# The Social Model of Health Practices

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In the context of *promotion of leadership and advanced training in public health* and the quadrennial priorities of the Pan American Health Organization (PAHO) for the period 1987-1990, six critical areas for the development of health infrastructure were identified and studied during 1987 and 1988 (public policies, information systems and epidemiology, economy and financing, human resources, technological development, and health services systems). In 1989 the study was expanded to include functional aspects of the health system, not only those that form part of its administrative model but also, and especially, those involving the delivery of services for the population/environment in response to problems, needs, or health ideals in the various particular realities. In other words, this new dimension of the study focused on the Model of Health Services Delivery (MHSD) as its main concern.

The process outlined above has coincided with the renewal of efforts to reorient national health systems by strengthening and developing local systems. The results obtained so far in both processes indicate thematic areas that are important for the development of *leadership in the health sector.*

The study of the MHSD sponsored by PAHO jointly with the Latin American and Caribbean Association of Public Health Education (ALAESP) and the Association of Schools of Public Health of the United States (ASPH) used the overall health action strategies as entry points: curative (Lima, 20-24 November 1989), prevention (Sao Paulo, 30 April-4 May 1990), and promotion (Santiago, 6-10 August 1990).

This effort had four distinctive characteristics:

- The subject of observation. In recent years there has been increasing concern for the infrastructure and general functions of the health system to the detriment of its essential purpose. In the present case, the provision of services for the population and the environment has been viewed in a comprehensive manner, taking into account the new conceptual and methodological developments as to health activities.
- The perspective. In studying the health systems from the standpoint of the services they provide, an attempt was made to view the system from below and from its interface with the population--that is, from a perspective close to the people.
- The way of viewing the issue. The dynamic pursued is *problem-oriented* with regard to the provision of services--that is, an attempt has been made to arrive inductively at the implications based on identification of gaps and areas of difficulty in the current model.
- The participants. In selecting the participants a balance was sought between professional origin (balance between personnel from the services and from education and research), and geographic origin, given the variety of health situations in the countries (developing, relatively developed, and in transition).

Throughout the process, concepts, affirmations, methodologies, and proposals emerged, which, enriched by the group dynamics and the basic study documents, made it possible to identify certain innovative elements for the development of *leadership in the health sector and advanced training in public health* that can also be considered as valuable inputs for *development of the theory and practice of public health.*

In selecting the MHSD as a subject for study (taken to mean the clearly defined series of concrete actions that the health services system delivers to people and the environment) and choosing the interface between the services system and the population as the vantage point in ranking the functionality of the system and the services it provides as the point for implementation of the model, a dimension emerged that exceeded the boundaries of the formal component of the health sector. This showed the existence in society of a set of practices, habits, and behaviors that have a decisive influence on the health of individuals and on the population as a whole that form a new, more complex and less linear reality in the conception of health, which has been termed the Social Model of Health Practices.

Based on this evidence, the need arises to reformulate and expand the use of a broader approach, *from the perspective of the people*, in order to reaffirm its meaning and place.

In achieving such a perspective, important elements deserving of comment and analysis begin to emerge that contribute to the comprehension and operation of this Model. A first approximation makes it possible to visualize the separation between the formal component of the Model, which determines health needs, and the population's perception of those needs. Conflicts thus appear between the behavior and standards recommended by the sectoral experts and the patterns of behavior of the population, with a consequent deficit in the results in terms of the resources committed by the sector.

Many difficulties exist in the links between the health sector and the community, and a barrier of varying magnitude may be detected that is made up of a web of biases, routines, deficiencies in training and lack of resources, interests, etc., that hinder the incorporation of technologies and procedures into the individual and community store of knowledge for future use.

Community aspirations, knowledge, and opinions do not significantly influence the MHSD. Whether because of deficient organizational capacity, a passive attitude with regard to sectors with greater formal power and greater resources, or a lack of political and organizational channeling, the members of the community fail to overcome the existing barriers so that their opinions can be heard and they can intervene in the design, development and evaluation of health programs or health services. In brief, no adequate opportunity arises for consensus between the formal and informal components.

An adequate critical attitude does not always exist for the acceptance of standards and services. The community has not effectively developed forms of defense and reaction to indiscriminate offers of benefits that have to do more with private interests than to priority needs for the health of the population and the environment.

This situation shows how the knowledge of the population, its culture, its models of social organization, and its forms of solidarity and assistance are devalued. On the other hand, the determination of responsibilities on the part of the population in terms of assuming its duties and exercising its rights appears to be confused.

Two main significant concepts are thus identified: Health ideals and citizenship. *Health ideals* are understood to mean the set of values, aspirations, representations, beliefs, and attitudes of a society that express the image of health it desires and its practices. This conception of health ideals entails the discussion and recognition of the distance existing between the formal and informal health systems, and the deficiencies of training in public health in terms of the limited incorporation of the tools of the social and political sciences--all of which shows how the various technical, administrative, and political rationales generate a conflict in which the power of the formal apparatus imposes its rationale upon other legitimate forms of perceiving the problem and its solution by the population.

