energy promoting family medicine in Puerto Viejo, and neither did he publicize the "successes" or "failures" of his clinic to health officials. He seemed, rather, to be waiting for the construction of the new, "integrated" clinic, and for those with "political will" to acknowledge the health resource needs of the community.

CHAPTER FIVE — CONCLUSION

This thesis has examined, in a qualitative manner, the process of the professionalization of family and community medicine in Costa Rica, as well as the jurisdictional spaces at the local, national, and international levels in which the negotiation for the new profession's legitimacy has taken, and is taking place. Theoretical guidance has come from two distinct sources: literature on the sociology of "professionalization" and a selection of ethnographic texts on "development." An attempt has been made to synthesize the two approaches into a specific analysis of "professional development" in the general context of "international development," and in the local context of one Costa Rican community.

In our discussion of the negotiation of social space, we have used the concept of "boundary work," the attribution of certain characteristics to the profession of family and community medicine in order to construct social boundaries that distinguish the specialty from other specialties or forms of health care provision. In the course of my research, and through the pages of this thesis, three notable boundary themes have emerged that permeate the discourse and the strategies of family and community practitioners, theorists, and planners, and that highlight the jurisdiction-building process of the specialty. They do not define family and community medicine per se as a scientific discipline. Rather, they characterize the strategy used by the specialty in its attempt to create social space for itself.

These three themes, to be discussed below, are "integration," "political will," and "community participation." The first characterizes the process and the concept of reform in the health sector, and in the health specialties; the second is cited by many as a main prerequisite for change, or as a means of externalizing loci of power, responsibility, and control; the third is an analytical variable deemed important by virtually all health workers and planners for the improvement and maintenance of communities' health.

"INTEGRATION"

As we have seen, inherent to the discourse of family and community medicine and of development in health in Costa Rica, from the level of international organizations straight through to the local level, is the concept of "integration." In international (or "universal," "biomedical") health terms, "integration" indicates the embracing of the "bio-psycho-social" approach to medicine — taking into account not only biological, but also psychological and social etiological factors of disease and illness. It must be remembered that the English term "comprehensive care" translates as "atención integral" in Spanish.

"Integration" is also important from the perspective of international health organizations such as the WHO/PAHO, as it indicates a discursive commitment by the professional class to grass-roots development. In other words, family and community physicians claim to dedicate themselves to the betterment of health conditions of the poor, by engaging in a democratic and creative dialogue with the them in order to determine their health needs, and also by becoming a part of the community through participation. At the national policy level in Costa Rica, there has been talk of integrating health bureaucracies since the early 1980s, following international trends put in motion by the 1978 Alma Ata declaration of Health for All by the year 2000. The realization of these plans has been taking place in the interim, albeit at a snail's pace, and not without significant resistance. For the most part, the two health bureaucracies still occupy distinct spaces, in terms of institutional culture, work roles, and work sites. In August of 1994, Minister of Health Weinstock announced the transformation of the Ministry into a policy-making body, and the "integration" of all health services under the Caja. The extent to which this plan has been operationalized is unknown.

The discourse on public health in Costa Rica focuses on the "integration" of health care workers into teams, or EBAIS. Evidence from this study points to the consistent struggles and barriers to such an integration. At the local level in Puerto Viejo, health workers were not, at the time of the study, working in a "comprehensive" or a "team-oriented" fashion. Instead, they carried out their duties in the "traditional" manner. There seemed to be too many structural, financial, and occupational impediments to the

creation of an "integrated" health care unit or the practice of "integrated," or comprehensive care. Most of the physicians guarded their institutional and occupational prerogatives; they did not invest in the community or their position, as all physicians except AC were in Puerto Viejo fulfilling their "social service" by obligation, not by choice. They tended to return home to San José on weekends.

Interestingly, the other health workers practiced a version of "integration," by necessity rather than by institutional edict. Indeed, by sharing tasks and knowledge, and thus blurring jurisdictional boundaries, the "subordinate" workers (those who were willing to stay in Puerto Viejo) engaged in what Abbott (1988: 66) calls "workplace assimilation." Thus, a certain measure of the "teamwork" envisioned in the EBAIS model was, informally at least, taking place. AC, the highest-placed public health authority in the town, foresaw the creation of an EBAIS and the possibility of formally practicing "integrated" care only in conjunction with the merging of Ministry and Caja personnel and infrastructure under one roof, and with a significant injection of resources and "political will."

