

# The field of Collective Health: definitions and debates on its constitution'

## O campo da Saúde Coletiva: definições e debates em sua constituição

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### Abstract

At first sight, Collective Health might seem to be multiple and fragmented. Aiming to understand better what defines it as knowledge and activity in society, we made a theoretical review of historical and epistemological considerations developed by researchers who dedicated themselves to characterizing it as a scientific and social field. First, based on this literature, we provide a brief panorama of the emergence of Collective Health in Brazil. It is important to notice that its origins date back to the end of the 1970s, in a context in which Brazil was experiencing a military dictatorship. Collective Health emerges, at that moment, connected with the struggle for democracy and with the Health Reform movement. We show the influences of preventive medicine and social medicine in its constitution. Then, we explore different attempts to delimit it as field of knowledge and practice. We sought to present Collective Health not through one single definition, but taking into account the multiplicity of constructions about it that we found. This allows us to point to an identity of difficult development and that is still under construction.

**Keywords:** Collective Health; Public Health; Social Medicine; Scientific Domains; Knowledge.

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## Resumo

A Saúde Coletiva pode, em um primeiro contato, parecer bastante múltipla e fragmentada. Buscando compreender melhor o que a define como conhecimento e atuação na sociedade, realizou-se uma recuperação de natureza teórica das considerações históricas e epistemológicas desenvolvidas por pesquisadores dedicados a caracterizá-la como campo científico e social. Primeiro, com base nessa produção bibliográfica, foi feita uma breve caracterização da emergência da Saúde Coletiva no Brasil. É de se destacar que suas origens situam-se no final da década de 1970, em um contexto no qual o Brasil estava vivendo uma ditadura militar. A Saúde Coletiva nasce, nesse período, vinculada à luta pela democracia e ao movimento da Reforma Sanitária. Apontam-se as influências do preventivismo e da medicina social em sua constituição. Ao longo deste estudo, foram exploradas distintas tentativas de sua delimitação como campo de saberes e de práticas. Buscou-se apresentar a Saúde Coletiva não com uma definição única, mas considerando a multiplicidade de construções encontradas, o que permite apontar para uma identidade de difícil elaboração e ainda em desenvolvimento.

**Palavras-chave:** Saúde Coletiva; Medicina Social; Domínios Científicos; Conhecimento.

## Introduction

What instigated the choice of the theme for this study was the perception that, at first sight, Collective Health seems to be multiple and fragmented, both from the theoretical and from the practical points of view. Therefore, aiming to understand it better, a study was carried out, based on the production in Collective Health in Brazil, in an attempt to answer the following questions: What characterizes and defines Collective Health? What distinguishes it from other fields of knowledge and intervention?

In this preliminary reflection on such issues, we decided to revisit studies that viewed it as a specific field and that were conducted by authors who are considered references in Collective Health, as they participated in the development and implementation of the proposal for a Collective Health in Brazil at the end of the 1970s. These authors are researchers in the areas of Epidemiology, Human and Social Sciences in Health, and Health Policy, Planning and Management, and have studied the constitution of Collective Health from these distinct fields.

The reference that Collective Health configures a “field” is registered in almost all the publications. In this text, we will maintain this reference following Paim and Almeida Filho (1999, 2000). In their reflections on Collective Health, these authors characterize it as a “field of knowledge and an specific sphere for practice”: “Collective Health can be considered an interdisciplinary field of knowledge whose basic disciplines are epidemiology, health planning/management and social sciences in health” (Paim; Almeida Filho, 2000, p. 63).

However, in a recent publication that focuses on Collective Health, this qualification of “field”, which, since the beginning, has been grounded in the concept coined by Pierre Bourdieu (1993), is relativized, in view of the fact that Collective Health, sometimes called “area”, sometimes “social space”, has, in its development, a tendency to consolidate as a field (Vieira da Silva; Paim; Schraiber, 2014).

In light of this open question, as a future or consolidated field, what most instigated us was the delimitation of a scientific and practical identity based on its knowledge contents and intervention scopes. Thus, in the above-mentioned revisit to pub-

lications about the construction of Collective Health in Brazil, we aimed to reveal which areas of expertise have been mentioned since its origins. Less than a bibliographic review, therefore, this study aims to present a rereading of important discussions on the identity of Collective Health.

This is an effort to clarify what constitutes the “whole” of Collective Health, in an attempt to overcome a possible fragmentary view that has been produced by the diverse disciplines that compose it, in order to provide a better understanding of the construction of its identity. According to Everardo Nunes (2005), this effort seems to be an important concern in the history of Collective Health:

Recovering the history and unveiling its internal composition (epistemê) has been one of the concerns of many studies and analyses that have been following the very construction of Collective Health in Brazil. This effort has been present since the 1980s and continues to the present day, with the aim of providing the elements that configure our identity and reveal who we are, where we are, what we do, and the products of our practices (p. 14).

