Social determination of the oral health-disease process: a social-historical approach in four Latin American countries

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Objective. This study sought to contrast the perspectives on the social determination of oral health present in the scientific literature published in Colombia, Brazil, Ecuador, and Mexico since 1970 until 2012. **Methodology.** This was a cross-sectional descriptive study on the Latin American scientific production published in specialized databases between 1970 and 2012. **Results.** The social determination of oral health in Latin America is characterized by the conflict among the players when seeking to overcome the limitations and traditional perspectives in health. The differences among the countries studied are explained by the existing relationship among research, higher education, and the socio-political trajectories of the countries and the similarities by health systems that have permitted accumulation of inequities in health. In Brazil, the concern for the individual and collective in local settings is important, while in Ecuador, Mexico, and Colombia the explanation based on the social determinants of the diseases predominates. **Conclusion.** The view of the social determination of the oral health-disease process in Latin America is characterized by a continuous dispute between emancipation and accumulation approaches. The scant impact of social determination in oral health obeys to the history of the odontology profession, the predominance of care policies and services of technical care nature.

Key words: Social determinants of health; Latin America; Health Inequalities; social medicine; public health; oral health.

Determinación social del proceso salud enfermedad bucal: Una aproximación socio-histórica en cuatro países de Latinoamérica

Objetivo. Contrastar las perspectivas sobre determinación social de la salud bucal presentes en la literatura científica publicada en Colombia, Brasil, Ecuador y México desde 1970 hasta 2012. **Metodología.** Estudio descriptivo transversal sobre la producción científica latinoamericana publicada en bases de datos

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especializadas entre 1970 y 2012. **Resultados.** La determinación social de la salud bucal en Latinoamérica se caracteriza por la conflictividad entre los actores al intentar superar las limitaciones de las perspectivas tradicionales en salud. Las diferencias entre países estudiados se explican por la relación existente entre la investigación, la educación superior y las trayectorias sociopolíticas de los países; las similitudes, por los sistemas de salud que han permitido la acumulación de inequidades en salud. En Brasil la preocupación por lo individual y colectivo en ámbitos locales es importante, mientras que en Ecuador, México y Colombia predomina la explicación basada en los determinantes sociales de las enfermedades. **Conclusión.** La mirada de la determinación social del proceso salud enfermedad bucal en Latinoamérica se caracteriza por una disputa continua entre enfoques de emancipación y acumulación. El escaso impacto de la determinación social en salud bucal obedece a la historia de la profesión odontológica, al predominio de políticas y servicios de atención de carácter técnico asistencial.

Palabras clave: Determinantes sociales de la salud, América Latina, inequidad en salud, medicina social, salud pública, salud bucal

Determinação social do processo saúde doença bucal: Uma aproximação sócio-histórica em quatro países da América Latina

Objetivo. Contrastar as perspectivas sobre determinação social da saúde bucal presentes na literatura científica publicada na Colômbia, no Brasil, no Equador e no México desde 1970 até 2012. **Metodologia**. Estudo descritivo transversal sobre a produção científica latino-americana publicada em bases de dados especializadas entre 1970 e 2012. **Resultados**. A determinação social da saúde bucal na América Latina se caracteriza pelos conflitos entre os atores ao tentar superar as limitações das perspectivas tradicionais em saúde. As diferenças entre países estudados se explicam pela relação existente entre a investigação, a educação superior e as trajetórias sociopolíticas dos países e, as similitudes por sistemas de saúde que permitiram a acumulação de inequidades na saúde. No Brasil a preocupação pelo individual e coletivo em âmbitos locais é importante, enquanto no Equador, no México e na Colômbia predomina a explicação baseada nos determinantes sociais das doenças **Conclusão**. A mirada da determinação social do processo saúde doença bucal na América Latina se caracteriza por uma disputa contínua entre enfoques de emancipação e acumulação. O escasso impacto da determinação social em saúde bucal obedece à história da profissão odontológica, ao predomínio de políticas e serviços de atendimento de caráter técnico assistencial.

Palavras chave: Determinantes Sociais da Saúde; América Latina; Desigualdades em Saúde; medicina social; Saúde Pública; Saúde Bucal.