In Barranca, GA was making every effort to establish a team-oriented work environment. However, it was not clear to what extent this was becoming institutionalized. He had managed to negotiate positions for up to nine family and community physicians in Barranca, but he was having trouble attracting them to his community. It seemed they resisted leaving San José. Furthermore, once GA was promoted to regional health director, the clinic came out from under his direct tutelage. We do not know what became of the clinic or of its "integration."

Perhaps the most striking manifestation of the concept of "integration" at the local level was not necessarily family medicine's use of a bio-psycho-social approach to solving patients' health problems (in any case, an analysis of the impact of this approach as compared to a "traditional" biomedical approach would be virtually impossible), but the construction of new "integrated" clinics. Coronado, just north of San José, had a new integrated clinic, the size of a small hospital. Puerto Viejo was about to get one as well, to replace the two existing buildings occupied by the Ministry and by the Caja. In theory, combining both cure- and prevention-oriented personnel under the same roof leads to a

sense of integrated care for the community. Whether this will work in practice remains to be seen, and will depend, according to many health practitioners and officials, upon a certain "political will."

POLITICAL WILL

Costa Rica is a country that stands out in international health literature. It has managed not only to develop and prosper as a politically stable and democratic nation, in contrast to its Central American neighbours, but also partially as a result of this, it has demonstrated tremendous success in raising the health standards of its population to near-"First World" levels. Yet this has not been done in a vacuum. International health agencies and their policies have played an important role in the Costa Rican health landscape. Given the country's 48-year tradition of stability and democracy, it is viewed by international health organizations as having the "political will" necessary to effect positive health changes.

This "political will" is a concept that is used at all levels of health discourse in Costa Rica, from the international health organizations to national health institutions to clinics and their patients at the local level. Minister of Health Weinstock claimed that what was essential for the improved health of Costa Ricans was for the political parties to come to an agreement on the fundamental elements in health, independently of who wins the elections. Thus, a "political will" is needed to agree not to disagree over health. In this sense, given political will, health is "above politics."

Yet the words of Dr. Weinstock were no more than replays of old, and tired, recordings: all governments since 1950 have preached the "apolitical" nature of health. All newly invested governments have gone against many of their predecessors' health policies. Of course, a universal health program and participation in health are part of the Costa Rican national myth, just as Medicare and other social programs are a part of the Canadian identity. Each political party, however, has its own version of the practical attainment of the myth.

According to Morgan, "Costa Rica is a country deeply influenced by international health policies, to the extent that the national health agenda may be held in abeyance while particular faddish international initiatives run their course" (1989: 230). If "political will" is seen as necessary to implement policies that determine what is "good" for the people, then ultimately, this means compliance with the prerogatives of international health agencies.

Yet this is not the only dimension to the concept: the mustering of "political will" is a highly contested process in Costa Rica, given that the two main political parties constantly jockey for power. Thus, any one version of "political will" is contested and resisted. Morgan warns against the assumption that "health improvements depend simply on commitment by national leaders," stating that this diverts "attention from global relations of dependency and institutionalized inequality" (Morgan 1989: 233). We would add that this assumption directs the focus away from local-level dynamics, which ought to be important in informing the health discourse and practices of health professionals, yet, unfortunately, tend not to be.

For AC in Puerto Viejo, it was clear who made the decisions of relevance to health care in his community: his bosses, and their bosses. Negotiating and waiting for "political will" to approve AC's proposed budgets, to assign new positions, to build the new "integrated" clinic, seemed to take up much of AC's time.

For family and community medicine in Costa Rica, "political will" seemed to be essential to the specialty's cause: the Minister of Health and the President of the Caja were being actively courted by the specialty's leading proponents. Furthermore, much hope was being invested in GA, EJ, and DM, who were rising rapidly in the ranks of the health care bureaucracy. It is to them that many family and community physicians turned in the hopes of creating a greater social space for the specialty.

