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Social Science and Health in Brazil

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This chapter presents the principal aspects of the origin and development of medical sociology in Brazil, along with a short discussion of the country's health situation. I will also provide an overview of the discipline's antecedents in Brazil, along with the relationship between medical sociology's origin and the pedagogic practices that resulted from the Latin American Preventive Project. Finally, the main theoretical formulations that have been favored in Brazil and the recent interests of Brazilian researchers will also be introduced. In prior studies, I have characterized the significant aspects of the trajectory of Brazilian social science in health (Nunes 1986, 1991, 1997) and in this paper I have tried to place this trajectory in its context while focusing more specifically on the development of medical sociology.

General Health Characteristics of Brazil

Located in the central portion of South America, Brazil is a Federative Republic comprised of 26 states plus a federal district. The country was discovered by the Portuguese in 1500 and existed as a colony until independence in 1822, followed by its establishment as a republic in 1899. Brazil is a multi-racial society whose population in 1996 consisted of the following population groups: whites (55.2%), blacks (6%), mulatto or mixed race (38.2%), Asian (0.7%), and local Indian (0.2%). It is the fifth largest country in the world in area, with 8,547,404 square kilometers, and has a population of 157,079,573 (as of the 1996 census). Nine urban areas, considered together, hold about 30 percent of the country's total population. The first census carried out in 1872 showed a population of only 9,993,478 inhabitants. The birth rate has been steadily dropping, from an average of 6 children per woman of childbearing age in 1950, to 4 in the mid-

seventies, and then to 2.5 in 1990. This decrease probably stems from changes in the lifestyle of the population, including rapid urbanization, widespread use of contraceptives, and, in certain areas of the country, sterilization. In 1930, infectious and parasitic diseases caused 45.7 percent of the total deaths in Brazil, and 11.8 percent of the total deaths were caused by cardiovascular diseases. More recently, between 1990 and 1994, cardiovascular diseases jumped to 34 percent of total deaths, traumatic injuries made up 14.8 percent, cancer caused 13 percent of the deaths, and transmissible diseases were only 11 percent of the total.

Although the nation has many accomplishments in the health area, serious health problems remain. In the rich, industrialized countries of the world, there was a gradual and progressive diminishing of infectious and parasitic illnesses and the rise of chronic-degenerative diseases, especially ailments of the cardiovascular system. In developing countries, like Brazil, there has also been a transition in morbidity profiles in the last 40 years that are similar, but not identical, to those of core nations. These transformations became evident in the 1960s and have progressed to the point today that Brazil has a polarized epidemiological profile: the simultaneous existence of a high incidence and prevalence of morbidity from chronic illnesses combined with a much higher incidence of infectious and parasitic diseases than that of developed countries (Araujo 1992).

The modern Brazilian health delivery system is characterized by two distinct periods: prior to the health reform that took place in 1988 and afterwards. There were many problems in the provision of health care by the government sector. During the first period, there were at least three parallel systems operating health delivery facilities. The first was the National Social Security Institute (INAMPS) that was responsible for curative care. It operated its own hospitals and health centers, as well as contracting services from private hospitals, clinics, and laboratories. The second system was the Ministry of Health, which was primarily responsible for preventive care. However, the State Secretary of Health carried out most of this system's activities at the state level. The third system was the various municipal networks of health facilities.

With these three different systems at work, many problems in the provision of health care arose; these were finally addressed in the 1980s by health reform. The 8th National Health Conference in 1986 produced a series of recommendations that were incorporated into the Federal Constitution of 1988. These recommendations, named the Unified Health System (SUS), included two main directives: (1) decentralization, with dedicated administration in each government sphere; and (2) priority to preventive activities, without loss to individual medical attention and community participation. Today, public health services, complemented by private services contracted under SUS's responsibility, cover about 75 percent of the Brazilian population.

There is also a private sector of health care that is paid directly by private insurance plans that fall into four categories: (1) privately owned insurance companies (*medicina de grupo*), which is a pre-payment system representing 47 percent of the private medical industry market; (2) physician cooperatives (physician-owned groups), which is also a prepayment system and represents 25 percent of the market; (3) self-health insurance, which is an association of self-

insurance and third- party out-sourcing that represents 20 percent of the market; and finally (4) reimbursement health insurance, which repays either the insured person or a third party and represents 8 percent of the private market. These private types of insurance were used by 20 percent of the Brazilian population in 1995 and involved about 6.4 billion dollars worth of investments.

