

# Latin American Social Medicine: Roots, Development During the 1990s, and Current Challenges

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The source of inspiration for Latin American social medicine (LASM) is the social movements that occurred in France, Germany, and England during the mid-19th century<sup>1</sup> and the development of European social medicine, together with political processes whose main representative was Rudolf Virchow. LASM originated in the reformulation of medical training that took place in Latin America during the 1950s<sup>2</sup> and differs from traditional disciplines of hygiene, public health, and preventive medicine.<sup>3,4</sup> The turning point took place in the late 1960s, when the ideology underlying the preventive model then in vogue in Latin America became explicit and the possibility of constructing a social theory in medicine arose.<sup>1</sup> Thus began a new and distinctive methodological tradition in the field: the critical and ideological analysis of what is usually presented as purely technical knowledge.<sup>5</sup>

This perspective, which appeared in the context of formalizing the contents of social sciences in health courses as part of undergraduate medical training, later advanced toward specific graduate programs in social medicine in different countries. The forerunners were the masters program in social medicine of the Autonomous Metropolitan University of Mexico in 1975 and the social medicine program of the State University of Rio de Janeiro in 1976, both supported by the Pan-American Health Organization.<sup>3</sup>

Although LASM is basically considered as a stream of thought and knowledge, it has strong roots in a political practice, carried out by a social actor of heterogeneous characteristics, known as the LASM movement. The link between theory and practice makes LASM an approach with explicit ideological objectives<sup>6</sup> that has undergone important changes throughout its nearly 40 years.

The complexity of the LASM movement may be defined when we identify its roots. They include

Latin American social medicine arose during the 1950s and 1960s, drawing its inspiration from the social movements that emerged in France, Germany, and England in the mid-19th century.

The Latin American movement of social medicine has clear ideological goals. It is organized around the Latin American Association of Social Medicine, which was founded in 1984 and is regarded as a social, political, and academic movement. This article takes a historical perspective and presents the reasons for the emergence and identity of the association, focusing on the main developments and contributions of this movement from the 1990s until the present time. (*Am J Public Health*. 2003;93:2023–2027)

- A conceptual framework within the field of public health called *social medicine* or, in Brazil, *collective health* that highlights the economic, political, subjective, and social determinants of the health-disease-care process of human collectivities.
- A political dimension represented by the attempts at political change and social transformation in Latin America, started in the 1950s, that valued the improvement of health status and equitable access to health services as essential pillars of the liberation of the people.
- An organizational modality originating in the social medicine seminars organized by the Argentine public health practitioner Juan Cesar Garcia from the Pan-American Health Organization at the end of the 1970s and beginning of the 1980s. During the third seminar in 1984, the Latin American Social Medicine Association (ALAMES) was created.
- A view of the concept of subjectivity that is theoretically and practically based on the Marxist tradition that considers the subject as historically conditioned and at the same time a maker of history, and that values political practice as a promoter of solidary subjectivities.

## ALAMES AS AN ORGANIZATION

ALAMES began in 1984 with a group of pioneers from Mexico, Ecuador, and Brazil and editorial committees of specialized journals.<sup>7</sup> ALAMES does not encompass the total diversity of the movement, but since its origin it has remained a leader in the region because of its role

in generating, harmonizing, and promoting the production of national groups and processes.

After 19 years of work, ALAMES has become a powerful collectivity, defining itself as a social, political, and academic movement aimed at guiding public health and social medicine toward resolution of the historical and social determinants of the health-disease-care process. ALAMES is present in all countries of the American continent.

The Latin American region is very diverse, and so are the different national groups and dynamics. National ALAMES groups may be formed around graduate institutions of collective health (Brazil), medical unions (Chile-Uruguay), pro-health peasant movements (Paraguay), public health schools or masters programs in social medicine (Costa Rica, Mexico, Peru), national health movements (Colombia), self-organized groups (Argentina), groups of research-action (Ecuador), or others.

In spite of the diversity of both the region and the movement, the idea of the movement is preserved by a regional vision highlighting the coexistence of a practice that articulates social, academic, and political aspects. Such coexistence has provided a huge potential but at the same time implies countless contradictions and challenges.