The need was thus identified for drawing upon the social customs and practices of health protection and promotion based on the identification and recognition of valuable elements in the informal component. This supposes identifying the "health ideals" and observing the MHSD from "the perspective of the people."

This decision requires a transfer of knowledge and power from the formal component of the MHSD to the population so that it can participate actively in the recovery, protection, and promotion of its own health and the health of the environment. This also implies a return transfer of the health ideals, values, aspirations, and social relations that the population wishes to exercise upon the formal component. This valuation and strengthening of the informal elements of the formal model and the interaction that takes place between its formal and informal components has been termed **democratization of knowledge**.

With respect to *citizenship* it is equivocal to make a simple extrapolation of the realities prevailing in the countries of higher income levels in which the demand for services and benefits is covered by direct payment--through taxes or by insurance schemes--and in which the transgression against solidarity is sanctioned objectively and systematically regarding defined responsibilities. In the developing countries with precarious subsistence levels and ever-increasing difficulties, the "contribution" of the population is expressed in terms of disease and death and in deficient standards of living.

The need is all the more evident for affirming basic rights of access to goods and services, the ~~lack of which~~ would be a threat not only to health, but to personal and social dignity.

Personal responsibility is thus linked to the exercise of the individual's right to associate and petition so as to be able to attain personal fulfillment and social recognition, and to be guaranteed favorable contexts for this transition.

Transgressive behavior tends to be qualified as such from the perspective of different cultural realities, and the forms of solidarity can also be elementary defense mechanisms that are employed in situations of extreme hardship or injustice.

Neither of these two aspects of citizenship (exercise of rights and duties) are clearly defined nor their intermediate stages, thereby depriving the sector of the possibility of promoting behavior that provides for personal and community growth as the concrete expression of promotion, protection, or recovery of health.

Extreme responses and proposals simplify the alternatives, imposing means of achieving solidarity and exercising the rights and duties that are linked to the model of developed countries, or subjecting it to actions to protest grievances.

The relationship between the two levels, personal and institutional behavior, has not been clearly established. In brief, citizenship supposes the active participation of the citizens in government acts and programs through their taxes in the developed countries and in the search for social justice, the defense of human rights, and acceptable levels of quality of life in the developing countries.

Throughout the process, critical areas and necessary interventions were identified in the services system, in education, and in research that made it possible to perfect the model.

Inclusion of the **environment** as a subject for study on an equal footing with the population and the services demanded an innovative approach that points to a long road of conceptualization and analysis that will make it possible to work on the population/environment from education and the services.

The concept utilized up to the present time that the environment is restricted to the physical, chemical, and biological environment in which people live should be updated to incorporate the social and human dimension.

The search for implementing the health concept and recognizing its transformation based on the new conceptions of prevention and promotion led to identifying it not as something absolute and indivisible but rather as something relating to space, population and history, inherent in life and with possibilities of promotion and protection of its components until death. This supposes the recognition of *positive health*, which, based on the new concepts of promotion, fundamental prevention, and use of the risk approach, is directed toward creating favorable contexts and conditions for the development of individuals, families, and communities and for the preservation and improvement of the environment in a task that should necessarily be multidisciplinary and intersectoral.

Elements such as the recognition of problems of functionality and residual harm caused by chronic pathologies, as well as the new modalities of care which accord a prominent role to self-help and community support groups geared toward specific health problems, call for a reorganization of sectoral resources.

An emerging core element in the analysis is the deficient assessment and development of **articulation of the health sector with the other sectors.**

A critical area of concern, and one that must be addressed in the short and medium term, is the deficient articulation with extrasectoral institutions, actors, and protagonists that share the stage and whose potential is not taken into account or utilized, and yet they compete for the population to be covered and the social space to be occupied.

The institutions define their own fields of responsibility and action, creating a partial relationship with a concrete reality (people, community, environment) that, even with regard to programming and evaluation, may be unaware of the presence of other actors with their own rationales, interests, and actions. This situation creates duplication of efforts and competition as far as actions and resources are concerned that fails to make proper use of the available potentials to attain common goals in the field of health.

Family and social disarticulation is an area of conflict that should be defined and overcome in the planning of actions on a geographic and population basis (geography-centered and population-centered).

One of the most significant deficiencies becomes evident here for the exercise of sectoral leadership, since such leadership can neither detect nor effectively influence extrasectoral decisions that affect health nor can it increase the contributions they make to improve the health situation of the population and the environment.

The health sector has lost ground in its ability to exert influence on the social decisions of international agencies, countries, and social groups in formulating and implementing policies and in fostering healthy individual and community behavior.