The majority of the SUS hospitals are privately owned but under contract with SUS. However, 75 percent of the ambulatory- care facilities are purely governmental institutions. Since 1994, the Ministry of Health has been developing a Family Health Program in order to give attention to the health of the family as a whole. In 1996 this program was extended to 226 municipalities, which also involved the institution of community agents that reached a total of 45,000 individuals in that one year.

Brazil's regional differences in health are significant. Many analyses (Lampreia 1995; Barreto et al. 1997; OPAS 1998) have shown evidence that Brazil is one of the countries with the most pronounced socioeconomic inequalities. Naturally, these socioeconomic inequalities have a strong impact on the living conditions of the population, and therefore on its health. Brazilian life expectancy in 1960 averaged 51.3 years and the infant mortality rate was 105.2 deaths per 1,000 life births. In 1995, life expectancy at birth was 66.6 years, and it reached 67.6 in 1996. The reader must remember the fact that women's average life expectancy surpasses that of men by about seven years. Looking at the accentuated differences between the various regions in Brazil, one can see that the South and Southeast regions have the highest average life expectancy, at 70.2 and 68.8 years respectively. The West-Central and Northern regions are next with 68.5 and 67.4 years, respectively. Finally, the Northeast region had the lowest life expectancy with an average of only 64.5 years (IBGE 1998).

The infant mortality rate in 1995 was 48.0 per one thousand live births for male and 36.4 per thousand for female babies. When broken down by region, this figure also illustrates the dramatic differences in living conditions and health. The best regional results, again, are in the South, with 25.2 per thousand for live male births and 14.8 per thousand for live female births, and the Southeast, with 27.7 per thousand for males and 17.2 per thousand for females. The West-Central region is again third, with 29.5 and 19.3 per thousand for male and female births, respectively. The urban Northern region has about 45.2 deaths per thousand males and 34.6 deaths per thousand for females. Again falling far behind the other regions is the Northeast, with 71.7 and 60.8 per thousand live male and female births, respectively (IBGE 1998).

Both life expectancy and infant mortality rates illustrate the regional differences found in Brazil, showing a certain "hierarchy of the poor, a pyramid at the base of which we find the poorer states – all belonging to the Northeast Region – and at the top the state of São Paulo, followed by the country's extreme south (Rio Grande do Sul and Santa Catarina)" (OPAS 1998: 8). Another striking statistic in Brazil is that in 1990 the truly poor represented 30.2 percent of the total population, and 54.1 percent of these poor were located in the Northeast (OPAS 1998: 9). The document from OPAS points out that in Brazil, two critical poles of poverty may be identified completely opposite in their characteristics. One of these is the Northeast (especially the rural part), with poverty typical of

traditional societies at the margin of industrial urban growth. The other is the Southeast metropolis with 23 percent of individuals below the poverty line, which is associated, socially and economically, with the participation of this region as the dynamic center of the national economy.

ANTECEDENTS TO MEDICAL SOCIOLOGY IN BRAZIL

In North America, research and teaching in the social sciences in the health area go back over a period of 50 years, while in the case of Latin America, the beginning was only 30 years ago. Furthermore, researchers have highlighted the lack of a classical tradition in health social sciences, especially medical sociology. As Cockerham (1988: 576) observed: "The notion that medical sociology has an aberrant character stems not only from its neglect by sociology's founders, but, more important, from the fact that it matured in an intellectual climate far different from sociology's traditional specialties, with direct roots in nineteenth- and early twentieth-century social thought." There were some minor developments in medical sociology in the United States in the first half of the twentieth century, obviously with different characteristic from those assumed later. But the reference point for the development of sociology as applied to health, both in Europe and the United States, without any doubt, is the end of World War II. It was only in the 1950s, however, that the United States advanced in the direction of the regular production of medical sociology with the seminal work of Parsons (1951).

The author agrees with Menéndez (1992) that a global revision of a discipline takes place not only in relation to a structural crisis, but can also occur because of restricted or unavailable paradigms and the discipline's own hegemonic tendencies. Both of these latter situations need not necessarily coincide and the growth and transformation of each area has an historical origin as well as internal and external determining factors. In the case of the United States, the federal government stimulated the development of medical sociology through funding for research intended to address the relationship between health and social conditions. In Latin America, it was the local middle classes who showed the first signs of concern regarding the relationship between the 1930s and 1950s as they made an effort towards industrialization, free-market capitalism, and social modernization.