## ORIGINS AND MAIN CURRENT ISSUES

It is important to understand that many of the members of the LASM movement come

from and belong to an academic environment<sup>9</sup> and consider that the generation and transmission of knowledge is a tool for change. Basic investigations—as well as the promotion of evidence-based advocacy—are promoted and undertaken according to this same theoretical framework, with the goal of contributing to the design and implementation of evidence-based counter-hegemonic public policies.<sup>10–16</sup>

To understand the specificity of this movement, one must understand that in Latin America the difference between the classic approach to public health and the social medicine paradigm is evidenced by

1. LASM's definition of populations as objects of study, not conceived as a sum of individuals but rather as collectivities.<sup>15–17</sup>
2. Studies of health institutions aimed at understanding their logic and their capacity to reproduce relations of dominance, and at developing alternative proposals.<sup>18,19</sup>
3. The consideration of the dialectic relation between being healthy, being sick, and health care practices, not as unrelated situations but as a historical process described as the health-disease-care process.<sup>20,21</sup>
4. The introduction of sociohistorical structures as determinants of the process of the health-disease-care process of individuals and collectivities.<sup>22,23</sup>
5. The articulation between theory and political practice known as *praxis*<sup>24</sup> that defines theory as both describing reality and inspiring social change.
6. The methodological development of “differing historical, quantitative, and qualitative approaches aimed at avoiding the perceived limitations of positivism and reductionism in traditional public health and clinical methods.”<sup>8,25–27</sup>

The clear link between politics and science, which defines the LASM movement, finds its roots in the social origin of university students, which was affected by the proliferation of free public universities in the region, and the marked political involvement of students that began during the 1960s. After graduation, this led many health care professionals to choose a professional practice that was related to the processes of political change in Latin America. Such radicalization has promoted theoretical and technical developments

that resulted in the scientific sector's contributions to social changes as a daily expression of the relation between science and power.<sup>28</sup> The consequences included important advances and achievements but also led to the death, disappearance, and exile of many key representatives of the LASM movement.

The conceptual matrix of LASM may be found in the incorporation of social sciences into the fields of collective health, in the beginnings of dialectic materialism, and, in the 1980s and later, to several developments of the European social sciences such as those by Althusser, Bourdieu, Foucault, Giddens, Gramsci, Habermas, Heller, Laclau, and Rorty.

A field in which LASM has been a pioneer is workers' health, with major methodological contributions to incorporating the concept of social class and the process of production and social reproduction in health research.<sup>20,29,30</sup> The second major field includes the effect of social policies on health and health care, a redefinition of the state as a heterogeneous arena,<sup>18</sup> public policies in health,<sup>31</sup> and the effects of international relations, mainly between central and peripheral countries, as determinants of the health conditions in the latter.<sup>22,32</sup> In the 1980s, the main issue was the impact of economic crisis, unemployment, and inflation on the increase in poverty and worsening of health conditions in the region, as well as the process of transition toward democracy.<sup>33</sup> Related issues included the impact of the violence and trauma that prior authoritarian dictatorships<sup>34</sup> and democracies<sup>35</sup> inflicted on the population's health.

In addition to issues raised by specific historical events, this movement has made specific and original contributions to international collective health<sup>6</sup>: developments in the area of social epidemiology,<sup>29,30</sup> policies and practices in health,<sup>31,36</sup> strategic planning in health,<sup>18,37</sup> epistemology and methodology,<sup>17,25–27</sup> and the incorporation of the subjective dimension into the field of collective health.<sup>38,39</sup> The incorporation of the subjective dimension addressed the effects of political violence at a psychological level, and incorporated Bourdieu's<sup>40</sup> concept of *habitus* to understand the social and historical determinants of subjective action. The subjective dimension also addressed the contributions of psychoanalysis with its critique of the health-

disease model, the body-mind relation conceived by positivism, and the inclusion of the impact of the unconscious dimension in the health-disease-care process.

## LASM IN THE 1990S

During the 1990s, scientific theory and research in the LASM movement grew, and in several countries, graduate programs in social medicine and collective health were consolidated. The graduate programs contributed many systematic studies of several population health issues approached from the perspective of social medicine. One should understand that the development of graduate programs has been very uneven in the region, and the creation of new programs remains one of the current priorities for several countries.<sup>41</sup> Brazil is the most advanced country in terms of graduate programs, and Brazil and Mexico have the greatest state support for these activities. Other countries that have a long history in this field but lack higher academic training in the field include Argentina, Chile, Ecuador, and Uruguay. The recent creation of doctoral programs in Mexico and Colombia must be celebrated.