The present paper is divided into two parts. The first briefly approaches the constitution of Collective Health in Brazil as presented by authors in the field. In this part, we emphasize schools of thought about health-disease processes in collectives as ways of thinking that are different from that of the traditional public health and from that based on the view coined by modern medicine. The way in which questions of medicine and of public health are articulated is the reference to understand the issues that surround the disciplinary content that the Collective Health proposal has embraced. The second part explores contrasts among distinct attempts to define Collective Health. These contrasts are also present in texts written by authors in the field, who present different perspectives on the delimitation of Collective Health, and indicate the existence of a large multiplicity of schools of thought concerning its definitions as a field.

## The constitution of the field of Collective Health in Brazil

Nunes (1994) situates the origin of the field of Collective Health in the 1950s. Vieira-da-Silva, Paim and Schraiber (2014) consider that it dates back to the end of the 1970s, as the benchmark they utilize is the emergence of the term Collective Health in Brazil, and the creation of the civil association that would represent the field: the *Associação Brasileira de Pós-Graduação em Saúde Coletiva* (Abrasco - Brazilian Association of Postgraduate Programs in Collective Health). However, the authors do not deny the roots that Nunes has pointed in previous periods. Thus, Collective Health consolidated with this name and with its specificities in Brazil. Although the name has not been adopted in other countries, many authors see Collective Health as part of a broader movement in Latin America, as Nunes himself has argued (1994).

Based on a distinction between “project” and “field” of Collective Health, Nunes (1994) proposes that the emergence of this field occurred in three stages: the first, called pre-Collective Health stage, lasted for fifteen years from 1955 onwards, and was marked by the establishment of the preventive medicine’s project; the second, which lasted until the end of the 1970s, is called social medicine stage; the third goes from the end of the 1970s to, at least, 1994, when the author wrote the paper *Saúde coletiva: história de uma ideia e de um conceito* (Collective health: the history of an idea and of a concept). The author considers that the last stage is the period of Collective Health per se. According to Nunes (1994, p. 2), “the emergence of these projects reflects, generally speaking, the broader socioeconomic and political-ideological context, as well as the successive crises that are present both in the epistemological level and in the level of health practices and human resources education”.

Paim and Almeida Filho (1999) also point to the importance of context in issues related to field of knowledge. These authors, based on the ideas proposed by Kuhn and Rorty, defend that the construction of scientific knowledge is not produced by investigators in an isolated way, in the abstract; rather, it is institutionally organized, within cul-

ture, and immersed in language. Therefore, science would be socially and historically determined. The authors propose that science should be understood as a social practice that has particular principles, is exercised in a process of dialog and negotiation, is targeted at the production of a localized and dated consensus, and is based on a certain solidarity of those who act in the scientific community.

We believe that an important advantage of this periodization is that it highlights preventive medicine and social medicine as approaches to the health-disease process in collectives that can be recognized as the roots of the Collective Health proposal that was developed in Brazil, and which influenced the institutional implementation of the field.

In the sections below, we will characterize these roots so that it is possible to understand the modality of disciplinary and practical proposition that they constituted.

### **1) Preventive Medicine**

According to Paim and Almeida Filho (1998), in the 1940s, some researchers started to diagnose, in the United States, a crisis of a certain medicine that was extremely specialized and fragmented, which caused an increase in costs related to medical practices. In response to this, proposals for changes in medical teaching emerged and incorporated into it an idea of prevention. These proposals were the basis for a reform of the curricula of medicine programs in many North American universities in the 1950s. International health organs adhered to the new doctrine, which was called Preventive Medicine. Thus, the proposal was internationalized.

Nunes (1994) explains that the emergence of the “preventive project” in Latin America occurred in the second half of the 1950s, in the seminars that were held in Chile and Mexico, sponsored by the Pan American Health Organization (PAHO). The reforms that were defended in these seminars were associated with a pedagogical plan:

The great balance of the period is the inclusion, in the medicine undergraduate program, of disciplines and themes associated with epidemiology, behavioural sciences, health services management, and biostatistics. Thus, when the biologization of teaching was

criticized, as it was grounded on individual, hospital-centered practices, the aim was not only to introduce other types of knowledge, but also to provide a more complete view of the individual (Nunes, 1994, p. 7).

The fact that teaching was based on specialization made medical education become shattered. As a reaction against this, proposals for changes in teaching were made, so that the future doctor could understand the individual as a whole, as it was believed that this would promote a recomposition of the bio-psycho-social dimension that had been fragmented. The social movement that originated Preventive Medicine as a discipline in the curriculum of medical schools was called Comprehensive Medicine, and aimed to recompose specialized practices (Schraiber, 1989). However, the only result was the inclusion of one discipline in the curriculum, even though it pervaded several moments of the doctor’s education. No integrative projects other than the teaching of prevention were incorporated, neither in doctors’ education, nor in their professional exercise in the health services. Schraiber (1989) has argued that these proposals intended to promote a reform of medical practice, but they assumed that this reform would be performed in the sphere of doctors’ education, as if each doctor in his/her practice was the main resource to transform the way of providing care for the population. This way of thinking about the reform of medical practice was well characterized, as a liberal and individualizing reading of social issues that was typical of the North American culture regarding the State’s role in society, by Arouca (2003), in a publication that is considered, today, a bench mark for Collective Health in Brazil (Vieira da Silva; Paim; Schraiber, 2014).