Introduction

The current of thought on collective health in Colombia and in Latin America has propitiated important progress in overcoming the hegemonic proposal on health/disease, through the development of a broad theoretical, methodological, and praxeological framework that addresses the complexity and multidimensionality of health to explain the origin and distribution of the diseases of individuals and of communities in different territories. For such, it proposes the social determination of health as a central tool of critical epidemiology. However, a hegemonic thought persists in health, which fragments reality facilitating the instrumentation of the body and the development of techniques aimed at specializing the intervention, without articulating the social medicine/collective health debate. This facilitated by the dialogue among the biomedical, medicalization, the market, and the State on the same purpose: accumulation of capital.

This research seeks to contribute to the state-of-the-art on the social determination of oral health in the region, by delving into the differences and similarities existing among Brazil, Colombia, Ecuador, and Mexico on the theme to promote research and political action in favor of the proposal of collective health. In this sense, this work proposes a contribution to the field of collective health from the oral component upon establishing a dialogue with other disciplines and areas of health in charge of its care, such as nursing.

Methodology

A cross-sectional descriptive study was conducted on the Latin American scientific production on the social determination of oral health published between 1970 and 2012 in Colombia, Brazil, Ecuador, and Mexico, through systematic review and deliberate search. The systematic review was conducted on specialized databases in health virtual library, SciELO, and PubMed from key words like: oral health, collective health, collective oral health, social determination, and odontology in Spanish, Portuguese, and English. Inclusion criteria were: publications available in text, written in Spanish, Portuguese, or English; produced and/or published in any of the countries of interest for the study during the period between 1970 and 2012. The deliberate search was carried out to overcome the limitations of the systematic review, in institutional databases and personal libraries including gray literature.

For the literature analysis the approach elaborated by Jaime Breilh was taken as theoretical reference on the social determination of oral health.[1,2] This approach questions the positivist and deterministic causality predominant in epidemiological studies of risk. The biological aspect in this perspective is placed in a subsumption relation with the social, given that all the diseases may be explained by the social and historical nature that reproduces them. Emphasis on modes of living permits questioning society's capitalist accumulation structure and understand the production and distribution of diseases in diverse contexts.[2-4] The contrast among countries looked for the existing differences in the development of collective health as in the use of the perspective under study. For this, the work by Everardo Duarte Nunes was used, who formulates an explanatory periodization on the evolution of collective health in Brazil with support on Works by Sergio Arouca, María Cecilia Donangelo, and Silva Paim.[5,6] Duarte Nunes characterizes three phases that start with pre-collective health during which the preventive model is established.[5] The second, without completely abandoning preventive ideals, introduces the social medicine perspective in universities, and the third structure is the social field of collective health as a current of thought based on a way of understanding health with support on the social movement by the Brazilian health reform gestated during the democratization process in the 1980s.[5] This proposal facilitated the contrast and comprehension of the social and historical process of each country.

Results

The systematic review obtained 271 records among which 31 articles were selected distributed mostly in Brazil, 29; one in Colombia; and one in Ecuador, while in Mexico no publication was found. The deliberate search permitted broadening and complementing the study, however, this search was only conducted in Ecuador and Colombia.

Contrast of the social determination "SD" of oral health "OH" among Brazil, Colombia, Ecuador, and Mexico

During this first stage, Latin America experienced a similar process of change on the development model, shifting toward an industrial capitalist accumulation regime of monopolist nature, based on the substitution of importations and on the intensification of industrial manufacturing production. This favored the adoption of social security and environmental health measures that

guaranteed the performance and increase of the labor force.[7] With this change, the countries were subjected to dictatorial political regimes; in Brazil, the dictatorship began in 1964 and culminated in 1985; in Ecuador, the political instability was mediated by different periods of dictatorship between 1961 and 1978.[8] In Mexico, the Institutional Revolutionary Party (PRI, for the term in Spanish) stayed in power since 1946 until 2000, and in Colombia, the National Front was imposed between 1958 and 1974. Based on this common situation, this stage is characterized by a regional process given between the late 1950s and 1970s, which is described and periodized in each country by the following:

Between preventivism and curative care, the boom of the mercantilism of oral health in the health and public education sectors, Brazil (1955-1969), Colombia (1960-1969), Ecuador (1970-1979), Mexico (1958-1969)

During this pre-collective health stage, change in health is minimal for the regional situation, given that the Flexner model remained predominant. This model comes from the United States guided the formation of the human resource in health, simplifying the social reality with support on functionalist sociology and behavioral sciences. Thus, rather than innovating, it sought the adaptation of professionals to changes without questioning them.