COMMUNITY PARTICIPATION

Just as the full implementation of family and community medicine in Costa Rica depends, according to its proponents, on "political will," so it does on the institutionalization and the realization at the local level of "community participation." "Community participation" was determined by international health organizations after Alma Ata in 1978 to be the panacea for improving rural health in the developing world. Unfortunately, according to Morgan, the concept of "community participation" did not take into account the political and historical realities of citizen-state relations of most developing societies. Thus most international health literature on "community participation" has assumed an ahistorical approach to the concept, and has interpreted only intra-community variables as impediments to participation, while virtually ignoring macro, structural variables.

Morgan's interpretation of participation has been corroborated, in part, by the findings of the present study: many important actors on the Costa Rican health scene assume that a "lack of participation" is largely due to a "lack of education" and "lack of leadership" in the community. For AC, the family and community physician in Puerto Viejo, the main problems in the community with respect to health are a "lack of community organization," and a "lack of education on health issues." AC's proposed solution to these problems, and his recipe for engendering participation would be first, to educate the people, and second, to proceed with a "real integration" of public services towards the population. Interestingly, then, he acknowledged and emphasized the importance of fostering an institutional culture that actually responded to the community's "felt needs." Thus, the institution, in his view, was also part of the "problem." However, his vague plans for working in collaboration with the community in the "medium term" did not appear to be convincing.

At the national level, there was little evidence that "community participation" was a priority in health policy. Instead, the assumption in the wording of the "Reforma" plans was that, by creating 700 or so EBAIS, institutional penetration into the population would be enough to induce some form of participation. However, this was neither elaborated

upon, nor necessarily hoped for by health officials. Indeed, Ministry of Health officials, whose "mystique" included an "understanding" of communities' needs, were left mostly frustrated by the perceived lack of institutional commitment to "community participation."

Family and Community practitioners tended to acknowledge the importance of "community participation," but they were frustrated at what they perceived to be a methodological weakness on their behalf. They seemed not to have the "tools" necessary to determine the "impact" of their interventions, or to understand the opinions and the felt needs of communities and their members.

CONCLUSION

What we have attempted to describe is neither a "success story" nor a "failure" of "development," nor an evaluation of the "new model" of health care brought to Costa Rica via the McGill-CENDEISSS project. Instead, we have sought to understand and to describe the variables underlying, guiding, and influencing the processes of professionalization and development contextually, from local to international levels.

"Integration," "political will," and "community participation" are themes that run deep in the discourse of family and community medicine, and of health and development in Costa Rica. They have served to buttress institutional and professional claims as well as to defend perceived weaknesses or failings. They both define and obscure what "development" really "is," and shape the plans, the practices, and the thoughts and motivations of actors and subjects of "development."

Whether strategies of "development" in fact "work," be they promoted by governments, international agencies, NGOs, or community organizations, is in part determined by the rhetorical strategies used and the boundaries created by the important actors involved. The "success" or "failure" of the McGill-CENDEISSS project and of family and community medicine in Costa Rica is yet to be determined; what is certain is that the specialty has changed and will continue to change the political landscape of the

health service sector in the country, and, for good or for bad, the rhetoric of health and development. If one believes "development" in health to mean an increased and more equitable access to services, both preventive and curative, an improved quality of life for the poor, and an increased community-level input into institutional decision-making, then one can only wait and hope that the practice of family and community practitioners and the institutions they represent come to reflect more closely the ideals put forward in theory.

FUTURE PROSPECTS

Numerous issues have been raised during the course of my research that have but cursorily been touched upon, if at all, in this thesis, and which deserve further investigation. For example, one could interpret the McGill-CENDEISSS project as an example of the transfer of technology or knowledge. Certainly, there is a large body of literature on the topic of technology transfer, but this often deals with specific techniques or with general models. To my knowledge, there is no text focusing on the transfer of a specialty or a discipline as a form of technology. Family and community medicine, insofar as it embodies a set of techniques for handling patients, could serve as such a case study.