Though there were no projects in the area of medical sociology as such during the 1940s, there are some forerunners to the discipline that should be noted. In 1942, there was a great deal of interest in the area of health when bilateral agreements were reached between the United States and several Latin American countries. As a result, the Health and Sanitary Division of the Institute of American Affairs had the following objectives: (1) from a military viewpoint – to improve health conditions, especially in relation to the demands of the army; (2) from a political viewpoint – to fulfill the government's obligations of sanitary programs promised during the 30th Resolution at the Rio de Janeiro Conference (1942); (3) from an industrial viewpoint – to increase the production of essential materials in areas with poor health conditions; and (4) from a moralistic point of

view – to use facts and not just words to show the tangible benefits of the democracy which was in progress and to obtain the support of the civilian population (García 1989).

Another antecedent is the establishment of medical anthropology in Latin America. Beginning in the early 1940s, the first medical anthropology programs were sponsored by the Pan American Sanitary Department, an international division of the Rockefeller Foundation, and the Inter-American Cooperative Public Health Service. Also important was the emergence of general sociology. Sociology began in Brazil with the School of Sociology and Politics in São Paulo in 1933 and the Faculty of Philosophy, Sciences, and Arts of the University of São Paulo in 1934. Elsewhere in Latin America, sociology had been institutionalized much earlier when faculties were established in Colombia (1882), Argentina (1897), Mexico (1900), and Ecuador (1906). An emphasis on positivism, with roots in European ideas, which had dominated much of Latin American social thinking prior to World War II, gave way in the middle of the twentieth century to new lines of thinking promoting empirical research and adoption of modernization theory. This development was strongly influenced by the empirical style of sociology practiced at this time in the United States.

Later during the mid-1960s, after the failure of many government-sponsored economic projects in Latin America, a period of sociological criticism arose. According to Pablo González Casanova, in 1966, the distinctive direction of sociology during this period in Mexico and the rest of the continent was to investigate "'the dynamics of inequality' – conditions including demography, food and nutrition, work and employment, consumption and economy, transport, domicile, clothing, leisure and entertainment, health and social security, and human rights (especially women's right to vote and participate)." These studies were part of what Sefchovich (1989: 29) had in mind when he encouraged "a social and political interpretation of conditions as a criticism of the State." In general, the primary topic of study for Latin America was to determine the social reality of each country within a Marxist focus. According to some analysts, during the period 1966–82, Latin American sociologists developed an original theory – the theory of dependence based on relations between the center and the periphery of the world capitalist economy (Cardoso and Falleto 1970). However, these theories disappeared after 1982 because they were "unable to predict the future of the region's political regime and even less so the character of the political forces that contributed toward these changes" (Garza Toledo 1989: 126).

The Early Stages of Medical Sociology (1960s)

The precedents set by medical anthropological research in the 1940s were important, but the systematic incorporation of sociology and other social sciences in health took place only in the 1960s when there was a great deal of criticism regarding the bio-medically-oriented model of medicine. This criticism occurred particularly in Brazil, Ecuador, Mexico, and Venezuela (Nunes 1986). About the same time, there was a major reformulation of medical education in the region associated with the Latin American Preventive Project.

In order to provide a more complete vision of the individual and his or her illness, medical courses were expanded to include other disciplines and themes linked to epidemiology, behavioral science, the administration of health services, and biostatistics. Two important aspects of the new pedagogical practices were the success of the biopsychosocial integration of the individual and a new "comprehensive medicine" focused on integrated family medicine within the community.

The functionalist view and systemic theories developed by Talcott Parsons, Samuel Bloom, David Mechanic, and other North American researchers were predominant among the theoretical perspectives introduced in schools teaching medical sociology. One of the original proposals of this period in Latin American medical schools was the teaching of sociology based on the natural history of disease perspective adapted by García (1971).

Brazil's Medical Sociology Develops Further (1970s and 1980s)

Some very important events in the area of medical sociology took place at the beginning of the 1970s. There was again clear dissatisfaction with the teaching models and references used in the discipline. Criticism arose particularly in response to the use of the natural history of diseases and atheoretical literature (whose possibilities were therefore limited), especially with regard to the literature's understanding of underdeveloped societies (Gaete and Tapia 1970). Because of this, sociologists and other social scientists found it very important to reevaluate other epistemological categories. The Pan American Health Organization organized seminars to deal with such concerns, such as the one held in Cuenca (Ecuador), in 1972. This seminar proposed an alternative model for sociological research that would analyze societal changes and include theoretical elements that would allow a better understanding of social reality and its internal contradictions at the specific structural levels (OPAS/OMS 1974).

