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Medical Sociology in Mexico

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The reflection on health problems from a social perspective constitutes an academic practice that has been present in Mexico for several decades. In regards to the study of such problems, various papers have credited the existence of a tradition, which is both sociological (Laurell 1975; Almada 1986) and anthropological in nature (Aguirre Beltrán 1986; Campos 1992) that has manifested itself very strongly, at least from the 1960s, in spite of having started in an irregular, heterogeneous manner. Currently, it is possible to identify several "traditions" or schools within the social thought of health in Mexico. These schools are substantially different among one another, not only due to the theoretical frameworks they have chosen to conceptualize the problems they study, but also because of the political positions they have adopted in their scientific undertaking. These differences have led to intense debates concerning the origin of the health inequalities in this country and on the public policies that are to be implemented to resolve them.

This chapter will discuss some of the main developments of medical sociology in Mexico over the last 25 years. This study does not pretend to be exhaustive in matters of all that has been produced in this field in this period. On the contrary, I will solely concentrate on the main authors and the most relevant contributions. This implies acknowledging in principle the injustice that, due to omission or simplification, I will have to do to the numerous researchers that currently carry out, directly or indirectly, social research in health. The first part of this chapter presents a brief description of the focus of the different social scientists specializing in the health of Mexico, namely, the health conditions in the country, the health system, and the public policies that regulate that system. In the second part, I will present the main theoretical and methodological developments that have resulted from their studies, differentiating between the main trends and schools and emphasizing the most relevant debates. Finally, in the third part of

this chapter, I will seek to make a brief characterization of the current situation of medical sociology in Mexico, pointing out some of its latest and most important developments and stressing some of the significant contributions of the social sciences to the study of health problems and disease among the population.

To facilitate the understanding of what follows, it is important to consider one of the distinctive traits of contemporary medical sociology in Mexico: its eminently Latin American character. This attribute results from the fact that Mexico shares the same mother tongue (Spanish) with almost all the countries in the region (exception made of Brazil) and very similar historical antecedents in that every country is a former colony of Spain and Portugal. Similarly, it is also a consequence of the military repression that took place in many countries in the southern part of the continent, in the 1970s and the 1980s, as many researchers of those countries emigrated to Mexico, seeking to preserve their academic careers. Social sciences applied to health were particularly enriched with this migration. The Latin American character of the Mexican medical sociology accounts in turn for the fact that many authors prefer to publish their papers in books and scientific journals in Mexico, Brazil, Argentina, or Chile, rather than in American or European publications. This may explain the relative lack of knowledge that prevails in those countries, regarding the socioscientific undertaking in health in places like Mexico.

Health and Health Services in Mexico

Evolution of Health Conditions

Due to a variety of reasons related to the backwardness in the development of the country, Mexico has lacked, for a long time, a reliable system for recording morbidity statistics. Only until recently has this problem begun to be solved. General mortality is only an indirect indicator of health conditions. Nonetheless, it is a useful tool to approach a description of the evolution of health and disease in Mexico. The first indicator of the transition in matters of health that this country has experienced is reflected in the advancement of life expectancy at birth: in 1950 it was 46.9 years, in 1994 it increased to 71.6 (Frenk 1997). However, in 1994, the states with the lowest life expectancy at birth showed the same rate that the states with the highest life expectancy had 20 years before. This serves to illustrate the marked contrasts that still prevail in Mexico in matters of health.

Table 12.1 shows the main causes of mortality in Mexico, at three different moments (1940, 1970, and 1997), that is, at intervals of almost 30 years. I would like to emphasize, above other considerations, the changing nature of the mortality profile. The main causes of mortality in 1940 were essentially attributable to infectious diseases. In 1997, in turn, the main causes of mortality were chronic-degenerative diseases and accidents, which in the 1940s were completely irrelevant. In addition to this fact I would like to note that the various diseases that in 1940 constituted the main causes of mortality in Mexico virtually disappeared in 1997.