Similarly, a cross-cultural comparison of the specialty of family and community medicine would be in order. Considering its universalizing discourse, and its claim to adapt to local specificities, an understanding of the processes of local adaptation, across cultures, would be useful.

In following more directly from the research of this thesis, we would suggest that an in-depth, longitudinal study of the "work" of family and community medicine in Costa Rica, their evolution as a "profession," and the "impact" they have on the Costa Rican health scene at both the community and the institutional levels, would be invaluable. This could be carried out in both rural and urban settings, in "traditional" and "integrated" clinics, and would provide a sense of the reality of "integrated" or "comprehensive" care, as well as the work, ambitions, and lifestyles of practitioners in

various settings. Comparisons of levels of "community participation" could be carried out to determine if indeed there is a link between "participation" in health and the form of health care delivery, or if indeed the concept of "participation" is no more than a bureaucratic construct. Finally, over the long term, health data could be collected in areas where the new model of family and community medicine has been introduced in order to determine the "impact" of the specialty on the health of the population, and indeed, the contribution of the profession to increased accessibility, continuity, and equity in care.

BIBLIOGRAPHY

Abbott, Andrew (1988). The System of Professions: An Essay on the Division of Expert Labor. Chicago: University of Chicago Press.

Alfaro, Gerardo (1993). Proyecto de Salud Integral para el Distrito de Barranca-Puntarenas. Unpublished document of the Barranca Clinic.

Armstrong, David (1983). Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century. Cambridge: Cambridge University Press.

Armstrong, David (1984). The Patient's View. Social Science and Medicine 18, 737-744.

Armstrong, David (1987). Theoretical Tensions in Biopsychosocial Medicine. Social Science and Medicine 25, 1213-1218.

Armstrong, David (1993). Public Health Spaces and the Fabrication of Identity. Sociology 27, 393-410.

Atkinson, Paul (1995). Medical Talk and Medical Work. London: Sage.

Basch, Paul F. (1990). Textbook of International Health. Oxford: Oxford University Press.

Bertrand, J.T., & Morris, Araya Cisneros (1982). Evaluation of Family Planning Communication in El Salvador. International Journal of Health Education 24, 183-194

Biblioteca Nacional de Salud y Seguridad Social (BINASSS) (1993). El Médico Familiar y Comunitario. San Jose: Ediciones BINASSS-CCSS.

Braveman, Paula A. and Mora F. (1987). Training Physicians for Community-Oriented Primary Care in Latin America: Model Programs in Mexico, Nicaragua, and Costa Rica. American Journal of Public Health 77, 485-490.

Bucher, Rue and Strauss, Anselm (1961). Professions in Process. The American Journal of Sociology 66, 325-334.

Buck, B., Kincaid, L. & Nichter, M. (1983). Development Communication in the Cultural Context: Convergence Theory and Community Participation. In W. Dissanayake and A.R. Mohel Said, Communication Research and Cultural Values. Singapore: Amic Press.

Caja Costarricense de Seguro Social (CCSS) (1987). Anteproyecto de Capitación con Enfoque Familiar en el Centro Integrado de San Isidro de Herédia, Con el Modelo de Integración de Servicios Ministerio de Salud - CCSS. CCSS Working Paper. San José.

Cambrosio, Alberto & Keating, Peter (1983). The Disciplinary Stake: The Case of Chronobiology. Social Studies of Science 13, 323-353.

Cameron, C., & Gatewood, J. (1994). The Authentic Interior: Questing Gemeinschaft in Post-Industrial Society." Human Organization 53, 21-32.

Casas, Antonio & Varga, Herman (1980). The Health System in Costa Rica: Towards a National Health Service. Journal of Public Health Policy 1, 250-279.

Chan, L. (1986). Primary Health Care in Developing Countries: Overcoming Operational, Technical, and Social Barriers. Lancet 29, 1260-1265.

Dougherty, J. & Keller, C. (1982). Taskonomy: A Practical Approach to Knowledge Structures," American Ethnologist ??, 763-774.

Doyal, Lesley, & Pennell, Imogen (1979). The Political Economy of Health. London: Pluto Press.