In oral health, the predominance of the individual clinical practice facilitates the entry of odontology onto the market in private and public services, but with differences among the countries. During the 1960s, health odontology, derived from preventivism, was defined by Brazilian Mario Chaves as "(…) organized work of the community, in the community, and for the community, to obtain the best possible conditions of oral health".[9] This, in practice, was reduced to educational programs conducted in schools under methodologies denominated incremental system, which is a theoretical-practical tool that due to its preventive nature was used in the health odontology of the period, without it being. It included an action to control the incidence, a curative action to affect the prevalence, and a parallel educational support program. Its foundation is the natural history of the disease by Leavel and Clark, which is why it does not develop the preventive idea in its full definition, and magnify the curative clinical intervention without studying the social origin of the disease. This system, characterized by Pinto as a work method for dental care of captive populations, is aimed at performing curative care and maintaining permanent preventive control, prioritizing school ages and the most acute problems of dental diseases.[9]

The incremental system in schools is what characterizes this first stage of oral health. Individualization of the care of the student's disease under the clinical parameters is common and the differences among the countries indicate the social and political trajectory. While in Brazil the first in questioning the model of individual odontological care were the students organized in the National Union of Odontology Students (UNEO, for the term in Portuguese);[10] in Colombia, the origin and insertion of the departments of preventive and social Odontology in the faculties of Odontology is discussed and hindered. Both in Universidad de Antioquia as in Universidad Nacional, the debate opposes the study of assignments related to the formation of future odontologists in the social sciences.[11] Clinical assignments and professionalizing formation assignments predominate until now.[11] Criticism against market and individualized dentistry was scarce and not very notable against the consolidation of the industrial capitalist accumulation regime occurring throughout the region.

From preventivism to social medicine: Brazil, Mexico, and Colombia 1970-1980, Ecuador 1980-1990

In this second stage, the differences among the countries studied become more evident in the midst of a similar historical process that favors the progress of industrialism in oral health with neoliberalism. While in Brazil there was sustained

economic growth that facilitated extended coverage of social security to the middle classes as a legitimizing strategy of the dictatorship, in Ecuador and Mexico the oil crisis strongly affected the national economies, causing reduced investment in health and, hence, on the coverage of health services. Colombia was characterized by the continuous process of selective industrialization with little development of the labor process and social security of workers, given the low wages and the increasing dependence on the economy of the United States.[7]

Social medicine - collective health continues advancing in its discussions and theoretical proposals with two meetings of great importance: Cuenca I and II, both organized by the Pan American Health Organization (PHO) in Cuenca, Ecuador; the first in 1972 and the second in 1983.[5] These meetings, led by Juan Cesar García, criticized the emphasis of the functionalist sociology,[12] giving way to central proposals from collective health, such as: the right to health from the State and the role of universities as generators of a new type of medical education: a social medicine. The recent social movement of Latin American social medicine began exerting influence in different ways in each country. In Brazil, graduate courses were begun in public health and preventive medicine that surpassed the classical preventionist model bringing social medicine closer to the double objective of theoretical formation and political practice.[5] In Mexico, this movement was developed from Universidad Autónoma Metropolitana, at Xochimilco, Jaime Breilh's alma mater, a leader of the ideas and proposals of social medicine in Ecuador, along with Edmundo Granda and of important thinkers in the Ecuadorian history of health.[13]

In the Masters program on Social Medicine in Mexico, the trend of the social determination of health took as reference and analysis framework the Gramscian Marxist theory, and incorporated the historical-social dimension in all the analyses of the epidemiological aspect. The contributions by Asa Cristina Laurel in this country were notorious and decisive.

