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Social representations of the right to health on the trinational border

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Abstract *This article describes a study based on a qualitative approach that aimed to analyze the social representations of opinion makers about the right and access to health in the cross-border territoriality of Foz do Iguaçu-Paraná. To achieve that goal, interviews were conducted with leaders of social movements, university professors, health workers and journalists. Moscovici's Social Representations Theory was used with a focus on the three-dimensional analysis to process data. Findings show a diversity of representations of the right to health in the territory. They range from a notion of restricted citizenship that is exclusively granted to nationals to a broader concept of health and to the understanding of health as a universal right. Regarding access to health services as an expression of that right, contradictory movements were observed that limit cross-border access by building a conceptual barrier that marginalizes and excludes what is not national. We conclude that financing, provision of services by the local health system and international cooperation achieved regionally are aspects that need to be part of the local debate on health policy, planning and management and should make up a praxis that meets the multiple specificities of cross-border citizenship.*

Key words *Collective Health, Organization and administration, Border Areas*

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Introduction

The trinational border between Foz do Iguaçu - Brazil, Puerto Iguazú - Argentina and Ciudad del Este - Paraguay is characterized by a lively territoriality and by consumer imagination that contributes to the configuration of a dynamic socio-historical, touristic and commercial flow.

Living in a tri-border territory is a complex phenomenon as relationships are not limited to the local aspect but rather reflect a global course of action and interactions between the national and international that may both promote integration and cause conflicts, especially in terms of human rights, such as the right to health.

The law is understood as a system of standards that regulates the behavior and conduct of men in society. The word can also be used as a synonym for justice or in a subjective sense when claiming the right to health[1]. In any of these situations, the concept needs to be analyzed in relation to its historicity. Lyra-Filho, quoted by Soares[2], states that the law in its historical-concrete procedural aspect "is an expression, in a particular and unmistakable angle, of the domination-liberation dialectics, which constitutes the plot, the substrate and the spring of the human itinerary through the times"(p.343).

Thus, social rights, which emerged in Europe in the second half of the 19th century as a result of the struggles about the so-called "social question", need to be seen and established in actual conditions of existence, in every specific social formation. At that time, social inequality caused by the capitalist mode of production allowed the working class, by contradictory ways, to develop a so-called "class consciousness" and to organize itself to demand minimum working conditions and public policies from the liberal State that would improve its existence. We agree with Iamamoto[3] that "the struggle for the affirmation of rights is today also a struggle against the capital, a part of the process of accumulating forces for a form of social development"(p.1).

In the course of this historical process, social protection systems were developed that result from economic production and the social political order[4]. In Brazil, the social protection model adopted by the Constitution of 1988 is based on the idea of social security, i.e., the tension among social classes caused by the economic model needs to be mitigated by adopting social policies and programs that reduce social inequality.

The right to health, seen as an individual human right, ideally privileges freedom, given that people are free to choose, e.g., the health service or treatment of their choice. However, from a collective point of view, it privileges equality, as limitations are imposed on human behavior so that everyone may equally enjoy the advantages of life in society and, regarding health, the provision of the same kind of care to everyone[1].

Dallari[1] states that as a collective right, "health also depends on the level of development of the State. Only a State whose right to development has been acknowledged will be able to ensure equal protection and health measures to everyone"(p.59). In fact, universal systems, such as the Brazilian Public Health System (SUS), need a material basis to support them to ensure the right to health to the entire population.

If it is acknowledged that the right to health is not applied equally inside the national territory due to differences in socioeconomic, political, health and social organization, this right becomes even more complex in international border regions, where territoriality crosses national boundaries, instituting a way of life characterized by the daily coexistence between Brazilians and foreigners.

The sub-citizenship built on these spatializations is based on the premise that fundamental human rights are still seen by national states as a mechanism that does not contribute to economic development, given that the fetish for profit sickens and mutilates health itself[5,6]. There are countless contradictions in collective health of border territories, especially regarding access to health care services. Some studies[7] reveal that border municipalities often require patients' IDs and proof of address to grant them access to health services.

Although there have been locoregional attempts to address that issue, "the legal-normative basis is a powerful tool to equalize social citizenship, but it is insufficient in most cases to put plans, programs and projects into practice, without which the situation will not improve"[8](p.300).