Edelman, Marc, and Kenen, Joanne (Eds.) (1989). The Costa Rica Reader. New York: Grove Weidenfeld Press.

Etzioni, Amitai (1993). The Spirit of Community: The Reinvention of American Society. Toronto: Touchstone.

Ferguson, James (1994). The Anti-Politics Machine: "Development," Depoliticization, and Bureaucratic Power in Lesotho. Minneapolis: University of Minnesota Press.

Flores Arechiga, Amador, H. Riquelme H., & I. Quintanilla C. (1985). Family Medicine: A Medical Care Alternative for Latin America. Social Science and Medicine 21, 87-92.

Foster, George M. (1978). Medical Anthropology. New York: John Wiley and Sons.

Foster, George M. (1982) Community Development and Primary Health Care: Their Conceptual Similarities. Medical Anthropology 6,183-195.

Foster, George M. (1978). Bureaucratic Aspects of International Health Agencies. Social Science and Medicine 25, 1039-1048. London: Pergamon Press.

Foster, George M. (1987). World Health Organization Behavioral Science Research: Problems and Prospects. Social Science and Medicine 24, 709-717.

Freidson, Eliot (1970). Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead & Company.

Freidson, Eliot (Ed.) (1973). The Professions and their Prospects. London: Sage.

Freidson, Eliot (1986). Professional Powers: A Study of the Institutionalization of Formal Knowledge. Chicago: University of Chicago Press.

Geyman, John P. (1985). Family Practice: Foundation of Changing Health Care, 2nd ed. Norwalk, CT: Appleton-Century-Crofts.

Gieryn, Thomas F. (1995). Boundaries of Science. In Sheila Jasanoff, G.E. Markle, J.C. Petersen, and T. Pinch (Eds.) Handbook of Science and Techonology Studies. London: Sage.

González Pantaleón, María del Pilar (1995). The Growth of a Secondary City in Costa Rica: a Case Study of the Development of Puntarenas. MA Thesis, Department of Sociology, McGill University, Montréal..

Grenholm, Gary G. (1983).The Paradigms of Health Care Delivery Systems: Implications for the Third World. In J. Morgan (Ed.) Third World Medicine and Social Change. Lanham, MD: University Press of America.

Horwitz, Abraham (1987). Comparative Public Health: Costa Rica, Cuba, and Chile. Food and Nutrition Bulletin 9, 19-29.

Jaramillo Antillón, Juan (1993). Salud y Seguridad Social. San Jose: Editorial de la Universidad de Costa Rica.

Justice, Judith (1986). Policies, Plans, and People: Culture and Health Development in Nepal. Berkeley: University of California Press.

Kroeger, Axel (1983). Anthropological and Socio-Medical Health Care Research in Developing Countries. Social Science and Medicine 17, 147-161.

Kroeger, Axel & Luna, Ronaldo (Eds.) (1992). Atención Primaria de Salud: Principios y Métodos. México: Editorial Pax México y la Organización Panamericana de Salud.

Locher, Uli & Scyner, S. (1994). Health and migration in a frontier banana town: Puerot Viejo de Sarapiqui, Costa Rica. Unpublished Survey.

Low, Setha (1983). Patient Satisfaction in Costa Rica: A Comparative Study of Different Levels of Health Care. In J. Morgan (Ed.), Third World Medicine and Social Change. Lanham, MD: University Press of America.

Low, Setha (1985). Culture, Politics and Medicine in Costa Rica. New York: Redgrave Publishing Company.

Lysack, Cathy (1994). "Community" and "Empowerment" in Health. Paper presented at the First Canadian Conference on International Health (November 13-15). Ottawa.

Mburu, F.M. (1981). Implications of the Ideology and Implementation of Health Policy in a Developing Country. Social Science and Medicine 15, 17-24.

McGill Department of Family Medicine (n.d.). Family Medicine: Introduction to Clinical Medicine. (Preceptor Manual). Montréal.

McGill Department of Family Medicine (n.d.). McGill Postgraduate Training Program in Family Medicine. Montréal.

McGill/CENDEISSS Project (1993). Report of a Visit to San José, November 13-21, 1993. Dr. Liliane Filion-Laporte, Project Co-Director.