In addition to Preventive Medicine, Community Medicine arrived at Latin America. It emerged, in the 1960s, also in the United States, in a period of intense popular and intellectual mobilization around social issues. Donnangelo and Pereira (1976) have shown that Community Medicine was a response to the low coverage of medical care for the poor, such as communities of migrants or low-income strata of the North American society, and to the low coverage for the elderly - as they were out of the job market, they had no adequate access

to medical services. Diverse intervention models were tested and institutionalized in the form of organized movements in urban communities, aiming to reduce social tensions in the ghettos of the main North American cities. In the field of health, there was the implementation of community-based health centers subsidized by the federal government, which were targeted at performing preventive actions and providing primary care to the local population (Paim; Almeida Filho, 1998).

Like in Preventive Medicine, there was, in the Community Medicine proposal, an emphasis on the “behavioural sciences”. In this case, however, knowledge of sociocultural and psychosocial processes aimed to “enable the integration of healthcare teams in ‘problematic’ communities, through the identification and cooptation of local social agents and forces for health education programs” (Paim; Almeida Filho, 1998, p. 304).

International organs in the field of health incorporated, once again, the new ideological movement, community-based and preventive, and translated its doctrine into the needs of different contexts in which it could be applied.

Although Community Medicine and Preventive Medicine emerged in different moments in the United States, they arrived more or less at the same time in Brazil (Donnangelo; Pereira 1976; Schraiber, 1989).

## 2) Social Medicine

The Social Medicine movement emerged in Latin America at the end of the 1960s and beginning of the 1970s. Its center is the discussion of the appreciation of the social dimension as the sphere that determines the emergence of illnesses and health possibilities, in disease prevention and health promotion. Furthermore, the social dimension is the adequate sphere for intervention, beyond and in articulation with medicine as intervention in individual cases (Vieira da Silva; Paim; Schraiber, 2014). Therefore, it is an alternative view to the biomedical reduction in which medical knowledge and practice structured themselves, even though with diverse explorations regarding the meaning of the appreciation of the social sphere. In this sense, the central figure in Latin America, with a strong influence in Brazil, was the Argentinian doctor

and sociologist Juan Cesar Garcia, by means of his work within the PAHO (Garcia, 1985; Nunes, 1983; Vieira da Silva; Paim; Schraiber, 2014). By valuing the presence of the social sphere in health, Garcia, like many Brazilian researchers who participated in the construction of Collective Health, searched for references in a historical-structural approach to the social sphere. Thus, he did not merely assume a segmented presence of the social sphere like the isolated approach to elements of the environment and of the population itself.

On the other hand, many authors refer to Social Medicine based on George Rosen’s studies, and they focus on the movement that emerged in Europe in the middle of the 19<sup>th</sup> century.

Regarding this, Nunes (1983) says:

This paper written by Rosen has been considered of fundamental importance to the understanding of social medicine, and one of the points that it raises is the question of sanitary problems, which increase due to the transformations deriving from the industrialization process (p.19).

Rosen (1983) argues that a central issue in Europe during the 19<sup>th</sup> century was which political orientation the government should follow in order to increase national power and richness. The industry was considered one of the main means. As a result, work started to be seen by political leaders as an essential element to generate national richness. Any loss of productivity caused by illness and death was, at the time, seen as a significant economic problem. This approach implied the idea of a national public intervention in health, which was developed in many directions, depending on the country.

The first place in which the State’s concern for the population’s health problems flourished was in the German states, even before they were unified or underwent the industrialization process, and the idea of medical police emerged for the first time. According to Rosen (1983), *Polizei*, in German (police), derives from the Greek word *politeia*. The theory and practice of public management came to be known, throughout the 18<sup>th</sup> century, in the German states, as *Polizeiwissenschaft* (science of police), and the branch that deals with health management, as *Medizinalpolizei* (medical police).



The development of the theory and practice of public administration was intimately related to the interests of the Absolutist State. Therefore, a systematization of managerial thought and behavior was reached and it attributed wellbeing activities to the absolute State. However, the legislator was responsible for determining the greatest wellbeing, so that the State had the power to intervene in the individuals' matters aiming at the common good. The development and application of the concept of "medical police" was a pioneering attempt to create a methodical and precise examination of health problems from the social point of view. At the beginning and in the middle of the 19<sup>th</sup> century, it was in France that this type of study developed theoretically. In France, however, the concept of medical police was not broadly accepted (Rosen, 1983).

