Health and Society: Contributions of Latin American Perspectives

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Introduction

From the social sciences perspective, the relationship between "human biology" and society has a triple dimension in the expression of a permanent recursive process: the multiple and diverse psycho-biological manifestations of human life (life itself, sexuality, conceptions, pregnancies, births, growing up, maturing, development, menarche, menopause, well being, health, disease, disability, death, etc.); the interpretations of these psycho-biological manifestations of human life, through culture, and the social practices that symbolize, ritualize, understand, explain, promote, control, avoid and/or solve the psycho-biological manifestations of human life. Although the process is integral and in constant change, in the research process its three dimensions are separated into theoretical, methodological and practical aims.

Thus health, as a social process (part of this sphere of thought) is also researched from this interdependent triple angle, taking into account: its historical forms, its symbolic representation on specific cultural groups, and the diverse social responses that are carried out, coherent with the two other dimensions already mentioned. These social responses are carried out and can be analyzed on different levels: individual, domestic, within the family, social networks, its cultural expressions, as social demands or as being part of public policies.

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It is necessary to emphasize that in the arena of "social responses" the obligations and tasks of State towards the citizens, the voice and the results of academic groups' researches and of other social actors in the field of health, etc., are also considered (Fleury, 1992; García, 1981); the impact of the international institutions (Laurell, 1994a; López, 1994; Laurell, 1995; Laurell and López, 2002). The thinking about the relationships between social sciences and health in Latin America had as its starting point the evident social differences existing in the area. This embraced also the epidemiological profiles, that changed historical thinking, as well as the diversity of socio-demographic patterns between countries and health patterns among countries, regions and/or social groups. In addition, these processes are dynamic.

The field that addresses health/disease and health systems as social processes have been given various names: Social Medicine, Social Sciences Applied to Health, Social Science and Health and Socio-Medicine, based on its "object of study". Other names use the disciplinary approaches from particular social sciences (Medical Sociology, Health Economics, Health Political Economics, Medical Anthropology). Yet another set departs from Medical Sciences (Social Epidemiology, Critical Epidemiology, Social Hygiene, New Public Health). In Juan César García's view, this variety of names implies differing approaches to the object of study, scientific traditions and theoretical perspectives. Nonetheless, they express a certain degree of agreement in that this field of knowledge is related to the "study of the social determinants of health/disease and health services" (García, 1984:21). Although twenty years later, social

sciences do no look for "determinants", and the role of culture and subjectivity in the processes is fully recognized. This new point of view theoretically progressed from the search of "causes" and economic determinants.

In Latin America, there are three moments in the development of perspectives that deal with health and its relationship with society. They are closely linked to three distinct periods in the historical and economic development of the region:

- A phase of capitalist expansion, based on the exploitation of the region's natural resources. This phase corresponds to a hygienist model in public health policies and the beginning of sociology as an independent academic domain.
- A period characterized by the intense industrialization in the area, based on the economic model called "import substitution". This model was based on a welfare state, the idea of "development", that was strongly challenged by the Latin American sociological perspective known as "dependency theories." During this period social sciences became an important academic field, public health policies were based on "ecological and multi-causal models," and health perspectives arose that addressed the importance of social inequality as an essential line to track and understand health problems in the area.
- A phase of economic globalization, characterized by the imposition by supranational institutions of a new economic model, named "neo-liberal." This model erased national borders and promoted social policies that dismantled the welfare state and its protective institutions. This had caused a process of "privatization of life" because all profitable areas of the economy were becoming privatively owned, including health care.

Health and society during capitalist expansion. The start of sociology and the hygienist model.

Up to the end of the World War II, capitalist expansion in Latin America was based on the exploitation of its mining, agricultural and forest resources. Therefore, in this process, the unhealthy conditions of "tropical" countries generated for companies and governments socio-sanitary problems that required control of infectious diseases, vectors, parasites and other environmental sanitary problems. These were carried out by private companies, multinational investors -mostly from the U.S- and local governments (García, 1981). It was necessary to create relatively safe working conditions in regions where malaria, yellow fever, parasites and other diseases were endemic to make possible the interchange of merchandise at borders and in ports with the least possible contagious risks. Such actions were carried out giving health an economic value. They did not have the aim of providing well being, good health and better living conditions the workers, so, their agenda was basically hygienist (Breilh, 1987, Franco, 1990).

The growth of capitalism in the region not only produced transformations of the economy, demographic structures, and social changes; it is also provoked changes in the representation of those societies at a symbolic level. By the end of the XIX Century and until the forties of the XX Century, social sciences developed in the region, particularly in Mexico and Brazil, partly influenced by the immigration of Spanish intellectuals fleeing the civil war, after the Spanish Republicans' demise. Also significant was the initial outflux of Latin American students attending European universities and any influence on their return (Briceño and Sonntag, 1999:106-107). However, the contents of these social sciences were strongly influenced by "Western" ways of thought that often did not take into account the cultural heterogeneity of Latin America. At the time, these sciences were just beginning, and it cannot be said that they were fully institutionalized. So, they were not used on health research.