Understandably, the lack of higher-level graduate programs in some countries of the Southern Cone (Argentina, Chile, and Uruguay), which at the same time have greatly developed social medicine, can be partly attributed to the dictatorships that devastated these countries during the 1970s and 1980s. Military interventions led to the persecution, disappearance, and death of teachers and students at the universities, thus creating a wide gap, which still remains, that slowed down the evolution of social medicine programs during the 1990s.

Also, this same period was characterized by the implementation of World Bank–recommended health system reform, which from its onset led to rigorous criticism by LASM workers and theoreticians.<sup>36</sup> Such neoliberal reform was implemented in the region on the basis of proposals of the World Bank, which, valuing efficiency and efficacy at the cost of equity, promoted the implementation of macroeconomic adjustment policies and reform of the public sector to enable such policies. In the health sector, measures implemented at a regional level included the

extinction of policies oriented toward the values of universality and integrity by applying focused programs and creating a basic package of services as the only health care service guaranteed by the public sector to the whole population.<sup>6,32</sup> Another measure was the decentralization of national systems and services toward provincial or municipal areas.

Decentralization led to an increase in fragmentation of many health care systems, as well as an increase in quality differences because of the large economic disparities that exist between the provinces and municipalities in the regions characterized as having the greatest inequality in the world between rich and poor. This is described in a recent report by the Pan-American Health Organization,<sup>42</sup> which states that

poverty in the Americas may be basically attributed to a poor income distribution, not to absolute poverty of the countries, as is the case of the countries of the Sub-Saharan Africa or some Asian countries where there is truly very little to distribute. If the distribution of wealth would be similar to that of European countries or the United States, our poverty level would only be a fourth of the one we currently have.<sup>43</sup>

The word “reform” encompasses different, sometimes opposing concepts. As an example, the Italian health care reform movement created a nationwide health system that tended toward equity, as did the Brazilian. Neoliberal reforms decentralize health care delivery but not real power or budgetary resources, as progressive reform did. They weaken the role of the state, short funds to emphasize the private sector, and tend toward social inequity.

More than a decade after the implementation of neoliberal health system reform, the general consensus (and not just voices from critical sectors)<sup>36</sup> is that this reform has not only failed to solve the problems that it aimed to solve, but has also created new ones: loss of leadership at the ministries of health; loss of financing of social security programs because of the decline in formal employment and the presence of corruption in management; and an increase in health care inequality and fragmentation.<sup>44,45</sup> One should note that during that decade when the public health care sector was being criticized for its inefficiency and lack of coverage, it continued to play—and even increased—its role as backup for the loss

of coverage by the private sector and social security systems.<sup>32</sup>

One of the promises of neoliberal health system reform was to allow freedom of choice for users of the social security system by allowing the transfer of salary-linked health care contributions from the social security system to private health insurance companies.<sup>46</sup> What actually happened was a concentration of the market by the insurance companies and a setback in terms of the right to health care. Instead of improvements in the health care system, the result was the introduction of market logic into the whole system.<sup>10</sup>

Demystification of the processes of neoliberal health system reform has been one of the central pillars of the academic work of the LASM movement during this decade and has also been part of its social and political practice, as part of the agenda for the defense of health as citizen’s right and a duty of the state.<sup>32,36,44,45</sup> Simultaneously, the LASM movement has expanded its areas of action to a wider span of issues that must be addressed for full implementation of citizens’ right to health care<sup>10–14</sup>; violence,<sup>35</sup> gender,<sup>47–49</sup> human resources,<sup>50</sup> public policy,<sup>31,36</sup> decentralization,<sup>51,52</sup> health system reform,<sup>44,45</sup> globalization, epidemiology,<sup>53</sup> environment,<sup>54</sup> equity,<sup>10</sup> bioethics,<sup>11</sup> social participation,<sup>13</sup> ethnicity, multiculturalism, and human rights.<sup>55,56</sup>

Examples of the specific mode in which the LASM movement works in these areas are given in this issue in the commentaries by Saul Franco on violence and Cristina Laurell on the implementation of public policies. One good example related to gender, the field in which I work, is Angeles Garduño’s thesis in progress (Metropolitan University of Mexico), a compilation of the ways in which LASM movement groups have focused on how the gender-based work conditions affect workers health. Another is the publication of 2 regional public forums co-organized by ALAMES on how to include gender perspectives in progressive public health policies. The forums were held in Rio de Janeiro, Brazil, in 1999<sup>48</sup> and San Jose de Costa Rica in 2002.<sup>55</sup>

This extensive agenda shows that in addition to its own subjects and methodology, the LASM movement represents a multidisciplinary ethical and ideological approach to health problems at the individual and collective level.