In the context of the French Revolution, health and wellbeing problems were addressed by the revolutionary governments. There was even an attempt to establish a national social assistance system that included medical care. Although it did not advance, some of the ideas and objectives of the period would deeply influence France in the first half of the 19<sup>th</sup> century. "Ideas of public service and social utility provided the seed from which new ideas germinated concerning the relation among health, medicine and society" (Rosen, 1983, p. 43).

During the first half of the 19<sup>th</sup> century, there was, in France, a fruitful encounter between social philosophy and medicine. "As a result, French medicine was permeated, to a considerable degree, by the spirit of social change" (Rosen, 1983, p. 46). The contact with the new living conditions deriving from the industrialization process, such as workers' conditions and the social reality in which they lived, caused the emergence of new ideas in the field of health in its relations to society. The idea of Social Medicine germinated in this scenario. Jules Guérin was one of the first authors to use this term, in 1848.

Nunes (2007) emphasizes that it was in a revolutionary context dating back to the 1840s that many doctors, philosophers and thinkers assumed the social character of medicine and illness. The ideas and proposals that had progressed in France before and during the revolutionary movement of 1848 spread across Germany. Among the main names of

the German movement, which assumed Social Medicine instead of Medical Police as its proposal for national intervention, were Neumann and Virchow. Neumann, in 1847 (apud Rosen, 1983, p. 50), states that "medical science is intrinsically and essentially a social science and, as long as this is not recognized in practice, we will not be able to enjoy its benefits and we will have to satisfy ourselves with emptiness and mystification".

The proponents of the idea of medicine as a social science employed it as a conceptual formulation under which they summarized defined principles:

The first of these principles is that people's health is a direct matter of society and society has the duty of protecting and guaranteeing its members' health [...]. The second, as Neumann noticed, is that social and economic conditions have an important and - in many cases - crucial impact on health and illness and that these relations must be submitted to scientific investigation [...]. The third principle, which follows the other two logically, is that the steps taken to promote health and fight against illness must be both social and medical (Rosen, 1983, p. 51-52).

The influence of this entire formulation on the Brazilian Collective Health can be seen, for example, in the fact that these principles were revisited in Brazil in the *VIII Conferência Nacional de Saúde* (CNS - 8<sup>th</sup> National Health Conference), in a rereading that was appropriate to the historical context of the 1980s and to the reality of a country in the periphery of the capitalist development. Therefore, these principles, as connections between medicine and the social sphere, will influence the Brazilian Health Reform.

However, the revolutionary process of the 1840s was defeated in Germany and also in France, and due to this, the medical reform movement ended quickly (Rosen, 1983). During the next decades, the broad reform proposal became a limited program. The idea of social medicine reappeared in a meeting summoned by the World Health Organization, WHO, in 1952, in Nancy and, later on, in a document released by the PAHO in 1974 (Nunes, 1994).

The end of the 1960s and beginning of the 1970s were extremely fertile years in terms of theoretical

discussions about health-society relations. There was a great influence of discussions held by authors in the human sciences, and a bench mark was the lecture that Michel Foucault delivered in 1974, in Rio de Janeiro, about the origins of Social Medicine (Nunes, 2005), in which he re-discussed the significant content of this term. According to Paim (1992), at this moment, there was, in Brazil and in the rest of Latin America, an important theoretical production that recognized the bonds between health practices and the social totality. In this sense, the contributions from the social sciences to the study of health were fundamental so that we could reach the current degree of systematization of knowledge in the field.

On the proposal of social medicine, Sérgio Arouca states:

Therefore, Social Medicine emerges with two tendencies; the first [...] a movement to modify medicine connected with the process of change in society, or [...] through its institutional change [...]; the second is an attempt to redefine the position and place of objects inside medicine, to make conceptual delimitations, to discuss theoretical frames. In short, it is a movement at the level of knowledge production that, through a reformulation of the basic questions that enabled the emergence of Preventive Medicine, tries to define an object of study in the relations between the biological and the psychosocial spheres. Social medicine, by electing these relations as its field of investigation, tries to establish a science that is situated on the boundaries of the current sciences (Arouca, 2003, p. 150).

In the fragment above, Arouca highlights two dimensions of Social Medicine: the formulation of proposals for intervention in social life and in medicine based on the health-society connection, and the proposal for establishing a branch of studies about this specific connection, focusing on illness issues and on issues related to the production of medical assistance and professional practices in the services. In addition to a criticism against a certain kind of medicine - expensive, fragmented and with few results to the population's health -, there was also a discussion on the amplification of the health service coverage to the population. According to

Nunes (1994), it was the beginning of the crisis of the developmentalist model of public health, which had postulated that one of the effects of economic growth would be the improvement in health conditions. This is particularly valid for Brazil at the time. Although the country was undergoing a moment of economic growth, this produced no results to the living conditions of its population.

In the 1970s, there was, in the international scope, an intensification of the discussion about the amplification of health service coverage. The 1977 World Health Assembly launched the slogan "Health for all by the year 2000" (Paim; Almeida Filho, 1998). In Brazil, in a context marked by the strengthening of repressive forces on the part of an authoritarian State, as well as by an increase in social inequalities and a worsening of the living conditions of a large part of the population, a field of knowledge and of innovative practices was gradually built in the area of health.