In this period, health "actions" were based on epidemiological "single-cause models". These were searching for pathogenic agents (viruses, bacterias, etc.) and their vectors to eliminate them, or they were attempting to control the spread of the diseases through vaccines. Therefore, official social answers in the scope of health were guided by a practical interest of controlling such "causal agents" without worrying about understanding the relationships between health and society (Jarillo *et al.,* 2004). The influence of the international context in the development of antibiotics, better diagnostic

techniques, and of new vaccines, increased the resources to fight infectious diseases. This made possible massive interventions with remarkable successes in the control or elimination of various pathologies.

These results made possible the institutionalization of the public health field, legitimizing the work of sanitary personnel that started to be recognized as necessary to care for health problems at the collective level –not only at the individual level- (Jarillo *et al.,* 2004). So, the expansion of this field was started with a preventive platform approach that based its interventions on research of a microbiologic and immunologic nature, resulting in developing of vaccines. This context created the basis for State interventions on public health (García, 1982).

This approach of prevention against infectious and contagious diseases, made possible the reduction of its lethal effects, owing to national campaigns of vaccination and vector control (for instance, tuberculosis, venereal diseases and malaria, the elimination of smallpox), but did not challenged its theoretical basis, nor addressed the social determinants of such actions nor diseases (Arouca, 1975).

Health and society during the import substitution period. Dependency theories, multi-causal ecological models and the appearance of challenging positions to official views.

After World War II, Latin American industrialization became increasingly established with the support of welfare states (in restricted versions if compared with its European counterparts) and driven by economic model called "import susbstitution." Welfare States invested in the economic cost of the reproduction of its citizens as part of the social and economic policy of industrialization of the area. These governments invested in the "reproduction of the labor force", created and supported institutions for social protection and granted subsidies for the so-called "staple goods", even by the South American military dictatorships in the second half of the 70's and the early 80's.

From a Marxist point of view -then dominant in Latin American social sciences- this policy was owing to the participation of the State in guaranteeing the reproduction of the labor force, to support capital accumulation. Thus, the State paid for or subsidized the cost of transportation, health care, education, housing and certain goods (dealt with theoretically as "staple goods"), like: bread, tortillas, maize, flour, salt and sugar.

However, the States' investments in goods and services were unequal: industrial workers received good health services and fringe benefits, especially strategic groups for capitalist expansion (oil, railroad and electricity). Bureaucrats were also supported by the state, while the rural population, at the time the countries' majority, received lower amounts for health care, education and services, and lacked fringe benefits. This drove a large migration from rural areas to the cities, creating the conditions that triggered the growth of the cities population and consequently, urban poverty.

As a result of these factors, Latin American economies are characterized now by: precarious and informal urban employment, a large number of bureaucrats –as a result of the intervention of the State in all economic areas– and the incorporation of women to the labor market. Of course, in Latin America's contemporary history these processes occurred in conjunction with other social events, since the early eighties, mainly related to the imposition of a "neo-liberal" economic model.

Growth of the secondary sector was viewed as the appropiate strategy to overcome unequal exchange in the international market. This exchange was based on the production and export of cheap Latin American raw materials as opposed to the expensive imports of manufactured products from the "developed" countries, mainly the Unites States. Thus, the import substitution model promoted the industrialization of Latin America. As a consequence, all cropping and animal husbandry activities were neglected and abandoned, producing massive migration from the rural areas to the cities (de la Garza, 2001). However, industrialization was not able "to solve" inequalities and poverty in Latin America, nor its status as an "underdeveloped" region. However, as previously stated,

industrialization transformed Latin America's socio-demography in a few decades and defined the important social problems that needed to be to be solved in the future.

Facts had already made clear then, that the problems of the workers and those in the "industrial reserve army" (as they were theoretically considered by Marxist theory) had only been re-configured (now called the "poor" by the World Bank). Their living and working conditions were different, but still below an acceptable standard, with a negative impact on their health and health services. Consequently, their main problems had only been "re-arranged".

Then, as now, health problems were a mosaic mixing health profiles and health services parallel with those of First World countries (for privileged groups), while for vast majorities. Health problems could be directly related to unsatisfactory living conditions. There were also groups almost completely excluded from health care systems and services. Also, in countries with a significant Indian population, health problems, "etiology" and therapeutics did not respond to "developmentalist" goals of homogenization and integration. These sectors continued using alternative health care practices, according to their own cosmovision of the world, distinct from "scientific medicine", known simplistically perhaps as "traditional medicine". In addition to cultural reasons, the persistence of these practices can be explained by the Indian population's exclusion from the official health care system, and its situation of extreme poverty through history.

Anthropology encountered this expression of human cultural diversity, which developed into medical anthropology. In Mexico the pioneer of this field, with personal contributions to the field and an attitude of respect to the original populations, was Doctor Gonzalo Aguirre Beltrán, physician and anthropologist. This research tradition has been continued in the country by Carmen Anzures (Department of Ethnology and Social Anthropology, National Institute of Anthropology and History), Roberto Campos (Department of History and Philosophy of Medicine, National Autonomous University of Mexico), Paul Hersch (Center of National Institute of Anthropology and History in the State of Morelos), Eduardo Menéndez (Center of Research and Graduate Studies in Social Anthropology, Mexico) and Luis Vargas (Anthropological Research Institute, National Autonomous University of Mexico), among many other Latin American researchers.