McGill/CENDEISSS Project (February, 1994). Internal Evaluation Report. Jeannie Haggerty. San José.

McGill/CENDEISSS Project (November, 1994). Training in Family and Community Medicine: Final Project Report. San José.

McWhinney, Ian R. (1981). An Introduction to Family Medicine. Oxford: Oxford University Press.

McWhinney, Ian R. (1989). A Textbook of Family Medicine. Oxford: Oxford University Press.

Mesa-Lago, Carmelo (1985). Health Care in Costa Rica: Boom and Crisis. Social Science and Medicine 21, 13-21.

Mesa-Lago, Carmelo (1992). Health Care for the Poor in Latin America and the Caribbean (No. 539). Washington: PAHO Scientific Publication.

Ministerio de Economía, Industria y Comercio. Costa Rica Calculo de Población por Provincia, Cantón y Distrito. July, 1993.

Ministerio de Salud (1993). Programa de Atención Integral en Salud de los y las Adolescentes. San Jose.

Ministerio de Salud (April, 1993). Proyecto Reforma Sector Salud, Resumen. Policy Document. San José.

Ministerio de Salud (January, 1985). La Atención Primaria de Salud: Una Filosofia en Acción para el Desarrollo Integral Deseado, Experiencias y Propuestas. Dr. Emigdio A. Balbuena Valdéz. San José.

Ministerio de Salud (1980). Manual de Metodologías y Técnicas -- Plan Nacional de Participación Popular en Salud. San José.

Ministerio de Salud (1987). Programa de Atención Primaria. San José.

Ministerio de Salud (1981). Salud en Costa Rica: Evaluación de la Situación en la Decada de los Años 70. San José.

Mol, Annemarie & Ber, Marc (1994). Principles and Practices of Medicine: The Co-existence of Various Anemias. Culture, Medicine, and Psychiatry 18, 247-265.

Morgan, J. (Ed.) (1983). Third World Medicine and Social Change. Lanham, MD: University Press of America.

Morgan, Lynn M. (1993). Community Participation in Health: The Politics of Primary Care in Costa Rica. Cambridge: Cambridge University Press.

Morgan, Lynn M. (1989).'Political Will' and Community Participation in Costa Rican Primary Health Care." Medical Anthropology Quarterly 3, 232-245.

Morgan, Lynn M. (1987). Health without Wealth? Costa Rica's Health System under Economic Crisis. Journal of Public Health Policy 8, 126-151.

Morgan, Lynn M. (1989). International Politics and Primary Health Care in Costa Rica. Social Science and Medicine ?, ???.

Morley, David, Rohde J., & G. Williams (Eds.) (1983). Practising Health for All. Oxford: Oxford University Press.

Narayan, Deepa (1995). The Contribution of People's Participation: Evidence from 121 Rural Water Supply Projects. Environmentally Sustainable Development Occasional Paper Series No. 1. Washington: The World Bank.

Nichter, Mark (1984). Project Community Diagnosis: Participatory Research as a First Step Toward Community Involvement in Primary Health Care. Social Science and Medicine 19, 237-252.

O'Connor, Ronald (Ed) (1980). Managing Health Systems in Developing Areas. Lexington: D.C. Heath and Company.

O'Neill, M. (1992). Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment. International Journal of Health Services 22, 287-301.

Organización Panamericana de la Salud (1982). Evaluación General del Programa de Salud Comunitaria. San José: OPS/OMS.

Organización Panamericana de la Salud (1987). Análisis de las Organizaciones de Salud. Washington: OPS/OMS.

Organización Panamericana de la Salud (1988). Proceso de Universalización, Desconcentración Administrativa y Atención Primaria en Costa Rica. San Jose: Minsterio de Salud y OPS/OMS.

Organización Panamericana de la Salud (1990). Desarrollo y Fortalecimiento de los Sistemas Locales de Salud: La Participación Social. Washington: OPS/OMS..

Ortega Canales, Luis Fernand (October, 1990). Desarrollo de Los Sistemas Locales de Salud en Costa Rica: Estado Actual. Master's thesis in Public Administration. San José: Instituto Centroamericano de Administración Pública (ICAP).