Nunes (1983), referring to Laurell, argues that critical reflection on medicine and its institutions in Latin American countries at the time can be seen as an answer to four groups of questions: 1) class position explains the distribution of diseases in the population much better than any biological factor; 2) the belief that the population's health conditions would improve as a result of economic growth proved to be wrong; 3) the development of medical-hospital care did not bring a significant advance in the health indexes of the groups covered by it; and 4) the distribution of health services across different groups and social classes does not depend on technical and scientific considerations, but mainly on political and economic considerations.

### **3) Collective Health in Brazil**

Paim and Almeida Filho (1998) have shown the existence of mutual influences between the development of a project of field of knowledge called Collective Health and the movements in favor of democratization in Brazil, especially that of health reform. This leads us to emphasize the importance of considering the historical context in which Collective Health emerged, which was that of a country living under an authoritarian regime. Thus, it is possible to state that the

Alliance of Collective Health with democracy and human and social rights is due to the historical fact that the field is gestated in a decade marked by social turbulences and movements claiming for changes, in the fight against dictatorship in Brazil and in favor of social reform (Schraiber, 2008, p. 15).

This social reform includes a health reform in the project of Collective Health. In Brazil, two institutions emerged directly connected with this project: Cebes and Abrasco. The *Centro Brasileiro de Estudos de Saúde* (Cebes - Brazilian Center for Health Studies) was created in 1976 “discussing the issue of democratization of healthcare and being constituted as an organizer of culture capable of reconstructing healthcare thought” (Paim, 2008, p. 78). According to Paim (2008), Cebes is recognized as the first institutionalized protagonist of the Brazilian health movement, and it has played an important role in the socialization of a critical academic production coming from the then-emerging field of Collective Health.

Two important moments in the creation, in 1979, of the *Associação Brasileira de Programas de Pós-Graduação em Saúde Coletiva* (Abrasco - Brazilian Association of Postgraduate Programs in Collective Health) - today, Brazilian Association for Collective Health -, were the 1<sup>st</sup> National Meeting of Postgraduate Studies in Collective Health, and the Sub-Regional Public Health Meeting of the Pan American Health Organization/Asociación Latinoamericana de Escuelas de Salud Pública (PAHO/Alesp), both held in 1978. They aimed to redefine the education of personnel for the area of health, and proposed an association that was able to congregate the interests of postgraduate education institutions (Nunes, 1994).

The movement for the Brazilian health reform, which emerged in the middle of the 1970s, aimed to fight for the democratization of healthcare. Paim (2008) argues that it was more than a project of health sector reform - it was a broad project of social reform:

[...] as a social reform centered on the following constituents: a) democratization of healthcare, which implies awareness-raising about health and its determinants and the recognition of the right to health, inherent in citizenship, in order

to guarantee universal and egalitarian access to Brazil’s National Healthcare System and social participation in policy-making and management; b) democratization of the State and its apparatus, respecting the federative pact, ensuring the decentralization of the decision-making process and of social control, and fostering ethics and governments’ transparency; c) democratization of society, reaching the spaces of economic organization and culture, in the production and fair distribution of richness and knowledge, and in the adoption of a ‘totality of changes’ around a set of public policies and health practices, and also through an intellectual and moral reform (Paim, 2008, p. 173).

In a scenario of crisis in the health sector in the second half of the 1970s - although the government’s official discourse mentioned a greater opening to the social sphere -, it is possible to say that the adopted measures were very limited, when we look at the determinants of this crisis, which “expressed itself through the low efficiency of medical assistance, high costs of the medical-hospital model and low health service coverage compared to the population’s needs” (Paim, 2008, p. 75). In this same period, “there was a rebirth of the social movements, involving the working class, as well as popular sectors, intellectuals and professionals of the middle class” (Paim, 2008, p. 77). In the scope of health, these movements connected with one another and became social forces that opposed authoritarian and privatizing health policies.

Concerning the theoretical foundations related to the proposal for a health reform in Brazil, Paim (2008) argues that the health conceptions that were used were developed by its academic branch, that is, by preventive and social medicine departments and public health schools or similar institutions. In the 1970s, the preventive movement had a lot of influence, as it brought the ideas of Comprehensive Medicine. However, as the criticisms against the Preventive Medicine and Community Medicine proposals were gradually issued, in Brazil and in other Latin American countries, part of these academic institutions started to be inspired by the Social Medicine that had developed in Europe in the middle of the 19<sup>th</sup> century (Paim, 2008). Therefore, Collective Health emerged in Brazil as a rupture, based on



the criticism against the movements of preventive medicine, community medicine, and institutional sanitarianism (Paim, 1992).