At the time, epidemiological rapid complexity saw the emergence of pathologies linked to urban modernity, a consequence of the industrialization and urban life (chronic diseases, heart arrests, accidents, psychological disorders, violence, alcoholism, obsessional disorders). Researchers looked for the relationships between society and health because mono-causal explanations, focused in microbial agents and vectors showed their limitations in dealing with to deal with diseases in these new historical scenarios. In central countries, more complex explanations to health problems arose such as the ecological multi-causal models (Leavell and Clark, 1965; MacMahon and Pugh, 1965), which, notwithstanding they did not abandon the "positivistic" tradition, nor the individual, biological and non-historical approach to health issues.

During this period, disease and death profiles were characterized by infectious, parasitic and deficiency diseases, immune-preventive pathologies and maternal deaths; with a high proportion of child and infant mortality and maternal deaths. Also, epidemiological complexity started with the rise of chronic pathologies (heart diseases, cancer, diabetes mellitus, etc.) and accidents (OPS, 1984).

In Latin American sociology, "dependency theories" sprang up, critical to ideological developmentalist views attached to the import substitutions economic model, strongly based on the experience learned after the Cuban Revolution (Cardoso and Faletto, 1971). Political progress had been made as theory emphasized that the place of Latin America in the international division of labor was "the cause" of the main social problems of the region, including those of people's health. Its dependency on the United States and the social problems that this position brought to the region, including strong internal stratification, resulted in an inequitable distribution of wealth collectively produced. So, the logical conclusion was that this

scenerio could change only by overcoming its subordinated position, just as Cuba had done after the 1959 Revolution. Only afterwards, was it possible to build social policies to benefit people instead of capital accumulation.

It is by the end of this period that thoughts of health linked to social dynamics were raised. Diverse interpretative approaches were confronted, mainly theoretical functionalist views, that do not question the social system, and the Marxist one, committed in generating social changes to build a more egalitarian society. These challenging thoughts, had as a starting point the dependency theories and Marxist traditions of Latin American social organization, focusing on the relationships between society dynamics and people health problems. Thus they started an entirely new line of thought and research that had been set aside by the two perspectives, because in spite of the fact that both challenged the social order, often they were in opposition in the academic and political arena at that time.

Latin American perspective of health

As said above, in Latin America, neither the ecological multi-causal model of health, based on place-time-person study; Leavell and Clark's (1965) epidemiological "triad" (agent, host and environment) or MacMahon and Pugh's (1965) "causal net" could account for people' health problems at the time. In this context, critical views looked for *causes* of pathological profiles on the organization of social production (then theorized as a mode of production because of the boom of Marxism in social sciences) (Navarro, 1976, Timio, 1979; Waitzkin and Waterman, 1981). They also took into account the living conditions that this organization created (the scope of labor force reproduction) (Breilh et al., 1987; Betancourt et al., 1991; Blanco and Sáenz, 1994). The unequal relationships of Latin America with the rest of the world were also addressed (unequal and combined exchange) (Castellanos, 1997). Additionally the organization of industrial production was highlighted (including in the analysis, the exploitation of the labor force to generate surplus value in the capitalistic factory) (Laurell and Noriega, 1989). To do this, these approaches used Marxist sociology to promote social change premises, with diverse expressions that were the object of multiple analysis (Nunes, 1987, Belmartino, 1994; Burlandy and Bodstein, 1998, Barbosa and Azevedo, 2002).

The inability of preventive and multi-causal paradigms as alternatives to solve health problems; the increase of critics to these views, and the accumulation of an increasing number of evidences of the limits of these conventional approaches in face of a new complex and diversified epidemiological panorama, speeded up the process to offer new public health study programs, especially at the graduate level. New innovating options appeared, with social and behavorial sciences integrated as part of the study plans to deal with public health in Latin America, called "the social medicine" approach (García, 1972; Nunes, 1991).

Social medicine view in Latin America challenged the prevailing public health assumptions based on the positive tradition (López and Blanco, 1994). For public health approaches, social collectivities are only an addition of individuals with similar demographic characteristics, such as age, sex, occupation, geographic location, income, terminal education age, etc. It also challenged the limited ability of clinical and hospital practices to cope with unequal distribution of health/disease-cultural representations of the social responses (López, 1984). Social medicine was also critical of the functionalist perspective in health situdies, typical of the so called "social sciences relevant to the dominant social order" to explain society and it's lack of power to intervene, to change, health/disease problems of the impoverished majority excluded by the social system from the socially produced wealth.

Of course, the development of the Latin American social medicine perspective was not linear. Theories, methodologies and the problems that it had raised to deal with health problems had changed, accordingly with the national and regional historical development of Latin America.

Iriart *et al.* (2002: 128-136) place the beginning of the Latin American view of health as a social

problem, in the first half of the 70's, in the group of the Pan-American Health Organization (PHO) with Juan César García (Argentinean), María Isabel Rodríguez (Salvadorian), Miguel Márquez (Ecuadorian) and José Ferreira (Brazilian), all of them physicians that encouraged and promoted social medicine in Latin America.

To do this, they worked on the subject and supported research development, the publication of books on the subject, conducting meetings with this perspective. They also assisted in the first graduate studies program that explicitly encouraged the notion of health as a social problem: Introducing the Master's Program in Social Medicine, Metropolitan Autonomous University, Xochimilco Unit, founded in 1975. Most of the professors who now follow this perspective are alumni of this original graduate program or the one at the State University of Rio de Janeiro, opened in 1976, also with the support of the team of the PHO. From these initial two graduate schools, many others developed around Latin America, as well as inter-disciplinary action and research groups, all interested in promoting the view of health/disease as a social problem.