Researchers conducted many discussions at this point regarding an alternative model that would (1) take into consideration the relation between concepts of health and actions as well as the modes of production and the socioeconomic structure; (2) conduct historical research about health practices and medical education; and (3) define the relationship between biological science and social science from an epistemological viewpoint. Emphasis on a theoretical approach based in historic materialism began in the seventies and is a distinct milestone for medical sociology in Latin America. According to Mercer (1986: 226), from the mid-seventies to 1980, medical sociology went through a period of "identification and legitimization." It was a period of acute theoretical turmoil and, alongside the traditional Marxism, there was also structuralism by Michel Foucault and Claude Lévi-Strauss. These perspectives, without doubt, influenced the objectives of many graduate courses in medicine that aimed at "a double target: theoretical formation and political criticism" (Bezerra and Sayd 1993). The courses' emphasis on sociology resulted in the production of several important dissertations and theses.

From a political viewpoint, the main objective during this time period was to guarantee health as an inalienable right of the citizen through State intervention. Although located within a critical financial context, the rationalization of resources and the expansion of services were deemed fundamental by the government. Brazilian sociologists conducted many of the important studies that marked this period, dealing with medicine and society, state medicine, historical analyses and health programs. In Latin America, during the period 1970–9, the production of scientific papers in the health service area made up 35.7 percent of the total paper production. For example, in 1975, Donnangelo conducted a study on the medical profession and its articulation with social practice. Later, the same author carried out an analysis to try to establish the relationship of medicine with the social structure in political, ideological, and economic plans in which the economy is the determining factor and politics the mediating variable (Donnangelo and Pereira 1976). Another example is Arouca (1975), who elaborated a critical aspect of preventive medicine using Foucaultian analytical methodology. His research also raised important questions regarding medical care as a work process. Nogueira (1977) and Gonçalves (1979) agreed that the topic was worth further research, as proven by their study of the characteristics and practices of medicine in a society with capitalist production.

Toward the end of the 1970s there was an acute economic recession in Latin American countries because of inflation, increase in international debt, unemployment, and fiscal deficit. This had an overwhelmingly negative effect on the health of Brazil, so changes in health care became necessary. The country directed primary attention toward health on an international level; on the national front the government took a stronger position regarding sanitary problems, preventive medicine, social medicine, and public health. In addition to the changes to medical education discussed earlier, two organizations were created which were important for the further organization of academic and political health movements. ABRASCO (the Brazilian Graduate Association in Collective Health) was founded in 1979 and the CEBES (the Brazilian Centre for Health Studies) originated in 1976. According to ABRASCO (1982) graduate courses in health-related studies should be oriented "by a critical analysis of the health sector within its social reality and should have the capacity to influence the teaching, research and services rendered."

Besides structural and political factors, which undoubtedly were important in reevaluating the health system, the financial factor positively influenced the development of research. This can be seen in the role played by FINEP (the financier for research studies), which provided "a scientific and technological infrastructure for research in health not subject to biomedicine" (Costa 1992: 129). During the seventies, it can be briefly stated that health became the main theme of the social sciences, particularly sociology, as seen by the concern given to theory, the institutionalization of new graduate health-related courses, and the finance provided for research.

A review of this period cannot fail to mention the importance given to methodology, especially qualitative, and its applications in the area of health (Minayo 1989). At the beginning of the eighties, a preoccupation with the methodology and theory of medical sociology was evident in a pioneer study

by Pereira (1983) in which he analyzed the manner in which functionalism, comprehensive and dialectic, was introduced when researching the social organization of health practices. Later Luz (1988) analyzed the socio-historical development of modern scientific rationality using strategies that were common in both medicine and sociology.

