ALAMES turns 24

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Introduction

It is not easy to capture the full richness and the many facets of the Latin-American Social Medicine Association (ALAMES) during its twenty-four years of existence. ALAMES brings together people and institutions of differing backgrounds: academia, social movements, health services, health policy, and research. It focuses on the production of knowledge in the field but maintains a specific political inclination that functions as a link among its members.

The history of ALAMES brings together other histories; these histories, in all fairness, deserve a deeper and more serious approach than what this paper attempts to accomplish. My intention here is merely to discuss some key issues- beginning with the history and meaning of the term "social medicine" and a description of its features. I also visit three simultaneous evolutions: 1) from the concept of health-illness to an emphasis placed on health practice, 2) from the insistence of establishing distinct disciplines to the search for unity in action, and 3) from the academic arena to other fields of practice. I conclude with some final perspectives on the future.

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History and Meaning of the Term "Social Medicine"

In 1984, the year ALAMES was founded, Juan César García[1] wrote the introduction to the book *Health and Social Sciences in Latin America.* In this text, which would be his last written work, he responded to the question: *What is the history and meaning of the term social medicine?* with the following answer:

> *The concept of social medicine was born in1848. This was also the year of great revolutionary movements in Europe […]ambiguous, tried to emphasize that illness was related to "social problems" and that the State should actively intervene in the solution of health problems. The term "social medicine" was the idea that the two states were qualitatively different. Indeed, its use always had a combative tint in support of the fundamental principles of the revolutions that had taken place during 1848.*

Juan César pointed out four fundamental characteristics in the term "social medicine," which was coined in Europe during the nineteenth century: 1) the social nature of illness, 2) the State's duty in resolving disease, 3) the possibility of studying illness through quantitative analysis with the growing number of available mathematical and statistical models developed within the natural sciences, and 4) the revolutionary and combative character of this proposal.

Juan César García was undoubtedly one of the pioneering activists of Latin American Social Medicine and we could very well say a founder of ALAMES. It is therefore relevant to reproduce his ideas as an interpretative summary of the debates that developed in the field during the 1950s and 60s.

The need to develop a discipline distinct from public health and preventive medicine was clear; it would have to incorporate sociological analysis, submit it to scientific criteria, increase the State's responsibility, and have a political commitment towards change.

Social medicine attempts to develop an identity by distinguishing itself from public health. Since its early years in England, public health had, in the words of Franco y Nunes, "*focused more on practices related to sanitation and considered the State a complementary agent of private initiative.*"[2] Its North American version, first developed at John Hopkins University, would later extend throughout the entire American continent, oriented towards forming public officers in state health departments.

The nascent social medicine critiqued the elitism and idealism of public health's technical and national emphases as well as its conservative spirit.

It also criticized preventive medicine. In the words of Arouca, preventive medicine constitutes an:

> *...ideological movement that attempted to transform medical practice yet lacked the will to emerge as a political movement which could do so effectively. Its discourse maintained a structured relationship with the historical experiences of American society, representing civil and liberal interpretations of health problems. […] Preventive medicine gives the impression of being an ideological practice linked to the hegemonic groups of civil society, existing as a standard instilled by its own contradictions in the field of medicine and economics.*[3]

Social medicine, in contrast, ever since its beginnings in Europe, emerged "as a *transformative movement in medicine, linked to social change*."

It has another attribute that situates it within

> *...the limits of science…an attempt to redefine the position and setting of objects within medicine, to develop conceptual separations, to question existing theoretical frameworks, in other words, it is a movement that, by reformulating the basic inquiries that enabled the emergence of preventive medicine, seeks to define an object of study with regard to the relationship between what is considered to be biological and psychosocial. […] It is a discourse that seeks its origins amidst the contradiction of social classes, assuming a position ahead of these contradictions.*[4]

This compelled social medicine to ponder the social sciences which had formed the conceptual framework for the thought and practice of conventional public health and preventive medicine. Participants in the *Meeting on Teaching Social Science in Schools of Health Sciences (Cuenca I)*[5] in Cuenca in May of 1972 criticized the functionalist approach of prevailing medical sociology in the following manner:

> *Functional analysis—centered on a static analysis of social phenomena, eliminating the progressive character of these phenomena and detached from the material base from which they are produced—became the prevalent model for the ordering of knowledge in social sciences. […] The theoretical consequences of this integration are that medical sociology, now defined as the application of functionalist analysis to health problems, has contributed to a static conception and a formalist description of the relations among health problems, as well as other levels of productive processes in general. Under these circumstances, health is considered an independent value, a function, and a service within society; it limits understanding the dynamics between health and other levels of social processes.*

Features specific to Latin American Social Medicine

Participants in the Cuenca meeting suggested the construction an alternative model incorporating the following features:

