Latin American Social Medicine: The Quest for Social Justice and Public Health

Social justice is the foundation of public health. This controversial assertion has been the guiding principle to some, and anathema to others, ever since the rise of the modern public health movement in the mid-19th century in Europe and the Americas.[1]

Translated to the realms of theory and action, the premise that societal arrangements of power and property powerfully shape the public's health has animated diverse efforts to develop cogent frameworks that explicitly identify determinants of—and can usefully guide efforts to rectify—social inequalities in health. Examples of such frameworks in the English-language literature appearing since the mid-20th century include "social medicine," "social production of disease," "political economy of health," and, most recently, "health and human rights," "population health," and "ecosocial theory."[2] A similar discourse generated by the social, academic, and political movement collectively known as Latin American social medicine[3,4] can be found in the Spanish- and Portuguese-language literature.

CONNECTING PROGRESSIVE PUBLIC HEALTH WITHIN THE AMERICAS

Until recently, these different strands of progressive public health thinking and practice in the Americas were barely intertwined. New connections, however, are starting to be made, spurred by growing awareness of the public health impacts of diverse regional economic and social policies.[1–5] Of particular concern are neoliberal economic policies, such as the North American Free Trade Agreement (NAFTA), which result in economic austerity plans, environmental degradation, and growing intra- and interregional social disparities in health.[5]

To encourage North–South dialogue within the Americas, for example, one recent initiative, based at the University of New Mexico and involving institutional partners in Argentina, Chile, Ecuador, and Brazil, is focused on increasing access to the Latin American social medicine literature via the Internet (see http://hsc.unm.edu/lasm). Its promise is to increase the flow of ideas not only from South to North but also across the South, by providing readily accessible structured abstracts for key works translated into English, Spanish, and Portuguese. Another example, reflected in the pages of this issue of the Journal, is the special session "Latin American Social Medicine: The Quest for Social Justice and Public Health—Linking History, Data, and Pedagogy" organized at the 2002 Annual Meeting of the American Public Health Association (APHA).

The idea for this session, organized by APHA's Spirit of 1848 Caucus, arose at the caucus's 2001 business meeting. The caucus, dedicated to addressing social inequalities in health, focuses on 3 issues: the politics of public health data, the social history of public health, and progressive pedagogy (see http://www.progressivehn.org).[1] At this meeting, Tony Casas, from the Pan American Health Organization (PAHO), asked about the similarities and differences between US and Latin American progressive public health thinking and practice. In response, we organized a session for the following year to tackle this question, consonant with our goal of building ties between people—within and across countries—who are vitally concerned about issues of social justice and public health. We decided that the appropriate venue would be our first "integrative" session, a session deliberately designed to address one topic in relation to the 3 foci of our caucus. This important collaborative effort was made possible by 2 key organizations: PAHO and the Latin American Social Medicine Association (ALAMES). ALAMES helped us decide on and secure the participation of our Latin American speakers, and PAHO covered their travel costs.

LATIN AMERICAN SCHOLARS ON "COLLECTIVE HEALTH"

The issues raised in that session, and elaborated in the articles appearing in this issue of the Journal,[6–9] underscore the importance of making explicit connections between social justice and public health—historically, empirically, and pedagogically—and acting to strengthen those connections. Reviewing the origins of Latin American social medicine as a social, academic, and political movement, Débora Tajer, professor

and research director of gender studies, Faculty of Psychology, University of Buenos Aires, and past president of ALAMES, describes the founding of ALAMES in 1984, premised on the defense of health as a public good and civil right.[6] To counter conventional, reductionist, and positivist public health frameworks and programs, ALAMES has developed an alternative focus on what the association terms "the social production of the health–illness–care process."

HISTORY

Beginning with an emphasis on the role of social class and the production/reproduction of class relations and inequality in relation to state policies, the ALAMES framework has expanded to include incorporating gender analysis and engaging with human rights movements. In practical terms, this has translated to an emphasis on building ties between academics and activists, with knowledge generation and transfer used as a tool for social change. Importantly, these ties are rooted in the recognition that collective action for collective health requires not only critical scientific expertise but also frank engagement with the politics of public health. This principled stance can entail considerable risk in times of repressive governments more committed to the defense of propertied interests than to public health.

DATA

Translating theory into a guide for research and intervention, Saul Franco Agudelo, a professor and researcher with the Department of Collective Health, National University of Colombia, presents a social-medical analysis of the violence in Colombia.[7] Defining violence as "a specific form of human interaction in which force produces harm or injury to others in order to achieve a given purpose," he emphasizes that violence is a process, has a historical nature, and must be analyzed in relation to "the specific combination of cultural, economic, social-political and legal conditions that make a phenomenon historically possible and rationally understandable." Analyzing the extraordinarily high rates of homicide in Colombia, he attributes these rates to "three structural conditions—inequality, impunity, and intolerance—and three transitional processes—illegal drug traffic, the internal armed conflict, and the introduction and development of a neoliberal model."

PEDAGOGY

Finally, underscoring that pedagogy for public health does not occur only in classrooms, Asa Cristina Laurell, secretary of health, Mexico City, and a professor at the Metropolitan University of Mexico City, describes the new Broadened Health Care Model now operative in Mexico City.[8] Drawing on the legacy of progressive Brazilian health reforms in the 1980s, which asserted health as a universal social right to be guaranteed by the state, this model serves not only as an important public health initiative but also as a critical civic lesson. The key values of the Broadened Health Care Model, which aims to decrease inequality between social groups and geographic areas, are the intrinsic and equal value of all persons; the obligation of government to honor and protect the life of all human beings; and the right to health as a social right and a responsibility of government as the guardian of collective interests.

At a time when the Mexican federal government was imposing an "austerity budget" that followed the neoliberal formula of slashing services to the most vulnerable sectors of the population, the enactment of this model resulted in an alternative "austerity program" that reduced the salaries of high officials and attacked corruption. These measures enabled the initiative to secure funds to provide free health services, prescription drugs, and a monthly pension to virtually all persons aged 70 years and older (there had previously been no social security program). In addition, more than 300 000 families (out of approximately 1 million) were enrolled into a new program offering free universal health services. Other accomplishments have included increasing public participation in health programs and improving transparency of government action in all 1352 administrative sectors of Mexico City, thereby challenging conventional notions of public institutions as incapable of offering appropriate services.

Seiji Yamada, clinical associate professor of family practice, University of Hawai'i, concludes this forum by reflecting on the relevance of Latin American social medicine to other regions of the world.[9] He focuses on the public health impact of early- to mid-20th-century Japanese imperialism and mid- to late-20th- and 21st-century US imperialism on the populations of diverse Asian countries.

INTEGRATION

As demonstrated by these contributions, the work of Latin American scholars on what they term "collective health" is highly relevant to public health researchers, teachers, practitioners, and advocates in the United States and elsewhere. For fruitful engagement to occur, especially within the Americas, it will be necessary to address more than simply language barriers. For example, important Canadian work advancing progressive thinking and practice about population health, readily available in English as well as French,[10] remains unfamiliar to many public health professionals in the United States. To counter the fragmentation that many of us face—within and between disciplines, within and between work on particular diseases or health problems, and within and between different organizations geared to specific issues or social groups—a different mindset is necessary. We need not start from scratch. As demonstrated by Latin American social medicine, we can build on the core social-justice principle of solidarity to make vital connections with others to develop our thoughts, strategize, and enhance joint efforts to eliminate social inequalities in health. ■

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