

The prospect of social medicine in South Africa

L F Adonis,^{1,2} MB ChB MMed FCPHM MMed PhD; D Basu,^{1,2} MSc(Med), MPH MBA MMed FCPHM, PhD

¹ Department of Public Health Medicine, University of Pretoria, South Africa

² WHO collaborating centre for SDH and HiAP

Corresponding author: Dr Leegale Adonis (leegale.adonis@up.ac.za)

The term “médecine sociale” (social medicine in English) was first coined in 1848 during the French Revolution by Dr. Jules Guérin. It is a branch of medicine that focuses on the impact of social and economic conditions on health, disease, and the practice of medicine, with the intention of creating a healthier society. It is an interdisciplinary program between medicine and social sciences, expected to equip medicine with the knowledge and skills needed for analyzing the social causes of health and illness, akin to how the alliance between medicine and laboratory sciences provided insights into the biological, chemical, and physical bases of diseases.

Social medicine is also interconnected with social determinants of health. While social determinants of health specifically target social and environmental conditions that affect health, social medicine has a broader scope, encompassing the entire social context of health, including societal structures and cultural factors. In the post-apartheid era, social medicine could play an important role in transforming the healthcare system to ensure equity and inclusivity, leading to improved health outcomes. This would require re-engineering the education of health professionals in South Africa at both undergraduate and postgraduate levels, as practiced in many parts of the world.

This will assist South Africa in joining the global movement of social medicine for the promotion of human rights and social justice in medicine, and a better understanding of the impact of social factors on the aetiology and management of medical disorders in the 21st century.

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Social medicine is recognised as one of the medical specialities in many countries. However, it has never been formally introduced in South Africa (SA), given the country's history with several social strategies and health inequities. Social medicine is often defined as a medical field based on the social factors that have an impact on health and illness.^[1] According to Ryle, *‘just as human pathology was the related science of clinical medicine, so should social medicine be viewed as the medicine and pathology of families, groups, societies or larger populations’*.^[2] Ryle continued, stating *‘social medicine embodies the idea of medicine applied to the service of man as socius, as fellow or comrade, with a view to a better understanding and more durable assistance of all her/his main and contributory troubles which are inimical to active health and not merely to removing or alleviating a present pathology’*.^[3]

History of social medicine

The need for consideration of social viewpoints in dealing with problems of medicine and hygiene was recognised by Bernardino Ramazzini and Johann Peter Frank during the eighteenth century.

^[4] However, the term ‘médecine sociale’ (social medicine in English) was first used in 1848 during the French Revolution by Dr. Jules Guérin. He introduced the term ‘social medicine’ in his writing in the *Gazette Médicale de Paris*, targeting French medical professions for the public good, simultaneously helping to create a new society

emerging from the revolution. He proposed a systematic integration of knowledge and information about medical issues, social factors and public affairs into the framework of social medicine.^[4] During the same period, Salomon Neumann, Rudolf Virchow and Rudolf Leubuscher promoted healthcare reform in Germany based on their understanding of the effect of social factors on health problems. Virchow studied the typhus epidemic in the Upper Silesia region of Prussia and provided empirical data linking social conditions with the epidemic.^[4] Subsequently, this theory was more actively developed by another German physician, Alfred Grotjahn, in Berlin who emphasised the aetiological relationship between social condition and disease, and the results of his studies formed the basis for a new scientific branch called Social Pathology.^[5]

Since then, it has expanded globally and developed in diverse ways. However, its core principles have remained the same.^[6] In 1948, John Ryle was appointed as the first professor of social medicine at the newly established Institute of Social Medicine at Oxford University. He was regarded as a pioneer in introducing social medicine in the United Kingdom.^[4]

Social medicine was subsequently introduced in other countries in the 20th century. Social medicine in Latin America was at its prime in the 1930s when Salvador Allende was central in promoting the field.^[7] In the USA, interest grew in social medicine after the end of World War II.^[8] Jack Geiger, who was trained in Pholela in