- A focus on the analysis of social change
- Inclusion of theoretical elements to enable the study of reality in terms of its internal contradictions
- Analysis of specific levels of reality, structural realities, and the associations between them

Given these goals and the constraints of functionalism, historical and dialectical materialism were seen as the only fields of knowledge and action

capable of capturing the complexity of present reality and of creating the associated theoretical and practical proposals in order to forge future directions in health. In *Medicina y sociedad: las corrientes de pensamiento en el campo de la salud*[6] *(Medicine and society: Concepts in the health sciences)*, published in 1983, Juan Cesar García analyzes this issue and illustrates the philosophical domain in which Social Medicine should proceed. He recognizes the existence of idealist and materialist schools of thought and clearly opts for the latter. He establishes that within the materialist schools of thought, it is Marxism that allows for the most adequate and scientific analysis since it enables the *objective study of the essence of objects in the external world, challenging all types of agnosticism, such as positivism and Kantism.* Furthermore, he prefers Marxist analytical tendencies since they place a greater emphasis on productive forces rather than those that make production relations a priority. He criticizes Neopositivism and Phenomenology, noting that the health sciences had taken on a reactionary tone when they had accepted Neoliberal proposals for reducing the State's responsibility in health, thus shifting the responsibility onto civil society.

García clearly and decisively considers that the advance of social medicine lies in its ties with Marxism and discounts any possibility that other schools of thought could offer real leadership, although he concedes that they may be capable of providing useful support. In other words, the potential for integrating social thought within medicine, its collective scientific projection, the potential for studying and placing the responsibility of health on the State, and the political commitment towards change must be undertaken through the historical-structural method.

This viewpoint was predominant during ALAMES' founding years, although it was not the only one. Within other areas of social medicine, different interpretations of Marxism were at battle. Some believed that science was not the sole answer to all existing errors in the field. Others argued that health services in Latin America should not just defended but also criticized given that they were becoming unnecessarily bureaucratic. Still others believed that excessive structural and economic determinism in health was producing a new version of Leftist Functionalism. Finally, some felt that a lack of probing analysis on health matters was making social medicine become just like the traditional public health, which it criticized. Despite these differences, all actors in the field of social medicine agreed and continue to agree that the foundation and point of union is the notion of change; the transformation of health conditions in our populations.

Since it was founded in Ouro Preto (Brazil) in 1984, ALAMES has brought together—from my perspective—different conceptions within the scope of Marxist thought. Marxism has been the glue which has bound people of like mind, but this also calls for the participation of those who think differently. Our analytic framework stimulates significant production in the theoretical and methodological realms and supports the development of significant actions related to health. But for some who participate in our meetings and congresses—particularly at the beginning—it can seem somewhat "dogmatic," creating a sense of "sectarianism" and possibly a distancing from "real reality" due to an infatuation with the "created reality" of academia.

My intention is not to discuss the absolute or relative possibilities of Marxism here, but it is worth pointing out that the ideas of 19th century European social medicine—political commitment to change, health-illness as a social fact, the importance of science in the construction of the discipline and the responsibility of the State in this field—were well seeped in Marxist thought. The methodological and theoretical production that developed within ALAMES during its early years (as well as during the decade before its founding), are marked by a historical-structural approach and this approach *defines the specific features* of ALAMES and make it different from conventional public health and American preventive medicine. Early Latin American Social Medicine, as was seen in the second meeting in Cuenca[7] in 1983, went through a period characterized by an exchange of knowledge between research groups, mainly in universities, reaffirming the central role of the social and

economic on the distribution of health-illness and on the social responses to them. In other words, the social aspect of epidemiology is enriched when the categories of production and labor as analytical axes are imported from historical materialism. The same also happens in health administration, which is also expanding its scope through the analysis of the State and politics, and through the critique of traditional planning and health technologies. The education of health workers comes to be seen as an area to produce both talents and ideologies, a process profoundly marked by the prevailing socio-economic conditions.

From the concept of *health-illness* to *health practice*

The four notions I have mentioned above, channeled by the historical-structural method, allowed us to accomplish the goal of distinguishing social medicine from public health and preventive medicine and to develop social medicine's conceptual framework. As social medicine was being developed, our partners in Brazil suggested that for the purpose of incorporating new theoretical and practical conceptions in the field, we consider the potential utility of another concept: Collective Health. After all, as Foucault pointed out, *all medicine is social, and what doesn't really exist is a non-social medicine.*[8]

Sonia Fleury proposes "*to take that which is collective in its historical-concrete manifest-tations […] as an object for analysis and a field for intervention*."[9] In doing so, we would establish an object that is characterized by the *social practices of medicine that provide for the recovery or maintenance of health or provoke disease…"* Thus, *"the object of this discipline would not be represented by biological bodies but by social bodies, by groups and social classes and by social relations that refer to health-illness processes,"* as was proposed by Pereira.[10] In thinking and acting in this way it is possible achieve what Donangelo y Campos had visualized as:

> *1. The triumph over the original vision of preventive medicine in its immediate subordination to the clinical. Consequently, the collective is reoriented. It is no longer reduced to the sum of the social influences that affect individual people*
>
> *2. The lessening, perhaps even the overthrow of the emphasis placed on the health/illness in terms of health practice and its replacement by other perspectives (moving from health administration to the analysis of the ideological and political bases for health practices).*[11]

Brazilian social collective health proposes that our object of reflection and intervention be not *mere individuals*, but *social subjects* and it also suggests moving the emphasis placed on health/illness and placing it instead on health practice which, as I see it, supports the expansion of the scope and action in collective health and enables a much more direct relationship with medical and non-medical practices that help promote health and prevent and treat illness.

Social medicine, as suggested by collective health, must develop practical acitivies and not simply focus on deciphering the determinants of illness. In doing so, it expands its scope inasmuch as it not only observes illness and death, but also contemplates health and life; not only explains causes of illness, but also interprets lifestyles that produce health; not only analyzes the medical practice determined by the development of the productive forces, but also expands its horizons and actions towards emerging medical and non-medical practices related to health and illness.

Brazilian collective health proposes transferring the emphasis placed on health/illness and placing it on *health practice* and it is not alone in this. Others have suggested that social medicine focus its analysis and action on the field of health practice. One of these was Mario Testa, had developed many of the tools necessary to conceptualize planning as a political act and not simply a technical exercise.

This leads us to consider a second evolution.

From Differentiating Social Medicine as a Discipline toward Unity in Action

In the early years of our organization, we insisted on fixing the special features of social medicine and emphasizing its differences from

preventive medicine and public health. As our area of interest moves towards *health practice* and with our commitment to constantly evolve, it is now possible to see many resources—theoretical, methodological, technical, ethical, aesthetic, social, and governmental—that can be used to foster understanding and action in our field. In other words, those of us who work under the mantle of social medicine, collective health and alternative public health can walk together as long as we can develop a common proposal to transform health practices, that is to say **identify with each other concerning a transformative political program that fights for the right to health and is built with the support of differing viewpoints and via consensual methods.** This seems to be social medicine's *identity* and it is what has allowed us to make a critical use of theories, to propose distinctive methodological approaches, and to use different techniques, as long as they take into account our current commitments and broad goals. This is the spirit of the Brazilian health reform, the Mexico City Health Department, the new Ministry of Health in Venezuela, and the Rosario health project. It is also the spirit of more limited proposals aimed at satisfying particular social health needs or strengthening public institutions in order to better undertake health programs.

From my point of view, current and future collaborations between social medicine, collective health, and public health will occur when social medicine – collective health *commit to examine and transform health practices*. Proceeding in this way, social medicine gradually transforms from being a discipline into a *movement*. This movement no longer tries to develop rigid plans determined by technical norms. Rather it becomes a force that interprets events and proposes possibilities that stimulate and improve the current situation, as well as build a new and more equitable future.

In social medicine, therefore, we have gone from being eager to possess truth to proposing a joint construction for transformative practice. This situation greatly corrects the somewhat "dogmatic" and "Promethean" image that some of us displayed in our formative years. We have evolved to propose a social medicine that is open to novel metaphors, new reinterpretations, and a diversity of methods. Now is the time for social medicine to ponder the need for science to walk with ethics. We better understand, with each passing day, that modern science must be self-critical in order to recognize that men and women will always set the goals while science will never be more than a means. In this way, the excessive eagerness at the birth of ALAMES for a positive science gives way to the idea that instrumental reasoning is just one way of producing knowledge and actions in health, but it is not the sole method for their achievement. It seems to me that we also understand the need to immerse ourselves in reality and produce a collective knowledge with the population, who creates their own health by living and then defends it through their own actions. This collaboration is far better than any false evidence uprooted from social practice.

We would only be expanding our field of action if what we had once considered a technical exercise was now seen as an action of interpretation and mediation or even one of *providing care*. Ayres argues that collective health has a dual task: technical success and practical achievement. *"The notion of practical achievemen,t"* says Ayres, *"is directed towards a clear change in normative horizons, seeking to include both the control of illness and the recognition and respect of a human being's fundamental needs"*.[12]

From Academia to Other Forms of Health Practice

Having been developed in classrooms and university research centers, social medicine—as well as Collective Health—has had to gradually learn to confront the complex problem of understanding the languages of knowledge, the arts, and the instruments of power that are used in health institutions. It has had to understand the world of the *could be* rather than that of the *should be*. Brazilian collective health has been growing and conquering these new realms of practice as the health reform has progressed. The reform has sketched out new landscapes that collective health must now paint. Collective health and the health reform seemingly play a duet, each placing a hand

on the same piano. This is not the case in other Latin American countries, where social medicine has to open doors that are only partially opened or that open only to shut tight again. Other times, social medicine opens doors only to tear down the walls and wander lost in new spaces in which it lacks the ability and resources to inhabit. On other occasions it attempts to place its proposals in areas where international financial agencies set the rules of the game based on market laws and the notion of cost-benefit.