Table 12.1 Evolution of the main causes of mortality in Mexico, 1940, 1970, and 1997

		1997		*1970*		*1940*
Causes	*Rate per 100,000*	*Order of importance*	*Rate per 100,000*	*Order of importance*	*Rate per 100,000*	*Order of importance*
Heart diseases	71.8	1	68.3	3	54.3	8
Malignant tumors	54.1	2	37.6	5	23.2	13
Diabetes Mellitus	38.0	3	15.3	12	4.2	17
Accidents	37.9	4	71.0	6	51.6	9
Cerebrovascular disease	26.1	5	24.7	7	18.9	15
Cirrhosis and other chronic liver diseases	24.1	6				
Pneumonia and influenza	24.1	7	170.8	1	365.3	2
Perinatal ailments	20.9	8				
Homicide	14.3	9	18.0	10	67.0	6
Nephritis	10.8	10				
Nutrition deficiencies	10.7	11				
Congenital anomalies	10.1	12				
Chronic bronchitis, emphysema and asthma	9.0	13	16.7	11	66.8	7
Infectious intestinal diseases	7.8	14				
AIDS	4.4	15				
Anemia	4.1	16				
Tuberculosis	3.9	17	19.9	9	47.9	10
Gastroenteritis and colitis			141.7	2	490.2	1
Malaria			0.6	16	121.7	3
Perinatal mortality			51.5	4	100.7	4
Measles			24.3	8	91.2	5
Pertussis			7.1	13	42.4	11
Typhoid			5.8	14	31.9	12
Syphilis			0.8	15	19.2	14
Smallpox					6.8	16

Sources: for the 1940 and 1970 statistics: Laurell 1982; for the 1997 statistics: SSA 1999.

The aforementioned trend is an indirect reflection of the epidemiological transition that this country has experienced in this century, which has been characterized by the gradual disappearance or decline in the importance of infectious diseases and their concomitant replacement with chronic-degenerative diseases, accidents, and cases of violence.

As mentioned before, Mexico is not a homogeneous country as it comprises distinctly different regions. A recent study (Frenk 1997) classified the 32 Mexican states as per their epidemiological lag (measured through child mortality) and its relationship with emerging changes (measured through adult mortality). The combination of such indicators (whether below or above the national average) produced five regions classified as follows: (a) of advanced transition, (b) of intermediate transition, (c) of incipient transition, (d) of child lag, and (e) of extreme lag. I would like to note that this classification is pursuant to an approximate geographic pattern, where the northern states of the country (those closest to the United States) are the entities with the best indicators. Conversely, the states in the southeast (those closest to Central America) are those that lag the most.

In 1994, the second national health survey was carried out in the country, which provided more updated information on the prevalence of diseases reported by the population, as well as on the differences that in that regard are found among the various social groups. Table 12.2 shows the main causes reported as health problems within 15 days before the survey, by socioeconomic index. This table shows that individuals from the low socioeconomic level reported infectious diseases more frequently, while individuals from the high socioeconomic level more commonly reported chronic diseases. Such differences, as reported by the survey (SSA 1994) may be the result of both the differential perception that the various groups have of their health and the different lifestyles of the social classes.

Table 12.2 Main causes reported as health problems within 15 days previous to the survey, by socioeconomic index (in percentages)

	Low	*Middle-Low*	*Middle-High*	*High*
Upper airway	27.2	24.7	26.8	22.3
Musculoskeletal diseases	15.2	13.7	12.0	10.5
Gastrointestinal diseases	12.6	12.4	9.2	8.8
Headache	5.7	5.2	2.9	2.1
Hypertension	2.7	3.9	4.5	3.9
Diabetes	1.0	2.1	2.7	2.1

Source: II National Health Survey 1994.

Lastly, table 12.3 presents a priorization of health needs in Mexico, based on three indicators. As is well known, disability-adjusted life years or DALYs is an indicator developed by the World Bank, the World Health Organization, and Harvard University, and it is a measure of the healthy years lost due to both premature death and disability. This table serves also to illustrate the complexity of the current epidemiological profile in Mexico: the identification of the main health needs is based on the type of indicator that is used.