Kwa-Zulu Natal with Sydney and Emily Kark, was the visionary behind the community health centre programme at the heart of US President Lyndon B Johnson's Great Society programme, which constituted the largest expansion of the social safety net in the USA in the second half of the 20th century.^[9] In addition, many medical schools across the world, including those in India, Korea, Myanmar, New Zealand, Malaysia and Thailand initiated departments of Preventive and Social Medicine during the fifties.^[10]

Linkage between clinical medicine and social medicine

Virchow formulated the somewhat rhetorical but striking slogan: *'Medicine is a social science, and politics nothing but medicine on a grand scale'*.^[4] Virchow and his colleagues postulated that social and economic conditions profoundly impact health, disease and the practice of medicine. Therefore, the health of a population is a matter of social concern and society should promote health through both individual and social means.^[5] Virchow and his colleagues proposed three basic principles regarding the academic and practical aspects of social medicine that were summarized by Rosen^[4] as follows: 1) population health as a matter of direct social concern; 2) important effect of social and economic conditions on health, disease and the practice of medicine at individual level and 3) both medical and social actions for promoting health and combating disease.^[10]

It could be postulated that people are simultaneously biological and social organisms, and thus, human health and diseases are affected by social factors as well as biological factors.^[11] The practice of clinical medicine often ignores social factors to be perceived as science-based. However, *'it needs to be emphasized that medicine is an art backed by science. Understanding social aspects of medicine in causation, precipitation, and perpetuation of distress is critical to understand multifaceted responses and social causations in the context of social determinants in the clinical practice as well as research'*.^[12]

The concept of social medicine as an interdisciplinary programme between medicine and social sciences is expected to provide medicine with the knowledge and skills needed for the analysis of social causes of health and illness. In a similar manner to the alliance between medicine and laboratory sciences, which has provided insights into the biological, chemical and physical bases of diseases.^[10] Sidney and Emily Kark, two physicians who practised social medicine in the first community health-oriented centre in SA in the 1940s proposed that *'social medicine as a study of medicine interested in the health of people in relation to their behaviour in social groups and as such concerned with care of individual patients as a member of a family and of communities in her/his daily life'*.^[5,13]

It is commonly perceived that the contributing factors to illnesses include trauma, infections, immunity, lifestyle, nutrition, environment and occupation. However, the social context of all these causes is critical for our understanding of the causation as well as the management of illnesses. This context depends on the social contract between the individual and society on one hand and between doctors and society on the other hand. Based on this, Rawls and others challenged the definition of health as promulgated by the World Health Organization (WHO) focusing on health as primarily the *'absence of diseases'*.^[14] The rationale for

their arguments relied on the following: (a) increased longevity along with complex comorbidities and chronic conditions (which may wax and wane), (b) individuals' ability to manage their life by fulfilling their potential and obligations with a degree of independence and (c) absence of clear definition or agreement of the exact degree required to be identified as 'healthy'.^[12]

In 1948, Ryle regarded 'social medicine' as a logical development from and a direct extension of clinical medicine,^[15,16] considering it as a natural evolution from three distinct but overlapping disciplinary periods: the 'pathological disciplines', 'experimental or laboratory disciplines' and 'technological disciplines'.^[14] He recommended regular discussion on social medicine at hospital practices.^[17] Stonington and Holmes^[18] suggested four primary domains for social causes or forces to be considered at the beginning of clinical encounters with a patient. These include cultural and social aspects of the relationship between patients and health professionals, a patient's beliefs, practices and experiences, culture of medicine and social determinants of disease.^[17-19]

Social medicine and public health

Ryle characterised social medicine, in contradistinction to public health, as *'deriving its inspiration more from the field of clinical experience and seeking always to assist the discovery of a common purpose for the remedial and preventive services, places the emphasis on man, and endeavours to study him in and in relation to his environment'*.^[4] He proposed that social medicine united clinical medicine with public health. Ryle summarised the difference between social medicine and public health as *'social medicine extends the interest and alters the emphasis of the older public health, just as social pathology extends the interest and alters the emphasis of earlier epidemiological study'*. Although anyone today would not define public health in these narrow terms deemed appropriate in the 1940s, the proposition of social medicine deserves emphasis, especially for its essential humanism approach within a health system.^[19]