This Latin American perspective of health as a social problem is clearly different from the North American field called medical sociology. The latter started by Parsons (1951) interprets medical practice as a social institution, but is consistent with the perspective and interests of the financial agencies and *policy makers*. So, as an applied discipline it produces social knowledge useful for the insurance companies, the institutionalized medical practices based on highly technological, targeted public health campaigns and policies to control specific diseases (Nunes, 2003). Furthermore, Latin American social medicine departs from official "public health views" in that, according to Edmundo Granda (2000), these are classified as "public *diseasology*" that looks to individuals before they become patients. Consequently, their goal is to recognize "risks", before the individual gets ill, sustained in what the author calls the *foundational tripod* of public health: functionalism to explain social order, positivist methods to study disease and the State's power to guarantee prevention.

Contributions of Latin American social-medical perspectives

Social medical research production in the last thirty years had been extensive. Thus, rather than carrying out an exhaustive review of all the research done, the general trends will be addressed here. There are places where the systemized search of the medical social production in the region can be found, such as: the Social Medicine Portal (**http://www.socialmedicine.org**) the catalogue of journals in social sciences and health of the Brazilian Virtual Health Library (**http://www.virtualhealthlibrary.org**) and the data base organized by Naomar Almeida Filho (**http://www.paho.org/English/HDP/HDR/series19.pdf**); which are the most important ones.

The initial social medical assumptions were based on Marxism, using its categories to build a conceptual basis. Human beings are seen as different from other living species, by their ability to appropriate nature for themselves, through work (Engels, 1974, Trigger, 1974; Juanes, 1980: Peña, 1982) and, in this process of appropriation, they self-create and transform themselves, through culture and social relationships. Social medicine incorporated general Marxist categories, such as: labor process (Marx, 1978); social reproduction (moment of production, moment of consumption) (Breilh, 1987); and social classes and social inequalities -in specific situations and social groups-, exploring social determinants of health, disease, death and health care, as collective processes embedded into the culture and social relationships (Blanco, 1991).

In its later development, social medicine goes beyond two arenas: the distribution and determinants of health/disease, and knowledge and practices around health, disease and death. To deal with these two arenas, Marxist concepts were used to build unique theories and methodologies; to this collective task diverse research groups that emerged during the late seventies and early eighties committed themselves to the task. Social medicine debated with functionalism and with the preventive perspective of hegemonic public health approaches, building broader explanations of the already known health problems (López y Blanco 2003). Social

medicine is also a scientific arena that is socially committed with the improvement of living conditions for everybody, as well as collaborating in making changes on the ways though which knowledge is generated.

To show the complex recursivity of collective health/disease phenomena, representations and social practices, from a holistic social scope, new interpretative views were put forward, including that the health/disease system is a social and historical process in itself (Betancourt et al. 1991, Breilh et al, 1987, 1994 and 2003, Laurell, 1982 and 1989); and that health knowledge, policies and health practices are organized social responses that deal with specific realities (Donnangelo and Pereira, 1976; García 1981, García 1982, Tetelboin, 1997, Vergara, 2000; Cohn and Elias, 2001; López and Blanco, 2001).

At first, health/disease as a social process was researched by relating morbidity and mortality with the historical and social processes of the population. This took into account a set of problems from natural-biological approaches which did not seem relevant (Laurell and Blanco, 1975). However, the task of linking social processes with morbidity-mortality profiles in specific populations, has a limitation in its ability to explain the diversity and complexity of these profiles. These explicit deficiencies lead to the need for constructing new knowledge objectives, to discuss the social determination of health/disease and ways of dealing with it. As a consequence, social medicine perspectives contributed to make clear the theoretical limitations of public health that split health from disease; representations and practices, from the social organization; and "naturalized" social processes; viewed collective problems as individual ones and used theoretical and methodological procedures from natural sciences, rather than social sciences (Laurell, 1994b).

Social medicine sees health/disease as a *continuum*, as different moments on the vital human cycle, not as opposed pairs, a process that is constantly changing and that expresses in the human body ways of appropriating nature, under diverse forms of social organization (Breilh and Granda, 1982; Laurell, 1989). Consequently, health/disease process is recognized as the synthesis of a complex structure of determination, where social processes "subsumed" biopsychic processes (Breilh, 1991). That is, health/disease is an expression in the human body and psyche, of social processes of an historic nature. Such social processes do not act as biological-physical-chemical "agents" in generating disease, and do not have "etiological specificity", nor follow a dose-response relationship (Laurell, 1994b).