Table 12.3 Priority health needs using three indicators – Mexico, 1994

Causes	*Mortality adjusted for age*	*Potential disability-adjusted life years*	*Disability-adjusted life years*
Ischemic Cardiopathy	1	9	6
Diabetes Mellitus	2	8	4
Pneumonia	3	1	3
Cerebrovascular disease	4	11	11
Cirrhosis	5	4	8
Homicide and third-party injuries	6	2	1
Chronic Obstructive Pulmonary disease	7	17	19
Acute Diarrhea	8	3	7
Protein-Energy malnutrition	9	6	9
Nephritis and nephrosis	10	12	14
Motor vehicle accidents (occupants)	11	5	2
Hypertensive Cardiopathy	12	27	21

Source: taken from Lozano 1997.

Summarizing, health conditions in Mexico have significantly changed throughout this century. However, this change has not been homogeneous for either the social groups or the regions in the country. As herein below discussed, a sophisticated explanation of these differences – based on variables such as social class, gender, region, ethnicity, and age, among others – constitutes one of the goals of Mexican social scientists and one of the axes around which one of the most important debates of the contemporary, medical sociology in Mexico, revolves.

Evolution of Health Policies and Services

From the beginning of this century to the early 1980s, as a result of the Mexican Revolution, the various Mexican administrations fostered a set of social policies that sought, with lesser or greater efficacy, to balance the socioeconomic inequalities and the poverty in the country. Health and education policies in principle, and to a lesser degree housing, employment, and food provision policies, among others, had throughout those years a relatively popular orientation and the intention of reaching broader layers of the population.

This accounts for the creation of the Mexican health system in 1943. That year, the Mexican Social Security Institute (in Spanish, IMSS) and the Ministry of Health (in Spanish, SSA) were created. The former was constituted to provide health and social security services to the workers of Mexican private companies and is funded with the fees paid by the workers of this sector, the employers, and the government. As from 1977, the IMSS broadened its coverage to include the

poorest zones in the country (a program known today as IMSS-Solidaridad), thereby providing free services to the most marginalized populations in the country.

The SSA, in turn, had the objective of providing basic health services to that segment of the population that was left on the margin of social security, mainly peasants and individuals of the poorest sectors in the country. Over many years, the services provided by the SSA, however insufficient and of poor quality, were free.

In 1959, the Institute of Social Security and Services for Public Employees (in Spanish, ISSSTE) was created to provide health services and retirement pensions for state workers. As from that year, some of the larger state-owned companies, like Petróleos Mexicanos (Mexican Petroleum), Ferrocarilles Nacionales (National Railways) and Comisión Federal de Electricidad (Federal Electricity Commission), among others, developed their own institutes for the provision of health and social security services for their employees. Finally, although developed parallel to the above-mentioned institutions, private medicine has gained importance only recently.

As a whole, social security health services serve slightly over 50 percent of the Mexican population, which is constituted essentially by employees of the private and public sectors of the country. Neither the SSA nor private medicine have the capacity to cover the rest of the population, thus, 10 million Mexicans lack access to health services (SSA 1999). This phenomenon derives, among other things, from the logic to which health policies have been subject in Mexico, and that, summarizing, have privileged the urban proletariat – work force of the capitalist industry – to the detriment of those sectors of the population that have been left on the margin of development of this mode of production in Mexico. This accounts for the simultaneous existence of two broad sectors of the population: one with access to several sorts of health services, and the other with no access whatsoever to any service (Hernández Llamas 1982; López Acuña 1986).

In the 1980s, the Mexican government adopted a neo-liberal orientation, pursuant to the recommendations of the International Monetary Fund and the World Bank. This action led to a reduction in social policies that the various sectors had been fostering hitherto, as well as to the promotion of the privatization of State institutions and their services. Health did not escape this trend. Recently, a law that allows private institutions to administer the retirement funds of the workers was passed, thus breaking with one of the fundamental principles that the Mexican State had previously endorsed: the possibility of implementing mechanisms of solidary assistance to help those in greater need. Currently, one of the central elements of the state-held policy refers to what is denominated the "Health Sector Reform," which consists mainly of the inclusion of the private sector in the service provision and the reduction or elimination of free services.

The present orientation of the health policy, evidently influenced by the World Bank's recommendations, constitutes the other pole around which the main debates of the Mexican medical sociology revolve. Consequently, carrying out a further analysis of the recent evolution of this discipline in Mexico is appropriate.