In Brazil, by the late 1970s, the ideas of collective health were the theoretical inspiration for the foundation of the Brazilian Center for Health Studies (CEBES, for the term in Portuguese) in 1976 and the Brazilian Association of Collective Health (ABRASCO, for the term in Portuguese) in 1978, which were established as spaces of resistance and of formation in the critical analysis of the health situation of Brazilians and of health policies.[5]

In the four countries traditional and market odontology continued being hegemonic during the 1970s and health odontology was reduced to the incremental system, or to the preventive and social-simplified odontology or to a mix with community practices. The scant change toward socialized odontology is explained by the maintenance of economic and political power of monopolistic forces tied to industrial and neoliberal capitalism. In Mexico, the PRI was maintained. In Colombia, the dismantling of the National Front regime was slow and gradual, while in Brazil – on the contrary – the country opens up to progressive democracy that favors the organization of the scientific meetings of odontology students (ECEO, for the term in Portuguese), with a central theme: re-democratization of the country and the change of the healthcare model.[10] A critical position is maintained against the hegemonic model of formation and of mercantilist care in oral health, which enables the ideas of the social determination of health to be part of the field of what will later be known as collective oral health. In general, the emergence of social medicine - collective health in oral health in the four countries studied was characterized by the formation of academic groups with discussion capacity within the field of odontology. The biggest strength of these groups was achieved with the union to the popular, student, and worker social movements to share the unconformity, questionings of the developmentalist economic model, and the alternatives of change, especially revolutionary change.[14]

In Colombia, the spaces for debate were also opened in the faculties of Odontology in public

universities; at Universidad Nacional de Colombia in Bogotá with the academic reform of 1964 that promoted the creation of the Department of Preventive and Social Odontology in 1965[11,15] although without recognizing its full sense within social medicine; and at Universidad de Antioquia with the creation of the Department of Social Odontology. The echo in both universities was minimal due to the scarce social organization and mobilization and because of resistance to change by the predominant clinical sector. In Ecuador, the debate on the social determination in oral health was made possible by the creation of the Center of Studies and Counseling in Health (CEAS, for the term in Spanish) and the *Instituto de Recursos Odontológicos del* Área *Andina* (IROAA), originated within the framework of the Andean Pact (1978).[16] The IROAA objective was to contribute to guaranteeing the right to health and gathering research and work experiences in oral health, given the lack of epistemological studies or systematic knowledge on the odontological problem.[17] This facilitated the development of research projects by using the proposal of social determination since the 1980s. The view of social determination in oral health developed in Ecuador during the 1980s maintains the Marxist approach in the analysis of epidemiological profiles of class to explain the distribution of diseases and of odontological human resources in this country. Ecuadorian authors state that the structure of how capitalist production has deepened and multiplied the social and economic problem of the peoples, which in oral health gave rise to patterns of health deterioration, given that models of formation and of care services do not respond to the real needs, but to foreign knowledge and technologies that facilitate the monopoly and industrialization of knowledge.[18]

Despite the potential of the analysis of the social determination of oral health to understand the complex causality of collective diseases and the processes required for the transformation of health inequities,[18] its development has been disputed in Ecuador with scarce effects on the oral health of Ecuadorians. Studies conducted in Ecuador on the theme zoned the country into three geographic areas corresponding to the different phases of economic development within the social formation in Ecuador (backward, in transition, and developed zones). The analysis of each zone considered the process of social reproduction of each of the social groups that comprised it, assessing the modes of consumption (education, nutrition, recreation, habitation, health services, communication media, oral hygiene practices, and smoking habits, among others) and the determination of social class. The class profile contemplated: work area, property relationship of the means of production, technical relationship, and social relationship with the zone. And in the recognition of the oral health-disease process these took the stomatognathic system as a whole.[18]