The trinational border territory between Brazil, Argentina and Paraguay has caused paradoxes in the health care of its inhabitants. The antithesis that results from the socio-spatial, political and economic inequality found in this border region intensifies the questioning of the bases of "globalitarianism". Santos[9] analytically expresses what the reality of globalization represents and evidences the perversity of the universal colonization process, the legitimation of the gap between rich and poor, metropolises and colonies, civilized and savage peoples. Globaliza-

tion, as presented in the actual platform, aims to homogenize the way of living of societies based on a logic according to which only a privileged few have power over either human culture, economy, society or even in the dispute for the modern State itself.

However, the border may also be understood as a rich space of mutual exchange between people from different cultures, creating the region's proper representations and subjectivities. These result from experiences and relationships that are built among people and which can either legitimized or modified by opinion makers.

To contribute to this debate and to expand the analytical horizon, we adopted Moscovici's Theory of Social Representations[10] as a reference. According to his theory, it is not only the unidirectional form of the social mode on individual behaviors that matters, but their participation in the construction of social realities in which they are inserted, i.e., people are seen as active thinkers who communicate and act according to their own social representations.

In social representations, the point lies in the interaction among the subjects of a given social group and they are fluid and dynamic, as they can change over time and even in short periods of time, depending on the interaction and interpretation that the group attributes to the phenomenon[11].

Studies on the three-dimensional analysis of the Theory of Social Representations[11-13] show that three dimensions coexist in every universe of representation: information (concept), the field of representation (image) and attitude. The dimension of information refers to the knowledge of the group about a given social object. The dimension of the field of representation or image evidences the idea of a social model, i.e., the organization of elements that are already structured in the social representation. Eventually, the dimension of attitude expresses the positive or negative general understanding of the group regarding the represented object.

Thus, the study of social representations about the right to health may show how the subjects represent their experimentation with the object, identifying values through which people give meaning to their experiences and based on this meaning, how they elaborate a shared collective reality[14].

Therefore, adopting as an object the concepts and praxis of opinion makers, such as journalists, university professors, collective health workers and leaders of social movements, is essential to understand a given narrative and for the debate on the right to health in border regions. Our study aimed to analyze the representations of opinion makers about the right to health in the cross-border territoriality of Foz do Iguaçu, State of Paraná, Brazil.

Methodology

This is an exploratory research with a qualitative approach which took place in the city of Foz do Iguaçu, state of Paraná, in the trinational border region between Brazil, Paraguay and Argentina. Data was collected from September to December 2019 by means of in-depth interviews with 12 opinion makers (university professors, social movement leaders, journalists and health surveillance professionals, ombudsman of the Brazilian Public Health System, regulation and control of access to health). Two questions guided the development of the interviews: What does the right to health on the border represent for you? What do you think about access to health in a border territory? Closing of sampling occurred by the principle of discursive saturation[15].

Narratives about the right to health and access to the health system on the border were grouped into three thematic groups: a) The right to health in the border territory: multiple social representations; b) The dialectics of specific policies and access to health for cross-border citizens; c) Overcoming obstacles: discursive possibilities and contradictions. Data processing was based on the assumption of the three-dimensional analysis of the Theory of Social Representations: information (concept), field of representation (image) and attitude[11-13].

Narratives were selected according to an information dimension analysis which associated the interviewed group's notions of citizenship with the organization they knew about the right to health on the border. The image dimension sought to identify with which social model of citizenship the narratives were represented. After that, the attitude dimension analyzed if those representations were based on either a progressive or a conservative understanding of the right to health by the group.

The present research was approved by the Research Ethics Committee of the University of Paraná-PR under the CAAE registration number 02513318.3.0000.0107 and it respects the ethical principles according to Resolution 466/2012. Participants signed the Free and Informed Con-

sent Term. To maintain anonymity, the interviewees' testimonies were coded by the letter "E" followed by a sequential Arabic number.

Results and discussions

Findings indicate a polysemy of social representations regarding the right to health in a cross-border territory and a discursive dispute about citizenship. Such divergences show not only a loss of the care dimension in the health-disease process in public health policies in the territory, but also a rhetorical resistance to protecting the right to health as a good of mankind, rather than just as a right of national citizenship.

From the point of view of regional integration, two institutions guided the debate on citizenship and rights in Latin America: the Southern Common Market (MERCOSUR), created in 1991 and the Union of South American Nations (UNASUR), created in 2008. The latter one progressed more in its discussion about rights, including the right to health of cross-border people. However, the defeat of progressive governments in the region and the legal and media coup in Brazil in 2016 interrupted discussions and froze initiatives that aimed to establish cultural and cultural integration[16], such as the Integrated Border Health System (SIS - Fronteiras). We assume that comprehensive care and health on borders should not be limited to a single nation, but rather provided as an inalienable human right ensured by national States, society and institutions.