TRENDS OF MEDICAL SOCIOLOGY IN MEXICO

Social thought in matters of health in Mexico has constituted for many years a very dynamic expanding field, where a number of leaders and trends can be noticed, though not without the risk of schematization. To that end, it is suitable to divide this analysis into specific topics.

Basic Trends

In the mid-1970s, the Master's in Social Medicine was established at the Metropolitan Autonomous University, at Xochimilco. Together with researchers from other Latin American countries, this institution has fostered the so-called Social Medicine trend (Laurell 1989). This trend represents one of the best examples, at the international level, of the contributions that Marxist analysis can make in matters of health. A well-known study by Laurell (1975) established that the objective of Latin American social medicine does not rest as heavily on the notion that the capitalist system determines the nature of the diseases of the populations, as pointed out by Navarro in the United States (Navarro 1976), among others. Rather, it is the specific manner in which such determination takes place that supports said objective. The author maintains that a disease cannot be considered merely a biological state or the mechanical consequence of poverty. Health and disease, as she argues, cannot be considered two separate entities; they have to be understood as two moments (dialectally united) of the same phenomenon. This concept leads to one of the main notions of the trend of Latin American social medicine: rather than discussing health and disease separately, the object of study of this school is the *health–disease process*.[1]

Due to its critical approach, social medicine favors the study of social inequality and how such inequality determines the health–disease processes in the populations. Another work, renowned throughout Latin America (Bronfman and Tuirán 1983; Bronfman, Lombardi, and Victora 1998), showed that it was empirically possible to achieve a sophisticated operationalization of the Marxist concept of social class and its utilization both to illustrate and account for child mortality differentials among the various social classes in Mexico. Such study became a model, which a number of researchers applied to their studies on social inequality and health (see, for example, Battellino and Bennun 1991; Salcedo and Prado 1993; Ortales 1996). The concept as such, however, was highly complex, which resulted in the reluctance by specialists to implement it. Consequently, some years later, Bronfman (Bronfman et al. 1988) proposed a simpler strategy for the classification of the population into differentiated socioeconomic groups, which has been widely accepted in the region (see, for example, Engstrom and Anjos 1996; Santos 1996; Tellez 1997).

Social medicine has also sought to problematize the health–work linkage in Mexico (Noriega 1989). In so doing, various authors have pointed out the importance of studying the "work process" itself (Laurell 1979) and understanding it as a source of the "wearing down" of the worker (Laurell and Marquez 1983) with direct consequences on the health–disease process. Based

on concrete, empirical results, the studies by Laurell have demonstrated that concepts like the "wearing down" of the worker and "specific patterns of wearing down" are more precise and pertinent than those of "absolute expropriation" and "relative expropriation" of health that other theoreticians of the Marxist medical sociology had proposed in the United States (Navarro 1982).

A second core of theoretical and empirical production of great importance is the Center for Research and Higher Studies in Social Anthropology that has promoted the development of medical anthropology from a critical perspective, since the beginning of the 1980s. Its main author (Menéndez 1978) surmised the concept of the "Hegemonic Medical Model" to characterize the prevailing model of medicine at the beginning of the nineteenth century under capitalism and that, apart from juridically laying the foundations of its exclusive appropriation of disease, privileged an outlook that was biologistic, individualistic, ahistorical, asocial, mercantilistic, and pragmatic in nature. The development of this concept fostered a series of studies on how the various institutions that act on health and disease are articulated, whether from a position of subordination (Menéndez 1984) or from the situation of "crisis" that the hegemonic medical model experiences (Menéndez 1985a). Similarly, as per this perspective, several studies on alcoholization (Menéndez 1985b), self-care in health (Menéndez 1983), and how professional medicine coexists with alternative (traditional and domestic) medical practices (Módena 1990) emerged.