Similarly, in the epidemiologic study of oral health in students, the indicators of oral health were zoned according to agro-industrial development to visualize the production process of the material means of life and the differences in social relationships among these zones. Social groups were identified by zones, according to the form of social reproduction (work-consumption), to identify the social determination of the epidemiological profiles of the health-disease process by social group and by domain.[19] Another source of elaboration of the wager on the social determination of oral health in Ecuador was the research on the situation and trends of professional odontological human resources in Ecuador. The results of that research questioned the most developed zones by their concentration in number of dentists and by the saturation in cities. This became explicit with the use of employment sources, whose emphasis in clinical practice benefitted curative, mutilating, and basic operative procedures, both in public and private services. In spite of the high and increasing unemployment of dentists, the population's needs in oral health services continued unattended, which was explained by the irrationality in the distribution of professionals, in keeping with the predominant accumulation economy model.[17]

In conclusion, in Ecuador ideas of social determination of health come from social medicine

developed by Jaime Breilh and Edmundo Granda; not only permeating oral health from this stage of collective health, but developing research projects with revolutionary analysis proposals, against hegemonic proposals both in the epidemiologic study and the analysis of the oral health-disease process, as in the organization of human resources in Ecuador. In Mexico, although the first spaces of discussion came about from research by Asa Cristina Laurell on the health of workers, with a critical nucleus in Universidad Autónoma Metropolitana, at Xochimilco, it did not permeate oral health directly, which deserves in-depth study in another research.

As a result of the contrast, it may be indicated in the first place that the frame that originates social medicine in all the countries is similar, nonetheless, development of social determination in oral health disease differs in each country due to their political trajectory. In Brazil, the pioneers of the theme were Dentistry students; different from Colombia, where Dentistry faculties conduct an institutional response under the influence of conferences and seminars by the PHO, with scarce development against the hegemony of the bio-clinical model. In Ecuador progress occurred through the creation of the IROAA and the CEAS. In Mexico, the first spaces were perhaps tied to the response of the public universities to the reforms that sought to end with the university autonomy, generating large student mobilizations with support from Universidad Autónoma Metropolitana de Mexico. Nevertheless, these were broken up violently during the "Corpus Christi masacre".[20]

Toward collective oral health against the neoliberal boom: Brazil, Colombia, Mexico 1980-2012; Ecuador 1990-2012

The third and last stage of consolidation of collective health as a social field started as of the 1980s. Globally, the economic, ideological, and political transformation was sharpened with the neoliberal globalization that made its way with the program of loans for structural adjustment promoted by the World Bank and the International Monetary Fund, both finance entities whose capitalist performance displaces technical cooperation organizations of the United Nations, like the WHO and the PHO.[7] Since 1980, the four countries have continued differentiating themselves in the development of oral health, but maintain certain predominance: private care and formation schemes with an industrial nature. In Brazil, the process of progressive democratization permits strengthening the social, popular, student, and trade union movements. The field of collective health[5] develops three types of social practices: the theoretical practice to construct knowledge, the ideological practice to create health awareness as part of social conscience, and the political practice to transform social relations.[21] Collective health grows and is consolidated articulated to social movements and contributing to strengthen the movement for the Brazilian health reform through the conquest of the right to health in a single health system.

Constitutional reforms and changes in health systems in the region influence oral health in different forms. In Brazil, the Constitution of 1988 defines health as a right of all and an obligation of the State. This historical conquest opens the way to the formulation of the single health system. In Colombia, the Constitution of 1991 was materialized, but with another simultaneously opposed front: with the announcements of a social rule of law, but with instruments of a neoliberal structural reform. This opened the way to the new health system proposed through Legislation 100 of 1993, based on privatization, which promotes the growth of private services and subsidies to the demand[7] with negative consequences on the oral health of Colombians. In Ecuador, the Constitution of 1997 consecrates a trend of economic privatization, but later the Constitution of 2007 opposed to the prior, defines health as a right the State must guarantee, which permits the implementation of the National Health System of Ecuador with the Comprehensive Intercultural, Family and Community Healthcare Model. Mexico, for its part, assumes the agenda of structural reform by the World Bank, producing a health reform similar to the Colombian reform, also

based on the neoclassic economy but with more socialized social security than the Colombian one.