A two fold situation thus arises in which the health sector makes pronouncements as to what "should be" done in order to achieve a healthy society while at the same time it fails to provide the coverage or effectiveness needed to counteract the consequences of the policies and actions of other sectors and pressure groups (smoking, pollution and environmental deterioration, undernutrition, violence).

Even in the intrasectoral area the real assignment of social resources does not correspond to sectoral recommendations, nor does it reflect an internal logic with regard to available cost-benefit knowledge.

In order for the health sector to increase its influence on society it must develop its advocacy capacity--that is, based on the efforts of individuals and organized groups, it must seek to influence governments, corporations, and bureaucracies so that they become more attuned to the needs of voters, investors, consumers, and socially and economically disadvantaged population groups. The strategies used by advocacy focus on bureaucratic or institutional insufficiencies and are inherently political in nature. Such strategies include social action, case advocacy, legislative advocacy, and administrative advocacy.

Goals and actions were defined operationally that make it possible to develop aptitudes and attitudes in an atmosphere of changing scenarios and vested interests, which generate tensions and decisions that are not always consonant with the interests of health and its effects on the population and the environment.

Study of the services system and its transformation made it possible to assess the effectiveness of *population interventions* based on the influence of epidemiology on the design and implementation of health policies. Local health system development provided the opportunity to apply the study methodology proposed with a certain urgency and to generate teaching contents oriented to the training of human resources and community participation.

In brief, examination of the problem from *the perspective of the people*, in keeping with the Model of Health Services Delivery, prompted an innovative visualization that raised numerous issues, not the least of which were: the conception of the social model of health practices; recognition of the health ideals of the population; renewed emphasis on the concepts of citizenship and social control; the proposal of democratization of knowledge; the assessment of intersectoral articulation; population-oriented intervention in health problems; questioning and application of the concept of health; the detection of instrumental deficiencies in the sector, for example with regard to the social sciences and communications; and the reappraisal of the very conception of public health.

With reference to this last point, the conception of public health either as the principles and methods leading to professionalization in the field of health, or as an activity of government, has been overcome by considering it the organized effort of a society to achieve its health ideals.

Although the origin of this process and its development make it difficult to present it as a fully perfected doctrine, it nevertheless indicates conceptual progress toward **development of the theory and practice of public health** and constitutes an innovative input for the **training of human resources, research, and the services.**

The strategies and lines of action defined in this process are an appropriate frame of reference for determining, from the fields of action identified and the objectives proposed, the development of theoretical contents, abilities/skills, and attitudes that should form--together with other elements--the curriculum for **advanced training in public health.**

This proposal makes it possible to complement the decision to *associate leadership and sectoral management with the need for advanced training in public health that is not strictly academic but rather is closely linked to the concrete situation being faced by the health sector.*

Application of this methodology of analysis to local realities will reveal its full value as a tool for change and as a contribution to **leadership in the health sector and advanced training in public health,** thereby providing courses of action that will contribute to development of the **theory and practice of public health.**

## References


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## Editorial Comment

*Evaluation of the impact on health of the health services and of other actions on the people, the environment, and living conditions, and the evaluation of technology in terms of its safety and impact* is one of the four broad groups of activities in which the field of epidemiological practice has been redefined (Meeting on the Uses and Prospects of Epidemiology, Buenos Aires, November 1983). However, limited progress in this regard has been made in recent years --as is also true of causal research--despite the changes that have taken place in the social determinants of health and its practices, the subsequent modification of health profiles, and the current development and revitalization of major action strategies.

The study of the model for health services delivery under discussion was conceived and carried out as a means of moving closer to the perspective of the population--of the people and of society. This approximation, essentially epidemiological in nature, attempts to scrutinize the appropriateness and specificity of the *what* and *how* of health actions and not only their *quantity* and *quality*.

The foregoing reaffirms and better defines certain aspects of the challenge involved in describing and explaining health and its practices at a time when a significant contribution must be made to current decision making and to the corresponding actions taken in the social field. Among those worthy of mention by virtue of the role of the epidemiological approach are the need for:

- continuous advancement from *cases and deaths* toward social needs, human needs, well-being, and quality of life;
- moving from problems and *normative* health needs toward *felt* needs, representations, and health ideals;
- shifting emphasis from disease/risk to the relationships between health/overall development and state/civil society;
- broadening of the concept of *care model* to models of health services delivery and social models of health practices; and
- moving closer to planning/administration, on the one hand, and to political sciences, anthropology, and ethics (especially macroethics) on the other.

The development of the theory and practice of public health required by the Region of the Americas in light of the crisis it currently faces demands parallel development of a more aggressive epidemiological approach than in the past if it is to become the keystone for promotion of sectoral leadership in health or, better yet, of revaluation of health in social terms on the American Continent. Such challenges oblige us to consider epidemiology not as the *discipline-synthesis* of the 1980s, but rather as the *transdiscipline* of the 1990s.

(*Source*: Health Manpower Development Program, PAHO.)