Pappoe, Matilda (1993). Household Participation in Health Development: Some Determining Factors. Ph.D. Thesis, Department of Sociology, McGill University, Montréal.

Paraskevopoulos, Chryssi (1991). Community-Oriented Primary Care. McGill Family Medicine Research Project.

Phillips, David R. (1990). Health and Health Care in the Third World. Essex: Longman Group UK.

Rakel, Robert E. (1977). Principles of Family Medicine. Philadelphia: W.B. Saunders Company.

Rathgeber, Eva-Maria L. (n.d.). The Movement of Paradigms of Medical Knowledge and Research Between Canada and Kenya: An Investigation into the Sociology of

Knowledge Transfers. Ph.D. Thesis, Department of Social Foundations of Education, SUNY at Buffalo.

Rice, Marilyn (1988). Health Promotion, Education and Community Participation in the Americas: Reality or Myth? Hygie 7, 7-11.

Roth, Julius A. (Ed.) (1987).. Research in the Sociology of Health Care Vol. 5, 1987: International Comparisons of Health Services. Greenwich, CT: JAI Press.

Sáenz, Lenín (1989). Logros de una Política e Impacto de una Crisis en la Salud de un País. San José: Ministerio de Salud.

Shires, David B., Hennen, B.K., & Rice, D.I. (1987). Family Medicine: A Guidebook for Practitioners of the Art. New York: McGraw-Hill.

Slater, R. Giuseppi (1989). New Family Practice Residency Programs in Nicaragua and Costa Rica. The Journal of Family Practice 28, 468-472.

Star, Susan Leigh & Griesemer, James R. (1989). Institutional Ecology, 'Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. Social Studies of Science 19, 387-420.

Stevens, Rosemary (1971). American Medicine and the Public Interest. New Haven: Yale University Press.

Taylor, Robert B. (Ed.) (1996). Fundamentals of Family Medicine. New York: Springer.

Testa, Mario (and many anonymous collaborators) (1993). Pensar en Salud. Buenos Aires: Lugar Editorial.

Tico Times (June 22, 1994). English Language Daily.

Tönnies, Ferdinand (1957). Community and Society. C.P. Loomis (Ed. and Trans.). New York: Harper Torch.

Turk, Dennis C. & Kerns, Robert D. (Eds.) (1985).. Health, Illness, and Families: A Life-Span Perspective. New York: John Wiley & Sons.

Ugalde, Antonio (1985). Ideological Dimensions of Community Participation in Latin American Health Programs. Social Science and Medicine 21, 41-53.

Viisainen, Kirsi (1990). Nicaraguan Midwives: The Integration of Indigenous Practitioners Into Official Health Care. M.A. Thesis, Department of Anthropology, McGill University.

Villalobos Solano, Luis Bernardo (1988). Hacia una Propuesta Conceptual Operativa de la Participación Comunitaria en Salud. Revista Centroamericana de Administración Pública 12, 51-58.

White, K.R. (?). Primary Care and the New Epidemiology. Journal of Family Practice 3, 579-580.

World Bank (September 20, 1993). Staff Appraisal Report, Costa Rica: Health Sector Reform - Social Security System Project. Report No. 11986-CR.

World Health Organization (1978). PHC: Report of the International Conference on Primary Health Care. Alma Ata.

Young, Allan. (1983). The Relevance of Traditional Medical Cultures to Modern Primary Health Care. Social Science and Medicine 17, 1205-1211.