The new possibilities of health practice require us to imagine the elements that enable, on one hand, the promotion of social participation as a means of paving the way for democracy and equity, and, on the other, the fight to correct the shortcomings found in our health institutions, such as fragmentation of public services, reduced budgets, deteriorated infrastructure, and the discredit of public institutions. Social medicine has been successful when it has participated in the public administration of health. As Cristina Laurell points out in her experience in Mexico City, *"health is a right of the people and a responsibility of the government as a guardian of the public interest."* This concept has been operationalized through actions that have extended coverage to the population, progressively redistributed the health budget, and globally and deeply changed operational and managerial processes. What Laurell proposes is:

> *Democratization of health care, reduction of inequality in illness and death, and removal of economic, social and cultural obstacles that impede access to services while strengthening public institutions as the only socially fair and financially sustainable alternative that guarantees equal and universal access to health protection; achieving universal coverage by dissolving the relation between access and economic capacity or a position in the labor market; expanding services for the non-insured population; achieving equality in access to existing services; and creating unity through fiscal financing and distribution of cost of illness among those who are sick and those who are healthy.*[13]

When social medicine participates in government, it is important that it has the chance to exercise actions guided by ethical-political principles. These principles, in turn, direct the technical, economic, and administrative interventions. For social medicine, sectoral reform is not a simple proposal for the improvement of tasks, but a task in itself, since it structures objectives and human rights so as to order and fosters the means.

But objectives and human rights can not be achieved without empowerment of a population which should demand and defend them. Social medicine and collective health have been loyal to this necessity since their beginnings. Reflections and experiences on this topic have possibly been one of the social medicine's most important contributions as a discipline. This contribution is an addition to both social thought and health practice. Social medicine–collective health have made objectives and human rights a priority in thought, action and government in health, and have simultaneously understood that those objectives and rights shall not be achieved without social participation.

Perspectives

Juan Cesar García pointed out four fundamental characteristics of social medicine, as it was developed in Europe during the 19th Century. These four characteristics can guide our actions in the American Continent of today: a) political commitment to change, b) health/illness as a social fact, c) the importance of science in the construction of the discipline and d) the responsibility of the State for health.

In this paper I have tried to illustrate certain issues: 1) the historical roots and meaning of the term social medicine and b) the delineation of its particular characteristics. I have also examined three simultaneous evolutions: c) from a focus on health/illness to an emphasis on health practice, d) from the insistence on establishing differences between disciplines to the search for unity in action, and e) from the academic arena to other fields of practice.

As I mentioned earlier, it seems that we have been creating our *identity* through social medicine as

a **transformative political program that fights for the right to health, built with the support of different viewpoints and via consensual methods.** The potential for our further development lies in the expansion of **transformative** experiences in the field of collective health that enable the opening spaces and paths toward the fight for health as a *right* through the commitment and *empowerment* of the people.

The reflections force all of us who are a part of social medicine to continuously confront the challenge of criticizing, conserving, and overcoming our mental horizons and knowledge while simultaneously strengthening those practices that seek not only technical success, but also *practical achievement;* that is to say, the duty and right to *take care of* our populations. In doing so, we develop the four-fold movement that Testa recommends: building sense, meaning, structure and determination. We understand that this is possible only as long as individual and social actors are equal subjects who create their own health, *in a permanent fight against the difficulties of the body and the environment,*[14] enriching the contributions of science and technology and exercising power and rights as citizens. Another important aspect of social medicine-collective health is the extensive reflection on science and practical knowledge. In other words, in our commitment as a hands-on political movement that fights for the right to health, it is vital that we utilize all possible scientific and practical advances that may be of assistance in our mission.

Faced with both the deterioration of the State, the emergence of new social movements and *the globalization of resistance*, social medicine faces diverse challenges. We should understand that our current potential for strengthening social health, improving deteriorated institutions, fighting for dignified work, and even the development of our discipline, lies in our becoming interpreters and mediators for the new forces that have emerged with globalization.

To enable the advance of social medicine, we must also give serious consideration to the state of our organization and overcome limitations to our achieving a lasting continuity. In this regard, Mario Hernandez has expressed that he is "*hopeful that we will create an organizational and administrative structure that will allow ALAMES to take on the challenge of promoting structural changes in the right to health in all of our countries. Today, we are barely able to organize congresses every now and then. In the future, we need more organization, resources, mobilization, and capacity for timely reactions.*[15]

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