Together with these approaches, which are rather structural and critical in nature, another school of thought in medical sociology that is more directly linked with public health has existed in Mexico. Since the early 1980s, Frenk has studied the behavior of the medical work market in an effort to link the characteristics of the phenomenon with the doctors' social class of origin (Frenk and Bashshur 1983; Frenk 1988a). To that end, the author first formulated a conceptualization that allowed him to differentiate the general determinants of the medical work market, among which he included the economic structure of the country, the State's policies, forms of social organization, social institutions, and ideology. Secondly, he was able to distinguish specific determinants, such as medical service supply and demand, and medical education. Afterwards, the author engaged in a historical reconstruction of the evolution of health services in this country, as well as of the influence of this factor on the medical work market (Frenk, Hernández, and Alvarez 1980). Frenk showed that the socioeconomic origins of doctors are closely associated with the type of university they attend, the specialization they choose, and the institution that finally hires them (Frenk 1984; Frenk 1985). These pioneering studies encouraged the development of a line of empirical research on the characteristics of the medical work market in Mexico, which allowed documenting the existence of grave contradictions in the sector – sub or unemployed doctors, on the one hand, broad sectors of the population lacking access to health services, on the other. Furthermore, these studies explored the various alternative solutions to such imbalance (Nigenda et al. 1990; Frenk et al. 1991).

By founding the National Institute of Public Health, Frenk contributed significantly to the legitimization of research studies that were no less sociological than those promoted by authors like Laurell or Menéndez. This allowed the

exploration of problems through different theoretical approaches tied to the structural, critical perspectives that these authors advocate. Frenk's new proposals emerged within the framework of a series of important, highly-politized debates he held with representatives of social medicine during the second half of the 1980s. These debates determined that it was of crucial importance to prepare theoretical and methodological frameworks that would avoid a rigid economicism when accounting for health problems and policies (Fragoso, Velázquez, and Hermida 1986; González-Block and Frenk 1986a, 1986b). Additionally, these debates highlighted that theoretical perspectives, such as public health and social medicine, which were so different from one another, had to be mutually enriched with their respective contributions and analytical capacities, or run the risk of working from the perspective of academic traditions interested in the health problems of the population, but having very little or nothing to say to one another (Frenk 1988b, 1988c; Eisbenschutz 1988a, 1988b).

New Developments

The debates held between social medicine representatives and public medical sociologists have continued up to the present decade. When the North American Free Trade Agreement (NAFTA) was signed by Mexico, the United States, and Canada in 1994, the discussion about the possibilities of including health services among the goods to be exchanged by these three countries began. While public health sociologists deemed NAFTA a beneficial opportunity for health services in Mexico (Frenk et al. 1994; Gómez-Dantéz et al. 1997), social medicine representatives noticed that such treaty showed an evident sign of a privatization trend of the Mexican State that would consolidate the disarticulation of the social policies in effect in former decades (Laurell and Ortega 1992).

Additionally, upon the release of the World Bank's 1993 Report (Banco Mundial 1993), the official health policy in Mexico adopted the proposals issued by that institution and started advocating the "reform" of the health sector and the privatization of services, or at least the participation of private capital for health service provision and the administration of the employees' retirement funds. These changes led to one of the most important debates in matters of health in which the various social sectors in the country have participated. Among the contributing academics were once more, on the one hand, the public health sociologists with their proposals on how such privatization could be carried out without detriment to the ideals of justice and equity (Frenk and González-Block 1992; Londoño and Frenk 1997). On the other hand, there were those that criticized the methodology and utilization of DALYs (López and Blanco 1996) and maintained that such a reform sought to benefit, mainly, the big-capital holders to the detriment of the least protected sectors of the population, seriously damaging, in the social sense, the State policies in matters of health fostered in previous decades (López Arellano 1994; Tetelboin 1994; Laurell 1999).

Simultaneously, without necessarily participating in those important debates, a second generation of studies on social sciences applied to health has been appearing in Mexico during the 1990s. Some of the authors of these studies have

been directly or indirectly formed in one of the three above-mentioned foundational poles, and a number of them have benefited from the contributions of these trends, apart from having been able to study at universities in the United States, Canada, Spain, England, or France, with highly specialized academics in the field. This has favored a sort of "oxygenation" of the contemporary debate, in that new theoretical perspectives and methodological approaches have appeared in a setting that was previously characterized almost exclusively by both the structural perspective and the public health approaches.