The right to health in the border territory: multiple social representations

Before addressing the right to health, it is important to clarify what is meant by right and health. There are several ways to define right and health. Freitas *et al.*[17] identify three ways of understanding right in three classics of sociology: Right as an affirmation of a group's will over a collectivity (Weber), as an emanation of a society's desires and needs (Durkheim) or as legitimation of inequality between social classes (Marx). In the present article, based on Lyra Filho cited by Soares[2], we understand right as legal frameworks linked to social dialectics, "which tend to be structured in precepts with a peculiar coercive intensity, polarizing themselves, on the one hand, to establish fair and effective order and, on the other hand, as standards that relate to Social Justice"(p.343).

Regarding health, we adopted the idea that it is a means to achieve life projects. Unlike the concept of health as absence of disease or complete well-being, which conceives it in a teleological and practically unattainable way, we adopt the idea of health as a means of evidence, as one of the elements for human development rather than its totalizing whole. Therefore, the concept of health as a means points to an understanding of health not as a synonym for life, but as a condition to achieve life goals. Based on social production of the human in people, we understand that health needs to be analyzed by means of the development degrees of the productive forces and their established social relationships[18,19].

In Brazil, the right to health is the result of historical struggles and the social pact of citizenship, enshrined in the Federal Constitution of 1988, although it is not applied equally throughout Brazil. In a border context such as Foz do Iguaçu, which was our field of research, the representation of the right to health results from a notion of citizenship, of the State, of social policies, of the very conception of right that are mediated by the daily coexistence of Brazilians with non-nationals in a specific territoriality with a unique and diverse way of life but not devoid of conflicts in the face of the marks of past historical experiences and its representation of the foreigner as the "other".

Although there are disagreements about the role of social policies in capitalism, there is a consensus that one may not dismiss the State as a guarantor of rights by means of universal public policies, as pointed out by E05 "[...] I defend a strong State of social protection that ensures access, as it is in Cuba and other countries".

Fleury[4] classifies social protection models in three types, which emerged at different historical moments and assume specificities in different countries, such as social assistance, social insurance and social security. These models influence the development of the citizen *status* in those countries, based on the implementation of social policies and their institutions. Regarding the type of social assistance, citizenship is inverted, since it is based on the failure of the individual or of certain groups for which social policies are made. Regarding the social insurance type, citizenship is regulated by a corporate ideology that associates social protection with the labor market, thus, the citizen *status* is a privilege. Regarding social security, citizenship is full and the State is in charge of ensuring a vital minimum to all citizens, such as health, education, employment

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insurance, among others, i.e., the social right is inherent to the condition of citizenship, in addition to the fact that social policies aim to reduce inequalities caused by the market. However, as these three types are not mutually exclusive, multiple social representations of the three citizenship statuses may coexist[4].

Opinion makers see the right to health as an achievement, the result of social struggles, the correlation of forces found in every historic moment and therefore subject to progress and setbacks:

Health is a conquered right. [...] the working class got organized to fight and conquer it, but it is constantly at risk. All achievements have to be preserved on a daily basis (E12).

The right to health implies access to goods and services, which may be limited when this right is reduced to a notion of citizenship that only acknowledges nationals and legal residents, as provided for by current Brazilian legislation and expressed by two opinion makers:

Foreigners may be treated in urgent and emergency situations only [...] unless they are residing here and are naturalized Brazilians. (E04).

People feeling ill may be treated by emergency services. After that, they need to go back to their territory. [...] The ideal is not to attend to everything, no, everyone stays in their own territory and in their own health system. (E09).

Postulating the national subject as an assumption for life care corroborates with individualism, where political strategies in the field of health are not confronted with life power, but with the possibility of power over life. The perspective of health as a universal right built by the Health Reform Movement is replaced by a private and mercantile one[20].

On the other hand, understanding the right to health as a universal human right and citizenship as a principle of justice strengthens the premise of a universalist awareness of the world[21], as expressed in the narratives by E11 and E06:

Right to life. It should be universal (E11).

I feel that everyone in need at a certain time has that right. Whether you are a foreigner or not, at that moment you are in that city and in that country and you should be treated like any other local resident or inhabitant (E06).