Two important concepts for the theoretical foundation of the sanitary reform, developed by the academic production in Collective Health, were: social determination of diseases and work process in health. According to Paim (2008), the “understanding that health and illness cannot be explained exclusively by the biological and ecological dimensions has allowed to enlarge the horizons of analysis and intervention on reality” (p. 165). Thus, the phenomena of health and illness began to be understood as being socially and historically determined, and historical materialism was an important epistemological foundation. Latin American Social Medicine, which was already aligned in this way, became, at the time, a school of critical thought in relation to the dominant field of Public Health. It guided many propositions of the health reform movement related to health policies (Paim, 2008).

A very important mark in the Brazilian health reform was the *VIII Conferência Nacional de Saúde* (CNS - 8<sup>th</sup> National Health Conference), which was held in 1986. This was the first conference that had a broad participation of civil society and “the leading role of health professionals, workers and popular sectors” (Paim, 2008, p. 99). Abrasco released a document to guide the discussions in this conference, and it ended up being a reference for texts and interventions presented there. The document recognized a conjuncture of economic crisis with changes in the political-institutional order, and aimed to review theoretical-political issues, as well as to recover principles and guidelines of the movement for the democratization of healthcare. It stressed that health should be seen as “fruit of a set of living conditions that goes beyond the health sector” (Paim, 2008, p. 100). Furthermore, it defended popular participation in health policy-making and the society’s control over the State’s apparatus, and recognized health as a public role.

In one of the axes of the conference, called “health as a right inherent in citizenship, in social rights and in the State”, in the discussions about social responses aiming at the amplifica-

tion of the right to health, the social movements connected with the emergence of the 19<sup>th</sup> century Social Medicine were highlighted. The principles proposed by Virchow and Neumann were, in fact, revisited (Paim, 2008). Paim also states that the understanding of health present in the propositions of the final report of the 8<sup>th</sup> CNS can be credited to the theoretical production on the social determination of the health-disease process, which has been carried out by researchers in the area of Collective Health in Brazil and Latin America since the 1970s. Some of its elements were: amplification of the concept of health, recognition of health as a right of all and a duty of the State, creation of the SUS (Brazil’s National Healthcare System), popular participation, and constitution and amplification of the social budget.

Another important event was the 1<sup>st</sup> Brazilian Collective Health Congress (I Abrascão), whose theme was “Health Reform and Constituent Assembly: guaranteeing the universal right to health”, which was also held in 1986. The entity’s president defined Abrasco’s line of action in that conjuncture as:

The recent summoning of the VIII CNS brought to us the great responsibility of giving continuity to this process and of contributing both to the technical-scientific knowledge produced in the area of collective health, and to the political competence of critically analyzing some conjunctures, mobilizing wills, and articulating actions and initiatives that advance a project of deep and radical transformations in the health sector. This is the responsibility and the commitment that Abrasco, by organizing this congress, wants to share with all the participants (Paim, 2008, p. 128).

Thus, it is possible to observe an intertwining, at the time, of Abrasco and Cebes with the theoretical production in Collective Health, in the political engagement around the health reform. In this sense, Paim (2008) states that “Collective Health has supported the Brazilian Health Reform theoretically based on the trihedron ideology, knowledge and practice, for it emerged and developed, as a scientific field, in a way that was connected with the proposal and project of Health Reform” (p. 292). To the author, the field of Collective Health presents

fundamental ruptures, in political terms, in relation to the field of Public Health, although it presents some continuities.

The view of the population's health as resulting from the forms of social organization of production, as conceived by Social Medicine and by Collective Health, was, by means of the health reform, assimilated by the legal framework in Brazil (Paim, 2008, p. 306). According to Schraiber (2008), the field of Collective Health was instituted as a project that aimed to reform two sets of elements: on one side, there was its criticism against culturally given health needs and the assistance model that met these needs "in medical care (biomedical, liberal and privatizing model of service production, the access to which is elitist) and in public health (sanitary education model whose nature is liberal and individualizing concerning prevention practices)" (p. 13); on the other side, there was its criticism against the alienation of the techno-scientific face of the field.

According to the author, the project of the field of Collective Health in Brazil "is situated in the tension between the countercultural criticism of a technical-scientific nature and the democratization of the scientifically traditional medical and sanitary models" (Schraiber, 2008, p. 14). The field has always been committed to democratization and to the struggle for human and social rights. According to Donnangelo (1983), it has been committed to the collective sphere since its origin:

This multiplicity of objects and of corresponding knowledge areas - from natural science to social science - is not indifferent to this field's apparently more immediate permeability to economic and political-ideological inflections. The commitment, even when generic and imprecise, to the notion of collective, implies the possibility of commitments to particular, historical-concrete manifestations of the collective sphere, against which the medicine "of the individual" has been trying to protect itself through the specific statute of the scientific nature of the fields of knowledge that ground it (Donnangelo, 1983, p. 21).