Therefore, it is adequate to devote this last part of the chapter to a summarized revision of some of the main contributions of this new generation of research studies. To that end, the analysis will be divided into three brief sections. The first will refer to some of the main theoretical or conceptual studies that have appeared in the last years. The second will follow suit, focusing on methodological research; and the third will center on substantive research that, as will be discussed, refers to various health and service utilization problems that are appealing to the attention of medical sociologists in this country.

In regards to *theoretical production*, in the early 1990s, a series of reflections that sought to review the prevalence – and the excesses – of structural approaches in health began to appear (Almada Bay 1990) and analyze the possibilities of the theoretical frameworks that privileged the analysis of those phenomena that are better observed at the "micro" level of analysis. In one of his best studies, Menéndez (1992) pointed out that the depletion of large ideological systems is linked with the inability of substantial theoretical paradigms when attempting to give a satisfactory account of the various levels of reality. As he maintains, this has driven the growing trend to seek the explanations of the phenomena of health–disease in social action (practices, strategies, transactions, etc.), rather than in macro-social structures. However, the author warns that unless this level of analysis is linked with the great social determinations, we will run the risk of not transcending the level of psychologism when accounting for problems of our interest.

In that regard, there have been very suggestive studies on the concepts of "quality of life" (Blanco et al. 1997), "lifestyles" and "risks" (Martínez 1993; Menéndez 1998), and "social support" (Castro et al. 1997). This research suggests that as long as the sociological character of such concepts – and consequently, the effort to elucidate its association with more general social processes – is preserved, these concepts will continue to be useful for the study on the determination of health and disease in society.

Other theoretical papers that were released in this decade updated the contribution of feminist theory in regards to the study of health problems, not only in North America and Europe, but also in Latin America (Castro and Bronfman 1993; Cardaci 1998). At the *methodological* level, within the context of medical sociology in Mexico, several studies with innovating proposals for the social study on the health and disease phenomena have been published in the last few years. In the mid-1980s, as per the thought of social medicine, the perspective of the "working-class model," originally developed in Italy, was adopted for the execution of research into the workers' health. At the beginning of this decade, the validation of such strategy was published in a modified version for Latin

America. This is a research strategy, whose foundation lies on the application of collective, not individual, interviews among the workers in the industry, with the triple purpose of generating information about health hazards derived from work conditions, promoting an awareness in that regard among those thereby affected, and formulating collective solution proposals among the workers (Laurell et al. 1990).

A second theoretical and methodological development has emerged in the field of social inequality in the presence of disease. Bronfman (1992) showed first that conventional explanations on the relationship between socio-demographic variables (i.e. the mother's education) and child mortality face very clear limits and leave a large part of the phenomenon unexplained. Afterwards, this author showed that the most powerful explanations of the problem could be reached by skillfully articulating quantitative and qualitative approaches. The author successfully tested an explanation that linked the structural determinations of child mortality (mainly the social class) with the interactional elements of the actors (such as family structure, family dynamics, and the operation of social networks). Additionally, he showed that the latter play a central role in both the generation and manner of solving the problems that lead to child mortality (Bronfman 1999).

Actually, in the 1990s, qualitative methods applied to social research on health (Langer and Nigenda 1995; Sasz and Lerner 1996) have become important, while some papers on epistemological reflection and ethics said that the articulation between qualitative and quantitative methods presents a series of yet unsolved problems. Furthermore, this research declares that such articulation would not be correctly achieved unless researchers remained anchored to the most relevant sociological theories and abandoned the mere empiricism and atheoretical approaches that flood this field (Castro and Bronfman 1999).

The level of *substantive studies* is the one that presents a higher degree of difficulty when attempting a synthesis, not only because of its including a large number of papers and topics, but also because it comprises both studies that utilize the theory and methods of the social sciences, and research that superficially alludes to these matters. In practice, many of the latter are largely public health research weakly supported by social sciences, which can hardly be considered medical sociology papers. Consequently, the rest of this brief review will focus on some of the most remarkable studies with an evident sociological orientation that have appeared in the last few years.