Social medicine and social determinants of health

Social medicine and social determinants of health (SDH) are interconnected concepts that focus on understanding and addressing the social, economic and environmental factors that influence health outcomes and disparities. While they share a common goal of improving public health, they approach the issue from different perspectives. For instance, SDH specifically target social and environmental conditions that affect health, focusing on determinants, such as education, income and housing. In contrast, social medicine has a broader scope, encompassing the entire social context of health, including societal structures and cultural factors.^[4]

SDH are non-medical factors that might influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These systems and forces include economic policies and systems, development agendas, social norms and social policies and political systems.^[20]

SDH pinpoint specific determinants that may contribute to health disparities, emphasising the need to address these determinants for improved health outcomes. Conversely, social

medicine looks at the overall impact of social, economic and cultural factors on health, considering a wide range of influences beyond the specific determinants highlighted by SDH.^[21]

Lastly, SDH are often approached from a public health medicine perspective, with a focus on epidemiology, statistics and policy interventions, whereas social medicine takes an interdisciplinary approach, involving not only public health but also fields, such as sociology, anthropology and political science to understand and address social factors affecting health.

Social medicine in SA

Social factors and inequalities play a pervasive role in the epidemiology experienced by SA citizens given that the population is a multicultural society. According to Coovadia,^[22] racial and gender discrimination, migrant labour system, destruction of family life, vast income inequalities and extreme violence, affected the country over several decades. The concept of social medicine was first introduced in SA by Sidney and Emily Kark through a series of case discussions based on their own field experiences in the 1940s.

^[22] They documented the tremendous impact of Pholela on the social medicine diaspora, based on the active role played by the residents of Pholela. These residents shared their knowledge and experiences in terms of accessing healthcare and managing their homesteads in the true spirit of the practice of social medicine. This knowledge later influenced the establishment of a similar model in Mound Bayou, a rural area in Mississippi.^[23] This model influenced the recommendations of the National Health Services Commission established in 1942 under the chairmanship of Dr Henry Gluckman.

^[24] This commission looked into SA health and health care and mentioned the work in Pholela in its proposition of establishing an integrated curative, preventive and promotive health service shifting from the existing high-cost private practice and largely urban hospital system.^[25,26] This remained contextual in the 1990s in the development of the National Health Plan for SA by the African National Congress, which stated '*The foundation of the National Health System will be Community Health-Centred providing comprehensive services including promotive, preventive, rehabilitative and curative care*'^[22] as well as the drafting the current National Health Insurance (NHI) Bill.^[25]

The last 30 years have been described as the colliding of four epidemics—HIV and TB; chronic illnesses and mental illnesses; injuries and violence; maternal, neonatal and child mortalities.^[27,28] The gross disparities during the apartheid era in access to healthcare resulted in the majority of the population, particularly Black South Africans, experiencing limited access to quality healthcare. The first comparative risk assessment study for SA quantified the contribution of risk factors associated with poverty and underdevelopment, such as undernutrition, unsafe water, sanitation and hygiene and indoor smoke from solid fuels. It also included those associated with a western lifestyle, such as alcohol and tobacco use, diabetes, high blood pressure and high cholesterol.^[29] Despite the end of apartheid, significant health inequalities persist in the 21st century, which is compounded by high rates of infectious diseases, such as HIV/AIDS and tuberculosis, as well as non-communicable diseases like diabetes and cardiovascular diseases. This epidemiological

transition of diseases as experienced in many middle-income countries such as SA, a protracted bipolar transition is expected to happen with the coexistence of both types of conditions for extended periods resulting from social stratification of society.^[30]