RECENT THEORETICAL PERSPECTIVES

The vitality of medical sociology is evidenced not only by its many publications in recent years, which includes the establishment of two journals – *Health and Society* and S*cience and Collective Health* – but also by the manner in which social scientists have addressed certain theoretical questions. As mentioned earlier, there was a preoccupation with methodology and theory in research during the seventies. It was present when attempting to better understand the health/illness process, as well as the social organization of health practices. Significantly, all of this took place in a context that favors debate. The following decades have continued these interests, resulting in important new perspectives on medical sociology. The diversity of theoretical reference, in particular, became evident during the eighties. The concept of "habitus" developed by Pierre Bordieu, the perspective of communicative action by Jurgen Habermas, and Michel Foucault's discourse analysis have been applied in recent studies. Clifford Geertz has served as a reference for research on symbolic and cultural aspects of medical practice. Agnes Heller's work on individual–community relations have also been influential, as well as Felix Guattari's ideas on subjectivism and territorialities as applied to mental health studies. Other studies have used Cornelius Castoriadis's concept of the construction of subjectivity, or Alain Touraine's ideas on the formation of new actors and actions, which are based on rules of collective life. Theoretical positions on the state, democracy, and modernity derive from authors such as Paul Evans, N. Lechner, and Guillermo O'Donnell. Finally, Claudine Herlizch's studies on social representations have been important, along with many other social scientists and philosophers.

There are three approaches that I feel define the present direction of medical sociology. The first deals with politics in the area of health – a field that has shown notable development. Many specialists have noted a crisis of the classical models. For example, Bodstein (1992) criticizes the predominance of structural-functionalist Marxism in the study of the state's health policies. According to the author, these analyses were extremely limited because they were highly generalized and abstract. One of the main problems lies in finding how the macro and micro social dimensions relate to the significance of collective agents and to the new identities that are created during the process. According to Bodstein (1997), social science since the mid-seventies has been heading toward "a questioning of the subject, the meaning of its actions, its various roles, complex categories that construct socio-political expectations and representations." The author emphasizes that "what is central in the sociological dimension today generally follows the Weberian tradition of obtaining an explanation of the social processes in two ways: starting from the exterior aspect, beyond the intentions of the social

agents, but without abandoning dimensions of human participation in the formation and transformation of social institutions and relationships" (Bodstein 1992). The author criticizes studies that give more importance to the functional character of social politics in health in order to guarantee the legitimacy of the system by establishing the clear subjugation of politics to economy. A reinterpretation of politics in health means the recovery of the relationship between social agents.

A second direction of Brazilian medical sociology is the health/disease approach, which shows the necessity of analyzing "the appropriation of the health concept by infirm social agents" (Chammé 1993). According to Minayo (1989), research regarding the field of social representations of health and disease could be better conducted through attention to three orientations: (1) health/disease as a social and individual expression; (2) health/disease as an expression of social contradictions; and (3) health as a political battlefield. The 1990s has witnessed the progressive advance of sociological studies on disease, with the use of qualitative methodologies and a focus on distinct pathologies like AIDS (Loyola 1994; Uchoa 1997: 94).

The third example that illustrates the recent (and future) direction of researchers is criticism regarding the use of macro theories. According to Ferreira (1993), in the face of an "explanation crisis" researchers adopted theoretical references that emphasized the constitution of identities and valued subjectivity, the imaginary and cultural phenomenon in themselves or as mediators between structures and systems and social action.

Conclusion

This paper shows that in Latin America and Brazil, the field of medical sociology not only reflects intellectual traditions but also the fact that the living conditions of the population are marked by deep social inequalities. According to Stavenhagen (1966: 20–1) there is no doubt that Latin American medical sociology was politically impregnated by reform and revolution. In the case of Brazil, the confirmation of the importance of sociology took place in the area of health – through the Faculties of Medicine and Public Health courses and not through the Faculties of Social Science and Philosophy. It is clear that during its development, medical sociology was strengthened and became more important. There are many problems and challenges to be overcome but it has achieved institutionalization. This is demonstrated by the fact that 44.1 percent of the subject matter in the Master's degree of Public Health/Collective Health is in the area of social sciences. For the Doctorate degree, this figure goes up to 44.9 percent of the coursework (Nunes and Costa 1997).

This study is a general review and it is therefore impossible to comprehensively list all of the research that has taken place during the last few years. Many developments have taken place only recently. The direct involvement of health professionals in discussing and critically evaluating health reform favored a political approach to health using a theoretical perspective. There has been a renewal of interest in historical research on diseases and public health organi-

zation. Also, basic theories of health planning have been reevaluated, and discussion has taken place regarding workers' health in relation to the new problems of economic globalization and technological progress. Finally, studies on biomedical practices and on bioethics have become very important.

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