IMAGE EVALUATION
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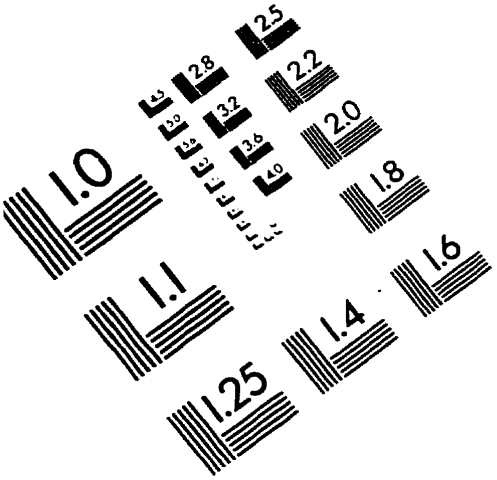

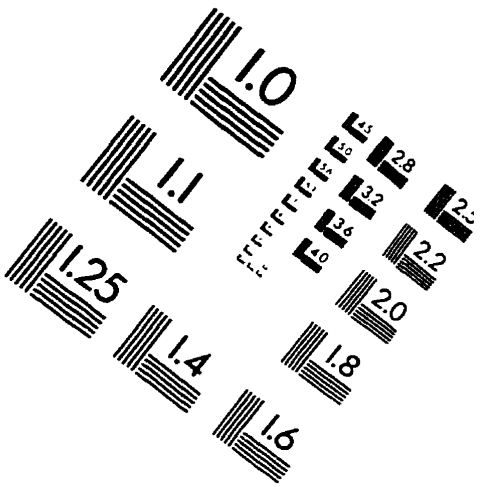

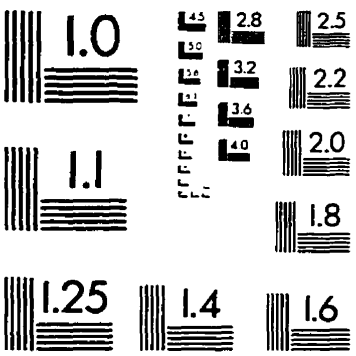

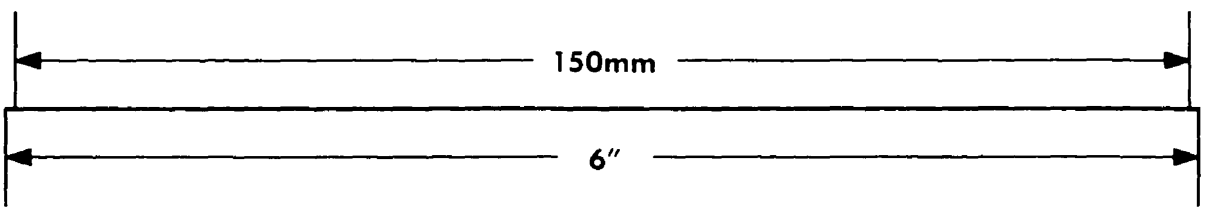

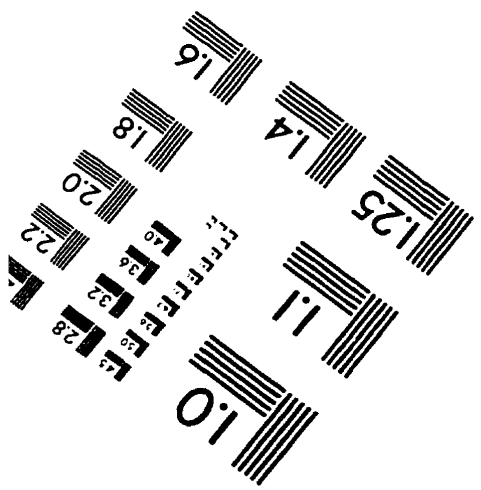

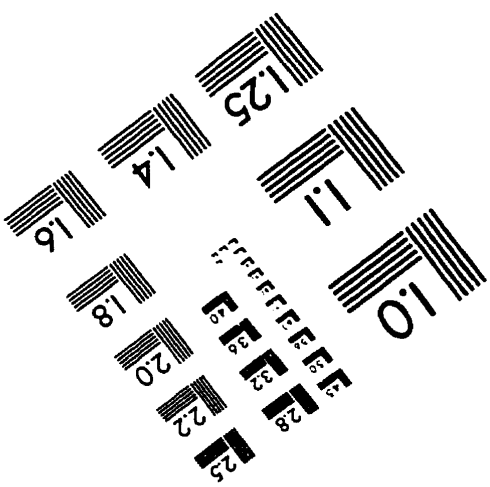

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