## Characteristics and specificities of Collective Health in Brazil: delimitation attempts

Today, with the development of Collective Health in Brazil and the emergence of a well-constituted body of scientific productions, it has become important to discuss its delimitations and competences. It is possible to see that the field of Collective Health, perhaps because it is new and exists only in Brazil, or perhaps because it functions in a more practical dimension of the health services, sometimes being confounded with this political-administrative dimension, lacks deep reflections in the epistemological field. Before anything else, our attention is caught by the fact that authors commonly use, as synonyms, in the same text, the terms Collective Health and Public Health, or Collective Health and Social Medicine, or Collective Health and Epidemiology.

It is interesting to notice that the difficulty in defining the field of Collective Health has been approached by some authors. Thus, Nunes (2007) argues that there have been many attempts to define Collective Health, but it has become difficult to reach a consensus. Referring to Stotz, the author attributes to interdisciplinarity and to the field's internal epistemological tensions the impossibility of a unifying theory that explains the set of objects of study. Therefore, the difficulty in defining the field would lie in the fact that it "is a creation that overflows disciplinary boundaries and is in the interface of areas of knowledge that have theoretical and conceptual specificities" (Nunes, 2005, p. 14). We could add that a possible factor is the heterogeneous composition, both institutional and professional, of the authors in the field of Collective Health, whose studies encompass diverse disciplines, like Epidemiology, Social and Human Sciences, Philosophy, or Management.

Campos (2000) is quite incisive in his arguments in relation to the field: "Has collective health created a new paradigm, denying and overcoming that of medicine and of the old public health? Does collective health correspond to the entire field of health or just to one part?" (p. 220). "What is the identity of collective health? That is, what is its core of knowledge and practices? [...] Who is the agent who does

collective health? Is there a specialized agent?” (p. 221). Finally, what new element has been brought by the change of names - from public health to collective health? “What ruptures have, in fact, occurred? Is there any continuity?” (p. 221).

A characteristic that has been frequently associated with Collective Health is that it is an interdisciplinary field (sometimes, its authors use the terms multidisciplinary and cross-disciplinary, but this discussion is outside the scope of this paper). Nunes (1994) argues that the field is grounded on interdisciplinarity, as it enables to produce an amplified knowledge of health, and on multiprofessionality as a way of facing the internal diversity of the knowledge and actions of sanitary practices. Collective Health needs to think about the general and the specific dimensions. To Birman (1991), the field “admits, in its territory, a diversity of objects and theoretical discourses, without recognizing in relation to them any hierarchical and evaluative perspective” (p. 15).

Another characteristic that has been emphasized is the role of the Human Sciences in this field of knowledge. According to Ayres (2002),

The field of “collective health”, a term through which we will generically refer here to a set, in fact a broad and contradictory set of disciplines interested in the “social dimension of health” (social medicine, preventive medicine, public health, etc.), has been the main center of agglutination and irradiation of this renewed concern about the relations between health and society in the academic field (p. 26).

According to Birman (1991), the conception of Collective Health “was constituted through the systematic criticism against the naturalistic universalism of medical knowledge. Its fundamental postulate states that the health issue is broader and more complex than the reading made by medicine” (p. 12).

This question is very important when we consider that the social scope has been progressively silenced, in the field of health, by the biomedical discourse. One of Collective Health’s main proposals is that of rescuing the social sphere. When Ayres (2002) outlines the history of epidemiology in his

book *Epidemiologia e emancipação* [Epidemiology and emancipation], he explains how this process of domestication of the social sphere has happened in the health sciences.

According to this author, from a certain historical moment onwards, the predominant discourses about health and disease started “to translate human privations associated with these concepts in strictly biological terms” (Ayres, 2002, p. 92). The social dimension has been, therefore, incorporated as a secondary element in the health-disease process, an adjective condition, a kind of auxiliary line of apprehension of phenomena, which only acquire positivity in the individual organism. To Ayres (2002),

Since the establishment of clinical hegemony in the reflection on and production of health, the extra-organic events of illness and its determinants have become, in the level of knowledge construction, only a logical or empirical support for physiopathological constructions (p. 27).

The extra-organic dimension of illness has become only one link of causal efficiency relations, of the “exact determinism” of the health sciences. The “restless social dimension” has been tamed by the morpho-functional and physical-chemical variables of the body: translated “by the collective behavior of these empirical qualities, the social determination of disease is imprisoned under the harmless emblem of an external conditioning agent of the health status” (Ayres, 2002, p. 132).

Therefore, health investigation in the collective dimension started to distinguish, on one side, population groups based on demographic characteristics, and on the other side, organic morpho-functional variables. “The quantitative behavior of these subpopulations becomes the necessary and sufficient element for causal inferences” (Ayres, 2002, p. 133). The nature of knowledge generated in this way acquires an air of neutrality, as if it were a universal form of apprehension of reality.

Ayres (2002) criticizes how this process has occurred and concludes: “When the social dimension of collective health phenomena is lost in their scientific objectivation, the possibility of rationally approaching their public substance is immediately

wasted” (p. 15). Due to the hegemonic scientific discourse, the apprehension of the public space of health has become unidimensional and naturalized.