In the methodological domain, social medicine has moved forward and has made important contributions. Has made clearer the identification of the main social processes that affect health. It has also defined criteria for the construction of "human groups" where the social dimensions of health/disease will be expressed better. It had also promoted the need to study health, disease and death profiles of social groups, rather than targeting specific diseases. Recognizing men and women as social beings, always merged in social relationships and cultural frames. Social medicine raised and answered to two fundamental questions:

- The recognition of health/disease as social processes
- The need to deal with human groups to assess their health/disease profiles, to show its social and historical character

In the knowledge domains, health policies and practices, through diverse and complex socio-historical dynamics and the institutionalization of different social responses to the health/disease process made them visible as a specific domain for analyses of social sciences in health (Cordeiro, 1978, Menendez, 1978; Fleury, 1985, Bloch, 1980; Testa, 1986; Passos-Nogueira, 1986; Fleury, 1990, Cohn y Elias, 1996). They are also an arena of political action. Their general academic object can be defined as the study of the forms and processes that establishes the permanence and change of "organized" social response, integrated by all the diverse and contradictory social organization expressions (institution in the broadest sense); and its contents: knowledge, resources and technologies. As a whole, they expressed specific practices directed to guarantee welfare, by promoting health,

as well as preventing and dealing with disease (Donnangelo and Pereira, 1976).

It must be said, however, that the study of macro-processes, based on social theories, to explain the role of society in the production of collective health/disease, only partially explained the most general tendencies of the complexity of health, disease and death profiles (Palloni, 1985; Loureiro, 1992). This is so, because these approaches leave aside the representations and actions that the individuals, organized in social groups, developed to face their structural social disadvantages, that, although they are often limited by their own social vulnerability, cannot be set aside in the analysis. This is why in recent years "mediations" were included between the macro-structural processes, the real subjects, and their actions, to better understand the diverse expressions of the human bio-psychic processes (Menéndez, 1990; Mercado, 1993, Mercado 1996, Peña, 1997; Castro, 2001; Bronfman, 2000).

Because of its importance in the understanding and transformation of expression of the vital human processes, some of the dimensions that acquired more visibility in the last years are: family life strategies (Tuirán, 1992; Peña, 1997; González de la Rocha, 1999); the forms of use and appropriation of the ecological context in rural zones (Daltabuit, 1988); studies about the quality of life (Blanco et al. 1997a; Blanco et al. 1997b); research of diverse vulnerable groups: children, elderly, disabled, women in different socio-demographic situations (targets of violence, women as a head of household, etc); the ethnic group impact (Blanco et al., 1996); gender impact (Figueroa, 1993; Langer and Tolvert, 1995), sexual preference, especially after the AIDS epidemic (Castro, et al.; 1998a; Castro et al.; 1998b); the role of social networks (Bronfman, 2000) and the auto-constitution processes as political subjects (Ayres, 2002).

On the other hand it is necessary to emphasize, that from the social medicine perspective it is not intended that a rigid and completely finished interpretative model be finalized, rigid and applied to all times, spaces and populations. The intention is to provide an innovating view, linked to a way of thinking about the historical, cultural and differential expression of "human bio-psychic processes" that helps to recover their multiple dimensions, as well as to recognize that their social production and expression is multifarious and complex, and in continuous change (Granda et al., 1995).

From the mid 70's to date, the importance of Latin American social medicine has been widely recognized in the region. Its theory, methodology and results have been taught and promoted among sectors of health workers, activists, university professors and researchers. In Argentina, Brazil, Colombia, Venezuela, Chile, Ecuador and Mexico, professionals that studied in graduate schools with this orientation are now quite influential. They hold or had held important positions in which they designed policies, prepared and evaluated programs and teach in almost all Latin American countries (Nunes, 1987; Mella, 1991).

In several countries among which Brazil, Venezuela, Colombia and Mexico stand out, this approach has been actively promoted and owing to its innovative importance has had academic effects and practical impacts. The social medicine perspective has also nurtured health issues and problem solving in national and local governments, allowing for the implementation of diversity angles of its contributions (Cohn, 1992; Torres-Goitia, 1992; Buselo and Minunjin, 1998; Tájer, 2003; Laurell, 2003).

Latin American experience in the field of research that amalgamates social sciences with health is young, has been developing for only three decades. In this period the relationships between the material basis (facts) and its symbolic order (representations) has changed according to the transformations of socio-economic and political-ideological problems, alongside the cultural and intellectual traditions at different periods and contexts of Latin America as a geopolitical area, and within. For instance, when the imports substitution model was in effect, health in the factory was exhaustively studied taking as basis the Marxist concept of the labor process (Possas, 1981; Da Costa, 1981; Laurell and Márquez, 1983; Tambellini, 1987; Laurell and Noriega, 1989). At first, without considering life experience of the "real

subjects" later, qualitative methodologies were included, mainly the collective survey to targeted groups (Laurell, 1991; Minayo, 1997). When in the early 80's the relationships between the State, the market and society were redefined, through the imposition of an economic model of neo-liberal structure with new public policies, Latin American social medicine turned to research the impact of such policies in the population living standards, and its consequences on health (Betancourt, et al., 1991; Laurell, 1997). In Colombia, Saúl Franco has approached violence as a social medicine problem, because there it as an endemic problem (Franco, 1999; Franco, 2003). The current social context, has made it a priority to account for the transformation of public policies, mainly –but not only– the reforms applied to the health sector (Fleury, 1985; Fleury, 1992; Laurell Ed, 1992; López y Blanco, 1993; Laurell, 1994a; Mussot, 1996, Almeida, 2002a and the effect of the increasing socio-economic inequalities with the concentration of wealth in a few hands, as a consequence of the new economic model (Tavares, 1999).