Processes and changes in the perspective of the determination in oral health in the countries studied are affected fundamentally by the socioeconomic and political dynamics of the region. In each country, the differences show that the constitution of a view of the social determination in oral health is related to the rise of what in this work has been denominated collective health and, hence, to the capacity of the countries to develop critical proposals and proposals of change in the health sector. In Brazil, that was facilitated by the creation of the Brazilian Movement of Odontological Renovation (1984-1992), comprising students and dentists, also participants in the movement for health reform. This permitted criticism more consistent with odontology reform projects and with the national health system.[10, 22] Thus, in 1988 collective oral health emerged in Sao Paulo as a theoretical/political movement with influence from the Brazilian health reform, which implies simultaneous political activism and militancy.[22] The dentists, militants of the Brazilian health reform, who participated in the movement for odontological renovation also developed the proposal of the social determination of the oral health-disease process. Some of them managed to position themselves within the nascent health system and, later, have been inserted into the graduate programs in public health of different universities, as was the case of Professors Paulo Capel and Carlos Botazzo in the Faculty of Public Health at the University of Sao Paulo.

From the publications found, we observed that the view of the social determination of the oral health-disease process in Brazil was characterized for retaking the ideas of the collective health movement, based on the Marxist theory, with strong influence from authors like Edmundo Granda and Jaime Breilh. They recognized the social as the scenario in which people, groups, and social classes establish their relationships and in which culture, science, human moral and values are reproduced. Social determination is the concept that permits explaining the production of diseases, territorial distribution and segregation, which is why its use permits understanding the oral health-disease process and simultaneously transforming it. It questions the organization of services and the traditional odontological treatments based on the ecologic uni- or multi-causality, with curative biological emphasis, of low coverage, high cost, mutilating, and which additionally does not solve the problems of oral health.[23]

Thus, pretensions are ratified of collective oral health developing a praxis that breaks dialectically with the hegemonic odontological practice, with the mercantilism of services, and with maintaining the monopoly of access and private control over odontological resources. This supposes the defense of health as a right and not as merchandize, and indicates an epistemological rupture and rejection with market dentistry.[9] In Colombia, the historical, sociopolitical, and economic trajectory has maintained political and economic power concentrated in a few hands; the lack of democracy and of aperture of the political system has delayed the development of a current of social medicine-collective health capable of reuniting the academic nuclei and social movements. In oral health, thereby, the traditional view is replicated and intensified with support on clinical teaching and practice throughout the country without resistance. Due to these reasons, the experiences of collective oral health or from the perspective of social determination in Colombia are invisible and scarce within a private and privatizing panorama. Although in recent years some academic groups have developed valuable experiences under this perspective, we must continue developing social and academic events and activities to think of and discuss on this approach; these could be international congresses on collective oral health and network meetings and groups like the Latin American Network on Collective Oral Health (network consolidated during the Latin American meeting for collective oral health held in Medellín in September 2012, with the participation of dentists from several Latin American countries, like Colombia, Argentina, Peru, Brazil), ALAMES, and other networks in the region that are being promoted in the country and the whole continent.

Groups have recently studied Jaime Breilh and display odontology as a social practice and as part of collective oral health, a field of political action under construction, where odontology has social responsibility within community, scientific, academic, and political settings.[24] In the analysis of the oral, it is recognized that orality participates in the social reproduction of the subject, hence, extending the field of action of odontology beyond individual clinical care, reaching the political, social, state, institutional spaces, as well as preoccupation for the collective, critique, and action. The aforementioned implies integration of knowledge from a socio-cultural and historical analysis of each population, bearing in mind the social players and the interaction among them within the health-disease process.[25]

Among the research experiences that have been developed on the social determination of oral health, we can mention the projects conducted in the Faculty of Odontology at Universidad Nacional de Colombia, specifically within the framework of the Interdisciplinary Community Support Program (PRIAC, for the term in Spanish) during the 1990s, the works in the locality Cuarta San Cristóbal from the fields of Institutional action in the municipality of Inzá, Cauca (Colombia) and in Soacha, Cundinamarca (Colombia) within the in-depth Family and Community Health line between 1999 and 2005, and the formation in collective health since 2000 with support on theoretical referents of decent life, quality of life, right to health and collective health under the recognition of health disease from a complex notion with diverse social representations on the mouth.[26,27] Likewise, the public policy on oral health of Bogotá has been proposed with the participation of several social players and politicians with effects of local interest of relevant importance.