In the post-apartheid era, there have been significant strides in transforming the healthcare system to ensure equity and inclusivity. However, disparities in healthcare access, health outcomes, and SDH such as education, employment, and housing remain. Emphasis was placed on re-engineering primary healthcare services to ensure that all citizens have access to essential health services. However, the legacy of the racist apartheid regime continues to influence health outcomes, particularly related to drivers of population cross-provincial socioeconomic inequalities and thus differences in health funding and health system development.^[27] As a result, the SA government implemented various public health measures to address SDH with an aim to reduce poverty, improve education and promote economic development as part of a broader strategy to improve overall health and wellbeing. Initiatives involving community participation and engagement at district, provincial and national levels through community health forums were incorporated into the National Health Act^[31] to understand and address the unique challenges faced by different communities. Most recently, the SA government has been working on the implementation of the NHI, aiming to provide universal healthcare access and reduce disparities between different socioeconomic groups.^[32] Social medicine efforts could assist in strengthening these initiatives by conducting implementation research on health equity, conceptualisation and implementation of evidence-based interventions that empower local communities to take control of their health based on shared decision-making and improving the overall wellbeing of the population. This may include health education, behavioural interventions and community based initiatives in addressing SDH. This could be further strengthened through collaboration with private organisations, international organisations, non-government organisations (NGOs) and other countries to exchange knowledge and skills in social medicine, thereby addressing health challenges. It is important to note that the practice of social medicine is dynamic and evolves based on the changing social, political and economic landscape. While progress has been made, challenges persist, and ongoing efforts are required to achieve health equity for all South Africans.

In SA, the term 'social medicine' is rarely used but many of its subject matters are included in the teaching and practice of public health medicine. The SA medical community opted to form community health (later on public health medicine) as a speciality in 1976 instead of social medicine, unlike many countries in the world. The SA speciality of public health medicine is distinguished from similar medical specialities in other countries by two key characteristics. First, it emphasises public health over prevention and second, it is detached from clinical practice. However, it is crucial to recognise that prevention, promotion of healthcare and implementing interventions at both population and individual levels are important for the improvement of overall health outcomes. This would assist in the appreciation of the effects of various social factors on health, diseases and the healthcare delivery

system. The understanding and application of social interventions should be incorporated into the undergraduate curriculum with emphasis on social factors as well as the relationship between society and medicine. This could be aided by renaming 'public health medicine' courses in medical schools to 'preventive and social medicine' and adjusting the course contents accordingly in line with the new title, as has been done in many countries.^[9] This might also assist in shifting from a technology driven health system to a more humane, holistic and humanistic medicine, thereby supporting the role of health professionals in better advocacy for patients as a high priority.^[10,11]

Global social medicine

Lastly, it is prudent to mention global social medicine in the context of discussion around social medicine which could provide a rich and relatively untapped resource for understanding the hybrid biological and social basis of global health problems. Global health can learn much from social medicine to help practitioners understand the social behaviour, social structure, social networks, cultural differences and social context of ethical action central to the success or failure of global health's important agendas. This understanding of global health as global social medicine can coalesce the unclear identity of global health into a coherent framework effective for addressing the world's most pressing health issues.^[16] The practice of social medicine at a global level is needed to promote human rights and social justice in medicine while simultaneously recognising the complex histories that exist throughout many parts of the world. It should involve analysing local and regional injustices in healthcare impact translational political economies and wider social determinants. Westerhaust even advocated for the incorporation of social medicine into mainstream medicine, envisioning a comprehensive transformation that would equip all future health professionals with the necessary knowledge and skills to practice social medicine. Three distinct models for accomplishing such transformation are currently presented: SocMed's month-long elective courses in Northern Uganda and Haiti, Harvard Medical School's semester-long required social medicine course in the USA and the Lebanese American University's curriculum integrating social medicine throughout its entire four-year curriculum.^[33] This could be facilitated by establishing a global repository of best practices, accessible to students, researchers, health professionals, managers and policy makers such as the Encyclopaedia of social medicine available at the website (www.socialmedicine.org).^[34,35]

Conclusion

The practice of medicine in the 21st century relies heavily on technology with a large number of investigative and interventional techniques affecting the humanity of doctors in their relationship with patients, as the focus has shifted from 'man in disease' to 'disease in man'. Furthermore, in many countries, medicine has become much more defensive and extremely risk averse where doctors tend to investigate more often and vigorously.^[11] Rapid advances in health technology will continue to add to the costs of healthcare delivery and consequently the increase in demand for newer and safer treatments as well as increased financial burden

on society and populations. Furthermore, increases in globalisation and urbanisation would lead to changes in social expectations and social roles, affecting the relationship between health professionals and the communities they serve. Therefore, understanding the impact of social factors on the aetiology and management of medical disorders is critical in not only providing better care through improved relationships but also bringing humanity and empathy back into medicine.^[11]

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