To date, various balances of the Latin American social medicine contributions to the study of health/disease as a social process there have been carried out. In 1991, within the frame of the Latin American Association of Social Medicine, the volume "Debates in Social Medicine" was prepared, with three chapters that made a balance of this area of knowledge. The first, elaborated by Everardo Nunes, refers to the social medicine production and its influence in Latin America since its origins, as a pedagogic practice, as a theoretical practice and as a social practice (Nunes, 1991). It should be stated that Nunes himself had realized a previous balance and other important contributions to the topic (1986). The second, written by Jaime Breilh (1991), reconsiders the field from the point of view of the methodologies used. For this, he carried out an exhaustive analysis of the theoretical and methodological contributions of an important amount of research. Thus, it is really an obligatory reference for those interested in these problems. Breilh himself, since his initial work "Epidemiology: Economy, Medicine and Politics" (1979) is concerned with building the object of study of "Critical Epidemiology", putting forward theoretical and methodological categories to comprehend such an object. Some of these categories are: social reproduction, determinant relationships, epidemiological profiles; that have been the basis of an important part of research concerning the links between health and society. Lastly, in this book, Laurell (1991) carries out a balanced study of the contributions regarding the relationships between work in factories and health, a central worry in Latin American social medicine in the 70's and early 80's. Theoretical approaches are analyzed using concepts such as a capital accumulation process, working process, production process, social reproduction, moment of production and moment of reproduction, the knowledge generated and the defense and development of the worker's health.

Waitzkin, Iriart, Estrada and Lamadrid (2001) carried out for the English speaking public an exhaustive review of the work done by the main academic teams of social medicine in Argentina, Brazil, Chile, Colombia, Cuba, Ecuador and Mexico, describing the emphasis and the contributions of each country, the most important work groups; their leaders and members, their research traditions, their theoretical and methodological contributions and the journals they have promoted. At the same time, they analyzed the differences between social medicine and public heath, underlining its integral view of health/disease, as well as their social base, the relationships between work, social reproduction and the environment, and the impact of trauma and violence. They discussed how at the theoretical level this perspective has taken Marxism as a basis, adding the recent philosophical European trends. They also stated, that among the fundamental concerns of social medicine now there are the new social policies and its impacts in the collectivities' health (Waitzkin et al, 2001).

In another paper, Iriart, Waitzkin, Breilh, Estrada and Merhy (2002), present the context in which the Latin American medical social approach came about, its theoretical and methodological debates, the main research problems this field of knowledge faces and the difficulties experienced in attempting

to spread it to the non Spanish speaking world. They also make a summary of the reasons why it is necessary to prepare an internet portal for the discipline (**http://www.socialmedicine.org**) that has a database of Latin American researchers accessible worldwide (Iriart et al, 2002).

The last of the previous balances that we consider here is that published by the *American Journal of Public Health*, December 2003. Latin American countries share a history, a language and have a specific identity in a world sense. However it is also characterized by a deep social inequality that severely and adversely affects the health of the majorities. This is a reality that has followed us for more than five hundred years so really it could be said that social medicine was created here. The contributions to this volume were originally presented at a symposium of the congress organized by the *American Public Health Association* held in Philadelphia, U. S. A. in 2002. The volume presented an historical review of this point of view and its impact in health improvement (Tájer, 2003); a discussion of how theory and practice interact when social medicine is given political power (Laurell, 2003); an example of the application of the social medicine knowledge to the field of violence (Franco, 2003) and a books and periodicals analysis of the production of this line of thought (Almeida et al, 2003).

Perspectives in collective health

Progress made in Latin America using economics, sociology, philosophy and anthropology in the building of the field of social sciences and health, over the last three decades, recognized the multiple dimensions of health. It also posed a critical approach to reality and constituted the conceptual and practical platform of the so-called "collective health" in Brazil, emphasizing the political implications of human actions (Costa y Riveiro, 1992). With this way of naming the field, Brazilian researchers tried to overcome the over-emphasis on treating diseases, inherent in the "medicine" concept.

Furthermore, collective health emanates from the recognition of the fact that the processes of social health/disease/representations/social responses express socio-historic facts concerning human collectivities and that, therefore, it is necessary to explain the determination and distribution of these processes beyond their proximal "causes" and the biological domain (Granda, 2003). This moves the discussion towards a linking point between what is biological and what is social, in an effort to establish its separation from other models that have a biological-natural base or epidemiological-probabilistic one, to build its own object of study. Its goal is to overcome the perspective that collective health problems should be faced as an unceasing struggle against death (prevailing view in medicine) or are reduced to the struggle for the control and/or elimination of certain diseases (prevailing view in public health) (Almeida and Paim, 1999).

In this process of separation and reconstruction, the challenge of overcoming biological and deterministic views was imposed by medical predominance and it is related to its sanitary approaches. The goal is to assess a transdisciplinary approach using mainly sociological and anthropological perspectives (Paim and Almeida, 1998). Because of this, collective health assumes the need to solve the old controversies between nature and artifice, the modern debate between history and nature, biology and society, recognizing that there incompletely understood relationships in human beings, at the epistemological level (DCSC/UAM-X, 2002).

