

The challenge of the unprecedented: rethinking social research in collective health in the 21st century

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The article by Gomes, Moreira and Deslandes¹ shows a synthesis and self-reflection on social sciences in collective health. The authors invite discussion about the circularity of social research in health and provoke a tension with contemporary possibilities that rid us from the situation of being captives of a recurring diagnosis: low theoretical density and a reliance on traditional qualitative approaches.

Criticism of the theoretical limits of the field should always be paired with a more systematic epistemological self-reflection, discussing how the editorial system itself and the criteria for evaluating scientific production reproduce the conceptual superficiality it denounces. The article fulfills an important function of assessment and self-recognition, within a discursive comfort zone, with a diagnosis already widely reiterated in the field in the critique of social sciences in health. To break with this, we consider that a reflection on conceptual, operational, and methodological frameworks in social research in health is convenient.

Although the article notes advances in methodological diversity – such as ethnographies, action research, cartography, and hermeneutics – we believe there should be more discussion

about how their application. These methods do not always provide sufficient conceptual validity or strong theoretical grounding. The field could use mixed designs, social network modeling to investigate structural inequalities, AI-assisted discourse analysis, field experiments or quasi-experiments in policy evaluation, or even longitudinal analyses of care trajectories and itineraries. When these methods rely on solid social theory, they do not negate the qualitative legacy, but expand it, allowing collective health to dialogue on an equal footing with empirical anthropology, comparative political science, and analytical sociology².

Furthermore, the discussion of social markers of difference is a strong point of the article. The text is right to see race, gender, generation, territory or disability as dimensions of power – not just profile variables. This is a big step forward from traditional conceptual frameworks³. Yet, criticism should be more than rhetoric. Health inequalities now demand quantifiable intersectional approaches. Dialogue with statistics, latent class analysis, and hierarchical regression models could help test empirically interactions between oppression and privilege. This integration does not depoliticize the debate. Instead, it allows a measurable demonstration of the structural effects of social hierarchies on health outcomes.

In a world with a new context, we need new questions in the social sciences in health to move beyond old methodological routines devoid of epistemological coordination and achieve epistemological innovation. The future of social research in health may depend precisely on overcoming this divide between reflective diagnosis and methodological innovation – incorporating mixed analyses, social modeling tools, and comparative conceptual networks that connect collective health to its roots and boundaries: anthropology, sociology, and political science.

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