Such studies refer to various priority health problems in this country. AIDS is one of such problems. Recently, significant research has been carried out on the change in sexual habits experienced by Mexican workers who migrate to the United States, which translates into increased risk practices (Bronfman and Minello 1995). Other studies have explored in detail the social construction of both solidarity and family and community rejection regarding those infected with HIV/AIDS (Castro et al. 1998a, 1998b), and the social construction of AIDS and sexuality among the youth in this country (Rodríguez et al. 1995). Such research is qualitative in nature and explores the subjectivity of the individuals in regards to this matter.

Additionally, along the line of subjectivity, a group of papers has explored the illness experience and how such experience is articulated with the more general social structure and gender inequality (Castro 1995; Castro and Eroza 1998). In other instances, research on the subjective experience has focused on chronic ailments (Mercado 1996), the negotiation of sexuality and the meaning of virginity (Amuchástegui 1999), as well as on the meaning of pregnancy for adolescents (Stern 1996; Tuñón and Guillén 1999), among others.

Reproductive health has gained great importance for medical sociologists in this country (González 1995; Pérez-Gil, Ramírez, and Ravelo 1995; Langer and Tolbert 1996). As of late, several studies that explore the relationship between the perceived social support and the experience of labor (Campero et al. 1998) have been published, together with sociological studies on contraception (Castro and Bronfman 1991; Lerner and Quesnel 1994), the dimensions of masculinity, and the role of men in reproduction processes (Figueroa 1998; Rodríguez and de Keijzer 1998). Other courses of research have centered on the situation of female occupational health (Garduño and Rodríguez 1990; Denman, Balcázar, and Lara 1995; Lara 1995), and the relationship between the occupational condition of women and child health (Bronfman and Gómez-Dantés 1998). Similarly, the problem of violence against women has gradually gained importance among scientists (Bedregal, Saucedo, and Ríquer 1991; Ríquer, Saucedo, and Bedolla 1996; Saucedo 1996), even though there is still much to do regarding the sociological explanation of this issue.

Lastly, a set of sociological research courses has referred to a variety of aspects of the utilization of health services and medication. In some instances, they have explored the linkage social networks-service utilization (Infante 1990). Others in turn have carried out qualitative studies to determine the perception of health service users (Bronfman et al. 1997a) and health providers (Bronfman et al. 1997b) in regards to the problem of the utilization of services or to determine the type of cultural barriers that hinder utilization (Lazcano et al. 1999). Still others have researched into the consumption patterns of unsafe medication without prescription, in private pharmacies (Leyva et al. 1999).

Conclusion

Medical sociology in Mexico is a discipline that has been enriched through the contributions of many social scientists that have carried out research in this country in the last 25 years. At the Latin American level, the Mexican leadership can be appreciated in the first edition of the recent compilation entitled *Salud, cambio social y política: perspectivas desde América Latina* (Health, Social Change and Policy: Latin American Perspectives), which having been disseminated throughout the subcontinent, sold out in less than six months (Bronfman and Castro 1999). Lately, the almost absolute predominance that the critical structural perspective had in the 1980s has begun to decline. This field has benefited by new interpretative approaches and discussions on the scope and implications of the various theoretical and methodological approaches. What these studies as a whole have contributed toward understanding health problems

has already reached a critical peak: nowadays, a great deal of research into public health in Mexico is based on the most important concepts and methods developed by the social sciences.

It is possible to state that, to some extent, Mexican medical sociology is on the frontiers of knowledge, especially at the global level. This is reflected in several studies – like the successful operationalization in the past decade of the Marxist concept of social class and its application to the study of various health problems and the development of a qualitative perspective incorporating variables, such as family structure and the operation of social networks, to further explore the role of social inequality in the face of child mortality – which constitute true, unparalleled innovations in the international literature.

Lastly, a final question upon which it is worth reflecting is that, in spite of its dynamism and productivity, Mexican medical sociology is practically unknown in North America and Europe. Consequently, the researchers in this country should seek to better disseminate their work in these settings. Nonetheless, does it not also mean that scientists in those places should make greater efforts to approach the scientific production of countries like Mexico, which due to natural reasons is mainly disseminated in Spanish and through Latin American journals?

Note

1 Years later, Menéndez maintains that the behaviors of the individuals in the presence of disease are also an integral part of the health–disease concept, hence inferring a concept of *health–disease-care process* (Menéndez, 1985b).

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