In spite of considerable progress made in the explanation of diverse forms of expression of health/disease, social representations and social responses within the human collectivity scope, in the frame of social reproduction processes, the theoretical-methodological scheme that sets the foundation for these approaches have not yet been satisfactorily solved. This means that collective health faces theoretical and methodological challenges, not yet solved by other perspectives, among which several stand out:

- The approach to the relationships between the biological, the psychic and the social
- The limits found in the social theory to understand the relationships between the individual and the collective

- The construction of the boundaries of study and forms to approach collective health as object of study (Almeida, 2001)

Consequently, in the analysis of vital processes (for instance, conception, pregnancies, birth, growth, development, sexuality, reproduction, including health/disease) its material dimension and a cultural and subjective dimension are recognized. Its material basis is expressed in humans at the organic and biological levels, but these events are tailored by cultural and subjective interpretations (both individual and collective). So, at the end nature and nurture, material basis and symbolic order are an integral unique process of comprehension. Collective health deals with the understanding of the relationships between human beings; of human beings with a humanized "nature;" and the processes by which individuals become humans, in cultural and social contexts. Based on these levels, the different arenas of analysis of collective health are positioned. As a field of knowledge it has the purpose of explaining more thoroughly health, disease, care and all human vital processes (DCSC/UAM-X, 2002)

The collective health objective generates knowledge and solutions concerning health problems of social groups. Without ignoring the individual level that only allows for a partial approach, and in order to assume a more inclusive level permitting to the understanding of vital processes –including health/disease– it subordinates individuals to human groups, embedded into specific societies, as a synopsis of complicated networks and contradictions. Its purpose is to contribute to enhance human capabilities and to guarantee an optimum development of the vital processes within human groups.

Health and society at the present time

Under globalization and the imposition of a neo-liberal economic model in the area, that started in the early 80's, there is now a movement towards new social policies implying a life-privatization process originated in the disappearance of the welfare state, the redistribution of the State's obligations towards its citizens, and the redefining of the State's role as investor and in regulating the market. Thus, the Nation-state's responsibilities were restricted. Social protection institutions were selectively dismantled, losing the state's financial support. Their work was reoriented under the aegis of targeted care, focused on the poor population, while all profitable economic areas were privatized, including those of health. These strategies were imposed by supranational organizations, such as the International Monetary Fund and the World Bank, at present they define the economic and social important projects for most countries (Laurell and Lopez, 1996, Armada, et al., 2001).

The demographic and epidemiological scene in this period became more complex: populations are aging and concentrated in urban spaces, so in Latin America there coexists "poverty pathologies" (deprivation and infectious-contagious diseases) with "illnesses of modernity" (neoplasias, heart diseases, high blood presure, diabetes, accidents and intentional injuries, psychological disorders) and new emergences (Acquired Immuno-Deficiency Syndrome –AIDS–, Mad Cow Disease, Acute Respiratory Disease, anorexia and bulimia).

Three fundamental phenomena made health profiles and its study more complex in Latin America in this period:

- Socio-epidemiological polarization, mainly owed to the deepening of social inequalities characterized by the concentration of wealth in a minority, a process which affected health between and within countries, regions and groups
- Sanitary regression, expressed in a new rise of diseases previously eliminated and/or controlled (López and Blanco, 1997)
- The emergence of new pandemics such as HIV-AIDS, and violence, that are combined in the region with poverty and a great number of inhabitants without access to health services

In social research, in the frame of global economies and theories, theoretical and methodological approaches that deal again with human action were developed (Bourdieu, 1977; Touraine, 1977; Giddens 1998), as well as views about the complexity and non-mechanic determination of social processes (Morin, 1996). These new approaches enrich the traditional views, diversifying them and augmenting the problems

they pose (Castro, 2000). In the face of repeated crises and rapid changes in this period, the strategies and actions of social actors, sometimes restricted because of their vulnerable social situation, made them visible as active subjects. So, the stage of development of researching processes without subjects that are capable to think, feel and act, was overcome, as the rigid economic determinants that characterized social medicine at some stages of development.

In the present situation global subordination by Latin American countries to the supranational institutions, the emphasis on individual response and on life privatization also affected the forms in which collective health was studied. From the economic and social megaprojects promoted by supranational institutions, the harshnesses of present life are understood as a transitory sacrifice to achieve a better future. From this view, globalization, elimination of economic regulation, eliminating and promoting "free" market process is the correct track of development (World Bank, 1990, World Bank, 1993, World Bank; 2003). Challenging these views, is the position that asserts that another more equalitarian and human world is possible and necessary, a view that now is promoted by diverse groups which have started to organize in different and innovative ways.

In this new scenerio, research has diversified and the trends towards interdisciplinary, transdisciplinary and multilevel views that combine these methods have strengthened. Also the divisions between those defending this globalized way, and its critics have widened. The latter see in the deepening of social polarization in the world and in the exclusion of millions of inhabitants of the planet from a basic conditions for well-being an unbearable injustice.

Latin American social thinking in health: Summary and conclusion

The socio-economic characteristics of Latin America made possible the development of an innovative, critical and socially based thinking concerning health (Cohn, 2003). There emerged in the region a goal dealing with this reality to develop theories and methodologies to incorporate to the analysis of health social inequality as a fundamental perspective to understand: diseases and death; the social and individual reproduction under adverse conditions as an essential element in the deterioration of life; the consequences on health of working conditions; the negative effects of the new social policies, such as low wages, a labor policy that produces vulnerability and on-the-job instability; the privatization of previously public services; and the decline of social expenditure budgets with the subsequent increase of the collectivity's health problems, owing to the impairment of living standards.