There is a dialectical movement between the narratives that sheds light on possible differences in social practices, understanding of the world and life, in the impulse to remove obstacles to health care assistance in the border region, as well as regarding the consolidation of the right to health in Foz de Iguaçu.

Putting the right to health into practice in a border region is a rather complex endeavor, as it requires that the local management of the public health system assumes a leading role, that financing policies address the specificities of the region, as well as technical cooperation between countries, such as paradiplomacy[22]. Paradiplomacy, i.e., international relations coordinated by subnational governments may be an interesting strategy to ensure the right to health across borders. Aikes and Rizzotto[22] found that "Brazil is afraid to institutionalize paradiplomacy for fear of losing sovereignty, but it tolerates it as it understands that it is an inevitable phenomenon"(p.7).

A study by Fagundes[8] points out that the legal-normative base is a powerful tool to equalize social citizenship, but it is most often insufficient to materialize plans, programs and projects without which the situation will not change.

In this sense, we may state that the complexity that emerges from the cross-border territory, such as, e.g., cultural, economic, political and anthropological integration should not be an argument to deny anyone the right to health. Local political initiatives show that there are spaces for negotiation to ensure the right to health:

I see that in a positive way because I feel that managers are making efforts to promote that right to foreigners, since they are aware of the financial impact these people may have here and the difficulty of funding services (E10).

The flow of people seeking health care services impacts the common sense and the dimension of information and image established in the city, which is promulgated by the social representation that the demand for health services occurs in the "other-us" direction on the trinational border. However, history shows a pendular migration, even in the case of health, as a study by Argentine physician Marta Schwarz shows. She was a trailblazer in collective health on the trinational border and treated Brazilian patients in the city of Puerto Iguazu, as stated by E10:

[...] *for many years, Brazilians from Foz went to Argentina for medical treatment because there was a hospital, there. Dona Marta got even honored by them. Women were going to give birth there, in Puerto Iguazu. The right to health applies to human beings, rather than to citizenship.*

A previously hidden social representation points out that the critical operational healthcare node for cross-border people is linked to the financial impact on the local healthcare system and to the fact that it is funded by national taxes. Thus, "their" citizenship is not respected:

Foreigners who come for treatment disadvantage us who live here [...]. Here, they get social assistance by social security and health but pay their taxes there. Thus, our citizenship is broken, it gets shattered (E03).

Thus, we may say that the representation of the right to health on the border is shaped by multiple aspects that involve the very idea of the right to health as a right that is either restricted to the citizens of a specific country or a universal human right; the responsibility to ensure the right to health as an assignment of the State or as an individual responsibility; the circumstances in which the right to health must be ensured to non-nationals; the care levels that should be granted to non-nationals and who should pay the costs.

The dialectics of access to health of cross-border citizens

The network of meanings reveals that most opinion makers are unaware of border health policy initiatives that aim to ensure access to health and care to cross-border citizens:

There is that [program], health without borders, and I don't know how it works (E10).

There was the sis-border program, but after that, there was nothing else (E04).

Interruption of specific public policies is represented as a kind of abandonment of the border territory, which would justify reducing access of foreigners to certain health care levels and the fact that they get rejected by health care services. In addition to the obstacles that cross-border and non-national citizens have in accessing health, there are other shortcomings. A recent study showed that under an increasingly restrictive "no-entry" policy, crossing borders implies worsening health conditions and obstacles to accessing services[8].

One notices that there is no consensus in the field of representations about access to health services, regardless of the fact that patients are either Brazilians or non-national citizens. Certain requirements are intended to restrict access to health rather than to ensure it:

There are difficulties, here. Documentation, especially proof of address. And this is not just for foreigners, Brazilians also suffer from that, here. They require a proof of address in the name of the person who will be treated, although we know that according to legal regulations the patient may issue a declaration he wrote himself and this cannot prevent him from accessing health services (E06).

Requiring a proof of address to grant health services can be understood as a measure that inverts citizenship in a border region and cripples care in a timely manner. The social health insurance model established in Brazil by its Constitution, the international human rights treaties and the conception in defense of life are elements that can contribute to changing that reality.

Despite a hegemonic representation that cross-border patients strongly impact the local health system, three facts need to be highlighted: the absence of data that proves an actual impact on the health system, academic research findings that show that the number of foreigners treated by local health services is small and the fact that migration has not always taken place "from the other to us".