In this sense, as one of the proposals of Collective Health is the close contact with the Human Sciences, it is possible to conclude that this field of knowledge aims to reconfigure the social sphere in health. According to Paim and Almeida Filho (1998), the significant elements of the field are “the overcoming of the dominant biologism, of the naturalization of social life, of its submission to the clinic and of its dependence on the hegemonic medical model” (p. 310).

Based on this scenario, Paim and Almeida Filho (1998) have proposed to understand Collective Health as a scientific field in which “knowledge about the object ‘health’ is produced and where distinct disciplines that see the object from many angles work” (p. 308). In addition, they view the field as a sphere of practices, in which “actions are performed in different organizations and institutions by diverse agents (specialized or not) inside and outside the space that has been conventionally recognized as the ‘health sector’” (p. 308). The authors have preferred to adopt the view of Collective Health as an interdisciplinary field and not as a scientific discipline or as a science.

As for the basic presuppositions of the field’s conceptual framework, the authors refer to a text written by Paim in 1982, that is, a document from a period in which Collective Health was still being born in Brazil. Paim and Almeida Filho revisit some of the presuppositions of that text:

- a) Health, as a vital state, sector of production and field of knowledge, is connected with the structure of society through its economic and political-ideological levels; therefore, it has historicity.
- b) The health actions (promotion, protection, recovery and rehabilitation) constitute a social practice and bring with them influences deriving from the relationship of social groups.
- c) The object of Collective Health is built on the boundaries of the biological and social spheres, and encompasses the investigation of determinants of the social production of diseases and of

the organization of health services, as well as the study of the historicity of knowledge and practices concerning these determinants. The interdisciplinary character of this object suggests an integration in the level of knowledge and in the level of strategy to gather professionals with multiple backgrounds.

d) Knowledge is not built through contact with reality; rather, this happens through the understanding of its laws and through the commitment to the forces that are capable of transforming it (Paim; Almeida Filho, 1998, p. 309).

The “provisional delimitation” of the field of Collective Health that Paim and Almeida Filho (1998) propose in the above-mentioned paper is:

As a field of knowledge, collective health contributes to the study of the health/disease phenomenon in populations as a social process; investigates the production and distribution of diseases in society as processes of social production and reproduction; analyzes the health practices (work process) in their articulation with other social practices; in short, it tries to understand the forms with which society identifies its health needs and problems, searches for an explanation and organizes itself to face them (p. 309).

These authors (Paim; Almeida Filho, 1998) and Nunes (1994) identify three disciplinary groups in Collective Health: epidemiology, social sciences in health, and health policy, planning and management. They also mention other disciplines that are complementary to these.

Campos (2000) follows another line and defends that Collective Health is a piece of the field of health. The author aims to oppose a tendency he identifies in academics who confound Collective Health with the entire field of Health. This tendency would contribute to the fragmentation and weakening of Collective Health as a field of knowledge and practice.

Campos (2000) proposes that the nucleus of Collective Health is the “support to health systems, to policy-making, and to the construction of models”; the “production of explanations to the processes of health/disease/intervention”; and, perhaps its most specific feature, the “production of practices of health promotion and disease prevention” (p. 225).

The inclusion of Collective Health in the field of health would occur, according to his proposal, in two levels: horizontal and vertical. In the horizontal level, the knowledge and practices deriving from Collective Health would form part of the knowledge and practices of other categories and social actors. Thus, all the health professions, to some extent, should incorporate, in their education and practice, elements from Collective Health. "In this perspective, the mission of collective health would be to influence the transformation of the knowledge and practices of other agents, contributing to produce changes in the care model and in the logic of functioning of the health services in general" (Campos, 2000, p. 225). In the vertical level, Collective Health would be a specific intervention area. "A specialized area with its own value of use, different from the clinic or from other intervention areas" (Campos, 2000, p. 225). Some problems are raised, like: Who would be the agent of Collective Health? Would there be a basic education course?

Anyway, Campos (2000) defends that the perspectives of the horizontal level and of the vertical level should be combined in Collective Health. That is, the knowledge and practices of Collective Health should be socialized and the existence of experts who produce more sophisticated knowledge in the area should be ensured, so that they are able to intervene in complex situations.

Thus, we come to the end of this journey still with many doubts. In this path, it seemed to us that the field of Collective Health in Brazil might not admit only one single definition about its delimitation and characterization. Perhaps because it is a new field, there have been just a few crystallizations towards the formation of traditional cultures. Therefore, there is, inside it, a large plurality (and tensions) in disciplinary and epistemological terms.

Always under construction and being able to advance in terms of production and reflection on its own identity, Collective Health, like other fields, constitutes a "living field" (Schraiber, 2008). However, the difficulty in finding agglutinating elements that weave common points can represent, on the one hand, a fragility, but, on the other hand, it can make Collective Health be a field that is always "open to the incorporation of innovative proposals" (Paim; Almeida Filho, 1998, p. 312).

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