Similarly, we can highlight the experience at Universidad de Antioquia with research on the experience of dental caries in children from one to five years of age, from low-income households in the Moravia neighborhood of the city of Medellín, which reflected the polarization of caries in this marginalized population with precarious living conditions.[28] Within the frame of the interinstitutional cooperation project Management of Public Policies and Health, sponsored by the Sectional Health Direction of Antioquia and the National Faculty of Public Health and which was created in 2002, the Work Group for oral health promoted the construction of public policies with impact on oral health. It states that the Colombian health system dismantles the general and oral public health under the market logic, besides favoring the predominance of odontology for the disease based on economic profit. In response, these propose recovering the leadership of the public sector, proposing public policies for health and its oral component, aimed at promoting health through intersectoral actions and reducing disparities in health.[29] In Mexico, the only publication found on the social determination of oral health was carried out by two dentists and professors in the Zaragoza Faculty of Higher Studies at Universidad Nacional Autónoma de Mexico: Alfredo Gómez Castellanos, PhD in public health from the University of Sao Paulo, Brazil, and Luiza Pizeta. This article sought to understand the relationship between the health-disease process and the professional curriculum-practice from existing paradigms and the alternatives constructed from the critical pedagogy. It seeks to establish parameters for a Latin American stomatology.[30]

This proposal of the Latin American stomatology seeks to overcome the functional instrumental, reductionist, biologist, and productivist approaches. Breaking with hyper-specialization and solving the separation between theory and practice, to advance in the complex emancipating critical paradigm, which from the social determination permits a critical understanding of the health-disease process and of its history in its cultural, economic, political, and social development.[30]

To end, it is important to highlight that there is no broad and available scientific production on the theme in Mexico, Colombia, and Ecuador, which is why it was necessary to recur to other secondary sources (theses, technical documents on policy

formulation, programs) and even gray literature and study groups to reconstruct how this vision was configured. This limited the development of the study, along with the impossibility to conduct interviews.

Conclusions

Collective health proposes a critical perspective on traditional public health and on the uni-causalist and reductionist approaches of the disease. The technical approach of odontology not only reduces it, but makes it dependent on the industry of dental materials and favors the reproduction of the lucrative and individualist nature of the industrial odontological complex and of the odontological practice. Hence, we sought to study the problems appertaining odontology and oral health in the region as of its social and historical determination, as basis to define culturally and politically pertinent actions. The view of social determination in oral health during the last decade in Colombia shares with Brazil the importance of the local, of the role of subjects and subjectivity in the health-disease process. However, in Colombia the approach of social determinants of health predominates, as in Ecuador and Mexico. In spite of the great potential on the transformation of the theory and practice in oral health, the hegemonic vision avoids greater progress.

In Mexico, as in Colombia, the scientific production on social determination needs more materialization. In Ecuador, research proposals have been developed to generate class epidemiological profiles. Brazil has broader production than the other countries with which it seeks to demonopolize knowledge and develop policies in oral health. A concern shared in Brazil and Colombia refers to the colonization of this vision by post-colonial trends that weaken the critical emancipating nature of this approach. New research efforts are needed on the development of the industrial odontological complex and its effects on oral health, as well as on the contributions of collective health to the social field of oral health.

At the general level, in the four countries it is observed that the view of social determination of oral health is in debate and permanent construction. Maintaining as analysis basis the ideas of social determination from Latin American social medicine/Collective health. Besides, it is characterized by the continuous dispute between an emancipating approach, based on the critique of reductionist, uni-causalist, and ecological approaches of the disease, and a capitalist accumulation approach that supports market dentistry. The scant impact of social determination upon oral health obeys a long historical tradition in the profession with technical industrial formation that lacks political and social support in the development of care policies and services. What is required is to break patterns and generate emancipation processes.

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