This view helped to incorporate qualitative methodologies of research on health research (Martínez and Huitrón, 2001; Mercado *et al.*, 2002), previously the exclusive domain of anthropology and rejected in other academic spaces as "non scientific". It also incorporated new methodologies to health research, such as collective interviews and various approaches leading to qualitative and quantitative combinations (Samaja, 1987; Baum, 1995; Castro and Bronfman, 1999, Mercado *et al.*, 2002). The Latin American view also contributed and made public the vulnerable conditions of different social groups and their relationship with specific health problems (women, migrants, children, elderly citizens, workers, peasants, native populations, the unemployed), making their problems visible, giving voice to those without social voice in academic forums and in political contexts.

Premises in this new line of thought started from an explicit commitment to search for equity in health, surpassing the science centered perspective of other research traditions. They are based on,

1. The recognition of social inequality, poverty and "crises of uncertainties" that with historical changes and regional characteristics, had affected and still affect wide sectors of the Latin American society. These conditions have been in the region, at least since colonial times, and have continued coexisting with the implementation of the import substitution model, the application of macro-economic structural adjustment policies and the imposition of the neo-liberal model. This model has deepened the socio-sanitary polarization that already

existed, excluding large sectors from health and health care. In addition it has dismantled social protection institutions (Navarro Ed. 2002).

2. The Latin American social sciences political commitments practically since their origin held a position favoring the deprived sectors, thus, becoming non neutral, because they were clearly working for social change (Briceño and Sonntag, 1999). At present, in spite of the political situation, social researchers fight for the promotion of greater equity, including, of course, greater equality in health. That is, the challenging speeches in health by social medicine practitioners would demonstrate its social and political committtmment to societies' transformation and to the search of forms that would reduce inequality and favor respect for cultural diversity.

3. The boom in Latin American social sciences, that since the dependency theories deeply questioned the economic and political model of *development*. By doing so they showed clearly that the solution to collective needs for healthcare, housing, education, nutrition, among others, has as the only possible alternative the radical transformation of the economic and political dependence of the countries of the region towards the United States of America. They also emphasized the need of power rearrangement within the hands of the nations' elite, functional to that dependence.

4. The construction of a Latin American perspective to view health at the collective level has become a space of interaction for diverse disciplines, such as sociology, economy and anthropology, the latter challenges classic indigenous studies. This view has contributed to make visible different health interpretation forms and practices, coexisting with "scientific medicine", that express the links and rearrangement of the Latin American ethnic groups identities.

5. The profound challenge to preventive medicine and public health, and its contribution to the widening and rebuilding of social sciences' knowledge related to two important objects of study: the complex analysis of the multiple process that converges in the expressions of human biologic-psychic "realities", including health/disease, as well as its historical and cultural representations and the organized social responses linked to them.

6. The development of a "Critical Epidemiology" postulating an integral interpretation of the collectivities' production/distribution of health/disease and questions the limits of probabilistic causalities, the restraint of reality to "factors", and the notion of risk as the "explaining" concept of conventional epidemiology (Breilh and Granda, 1982; Goldberg, 1990; Almeida, 1990; Breilh, 1994; Almeida, 2000; Breilh, 2003).

7. The need to explain reality in Latin American health from critical perspectives that gave rise to innovative thinking which, questioning the biomedical and epidemiological knowledge, integrated theories and methodologies of social science to arrive at new concept of health as *social in itself*. By doing so, this new thought crosses the disciplinary boundaries to conceive collective health as an analytic axis of transdisciplinary nature, generating an innovating view that surpasses by thirty years the suggestions set forward by the *society of information and knowledge (*OECD, 1996), which concludes that the new and creative thinking responds precisely to transdisciplinary problematic axis.

8. From Latin America the advance of medical anthropology went from the classic studies of *folk* or *traditional medicine* (that by focusing in symbolisms and/or therapeutics, left aside the clinic disease, the biology of the individuals and their social vulnerability before national societies) to the study of the role of culture in diverse manifestations of human vital processes (Del Vecchio, 1995). It also studied social medicine and/or collective health moving forward from economic determinisms to consider the "real subjects" actions and its subjectivity (culturally based) in the analysis of health/disease profiles. Through all these processes and the incorporation of qualitative research methodologies (Castro, 2003), they have created a promising scenario for innovative research in health within a context like the Latin American one: multi-cultural, socially unequal and economically diverse, that polarizes the epidemiological processes (Inhorn, 1995).

Starting from these bases, Latin American contributions to the study of health were also innovating because of the form in which health knowledge started to be produced. In effect, multi-disciplinary spaces and teams were conformed, using tools of quite different sciences and traditions, to approach the complexity of the field. That is, Latin American views produced an original knowledge both in content and in its production mechanic. To paraphrase Sawyer: the study of health differentials seen as socially produced problems *required an organic inter-disciplinarity (*quoted in Bronfman, 2000:13), which was conceived and consolidated in Latin America.

As Iriart *et al.* indicated (2002:128) "Latin American social medicine is a very important knowledge and practice field that is little known by those practicing medicine and public health, especially by those who cannot have access to information written in Spanish or Portuguese", a fact that puts such information out of reach of the Anglo-Saxon world. So, we hope that the ideas discussed here contribute to make visible the important Latin American contributions to the study of collective health and its commitment to promote equity in all living levels.

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