This approach considers that health goes beyond health care per se<sup>12</sup> and is in a wider sense linked to quality of life and justice.

This approach has led to several internal changes in the LASM movement. From a group of physicians interested in “the poor,” it has evolved to a group of health care workers from all disciplines, involved in health problems from a wider perspective as citizens. From an ideological vision of processes but using the classic methodology of public health, it has evolved to the creation of its own methodological models, which are tools to study an object that has been redefined.<sup>6</sup>

In the political arena, one of the lines of implementation of neoliberal health system reform in the region has been the decentralization of health management through the municipalization of services and actions in health. This opened an interesting scenario for the praxis of the LASM movement during the 1990s, because after the election of progressive local governments during this decade, several leaders of the LASM movement entered the political arena as municipal secretaries of health.

Realizing they could not achieve their whole program, they stuck to the areas under their control. This led to a change in the way state health policies were conceived, as well as a change in the role of the LASM movement. Until then, the LASM movement’s role consisted mainly of criticizing the state for reproducing conditions of dominance, and health management could only be imagined through a revolutionary process or radical change. In the 1990s, the political approach of many members of the LASM movement, then in power, might well have been considered not revolutionary enough, by the same actors in the past.

The coexistence of these 2 processes, decentralization and a change in how the political approach was viewed, caused a very characteristic praxis of this period, which was to engage government in the full local management of health, from the standpoint of training and research as well as direct political practice.

Brazilian health reform followed this trend and became a very important inspiration for the LASM movement. The Brazilian reform was undertaken during the 1980s in the spirit of the Italian health reform of the

1960s and 1970s, which—unlike World Bank—dictated reform—considered decentralization as a way of eliminating concentration of power. In both Italy and Brazil, this approach effectively promoted popular participation and the social control of health management, aiming at strengthening the public sector as a guarantor of citizens' rights.<sup>58,59</sup>

Guidance from Brazil was very inspiring and promoted political creativity among LASM movement members in other countries of the region. This is because decentralization processes in most other countries were implemented as part of the neoliberal reform process, to detach the state from its commitments in the area of health.

One should note that in contrast to the hegemonic neoliberal trend of the World Bank-promoted reform that encourages this kind of decentralization, many of these local health managers are genuinely interested in transforming the local health arena into a larger arena for implementing citizens' rights and in building up the public sector. Going against the neoliberal thought that prevails in most countries at the national level, these managers took a chance on progressive reform.

Many of these managers belong to either counterhegemonic or progressive parties, such as Brazil's Workers Party; Mexico's Democratic Revolution Party; Argentina's Front for National Solidarity, Affirmative Movement for an Egalitarian Republic, and Popular Socialist Party; and Uruguay's Frente Amplio, which have had local victories. Many members of the LASM movement participate in these victories as managers, teachers, evaluators, and advisors. One example of key representatives of the LASM movement who now occupy management positions is Cristina Laurell, current municipal secretary of health of the Federal District of Mexico, whose commentary is published in this issue. Another is Maria Urbaneja, who is minister of health of Venezuela, formerly secretary of health of the Municipality of Caracas. The latter, drawing from her experience at the local level, now faces the challenge of implementing a new concept of the role of a national health manager who is committed to the public arena from a regulationist perspective and who guarantees citizens' rights, but without the centralizing perspective that the LASM movement promoted decades ago.

In this review of the political action of the LASM movement during the 1990s, I stress the movement's harmony with other social movements during that period and their emerging stress on political action in the joint fight against globalization. Many members of the LASM movement also belong to other movements; they include movements for the rights of young people, women, landless people (sin tierra), peasants, and indigenous people, and sexual rights and human rights. ALAMES has participated in the Social World Forum of Porto Alegre on 3 occasions and organized 2 international health forums during the 2 days before the forums.

## CONCLUSION

Since its beginning, the LASM movement has been characterized by having established a critical framework and a proposal to change the classic form of public health in Latin America by transforming it into a tool for change and social justice. During the 1990s, the LASM movement offered alternative proposals for knowledge generation as well as political practice to the neoliberal model, through a new progressive way of working in health and by continuing to create an agenda that would not mimic the existing international cooperation organizations. Hence, the LASM movement is in an excellent position to offer theoretical and practical elements to colleagues from other regions of the world who are interested in building a public health practice that helps guarantee health as a right and a public good for all people. ■

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