According to some interviewees, there is a dialectics about the level of care to be provided by the locality, permeating what can be considered a mutilation of citizenship:

Eventually, we have to treat them. Mainly emergency and urgency services don't close their doors. The high complexity, I think, is due to the fact that patients have to obtain a SUS card [Public Health Service Card]. Foreigner are not well received in the health area of Foz do Iguaçu. There is some resistance against treating them (E04).

The network of meaning and the dimension of the attitude that materializes in the discourse of opinion makers point out that local managers build barriers against cross-border patients:

They say you can't include them into the system. The previous secretary sent a memorandum to UBS telling us not to treat foreigners (E02).

However, shortcomings in offering health services are not limited to foreigners:

First of all: we lack accessibility, [...] how come that the municipality of Foz do Iguaçu, given its size, lacks a clinic that performs an anatomorphological study? (E02).

The hegemonic health care model shows a fragmented practice that is centered on the production of acts, resulting in disconnected types of services that are unable to meet the sheer amount of user issues[23]. From the perspective of integrality, the State needs to grasp the specific context of the different encounters, including those of the other, based on his sufferings, expectations, fears and desires[24].

In addition, the perspective and the dimension of attitude shows that there is an antithesis regarding full, equitable and resolute access of cross-border citizens to local health systems and services in the region of Foz do Iguaçu and representations coexist that point to selecting access to certain

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health care levels and technological densities of public health policy.

Overcoming obstacles: discursive possibilities and contradictions

Collective health in border territories requires a network of sectoral, intersectoral and paradiplomatic actions to ensure that the right to health applies to everyone, including cross-border citizens who cross the border every day either to work, study, for leisure or to solve health issues. The role of national governments, despite political difficulties, is highlighted in E11's proposal:

The three countries have to reach an agreement, although it seems distant, at the moment. Now that there is going to be a change in Argentina, [...], but Brazil and Paraguay tend towards privatism and we cannot agree with that.

The reference to changes in governments in the tri-border countries shows how local actions are impacted by the political orientation of national governments. At times, when there was a strong movement for regional integration, especially during the governments of the Workers' Party in Brazil, the border was seen as a privileged space that favored the South American integration movement, as mentioned above.

That appeal to local governments and institutions reveals a concern and a concept of citizenship that approaches a universalist vision, according to which the right to health constitutes in fact a universal human right, despite the idea of insurance being divergent from the proposal of universal public health systems:

I think all border cities should contribute, as well as the three countries, just like Mercosur. Offer insurance to everyone (E01).

Thus, at the local level, registration initiatives to identify non-residents using the health system may contribute to a better understanding of the issue, subsidize the formulation of public policies and the planning of local actions, as well as help require more effective action from national governments, especially regarding financing:

The municipality is registering all residents to understand how many there are. [...] to identify non-citizens and thus to think about public policies and the collection of financial incentives to be able to pay for what goes beyond our responsibility. I think everyone's commitment should be required, Paraguay, Argentina and Brazil (E08).

However, as long as these measures are not implemented, informal mechanisms are applied to obtain access to health services:

To this day, they lie about their address [cross-border citizens]. They use a friend's or acquaintance's address to obtain primary care. It's all informal (E07).

Informality in access to health services may greatly impact longitudinal care and the resolution of health problems, prolonging suffering and increasing the costs of avoidable complications. Failure to protect the right to health by laws and institutional rules distorts measuring the number of total users and may encourage segregationist, xenophobic and sub-citizenship discourses:

Trying to develop a regulation stating what types of access foreigners may be granted to [...] and share them with all public and private institutions (E04).

Given the differences between the public health systems of Brazil, Paraguay and Argentina and the little attention that the border has received from central governments, the development of strategies at local level may be a possibility of ensuring access to health services and solidarity care to cross-border citizen.

Final considerations

The dimension of information or of the concept that relates the group's knowledge about a given social object shows that opinion makers who live in international border territories have different representations of the right to health.

Regarding the dimension of representation or image, we find the idea of a social model and the existence of tensions between different worldviews based on either nationalist or universalist perspectives, which results in a discursive distance that ends up consolidating the view that the right to health was and is being hijacked by more conservative forces in society so that access to social policies is mutilated if one is not part of the National State.

Regarding the dimension of attitude, which expresses the group's positive or negative understanding of the represented object, it becomes clear that access to health used in a negative way in society and in public health systems on the borders of Latin American countries may be considered a critical factor for successfully applying the right to health.

We conclude that there is an uncompleted debate on how the right to health should be applied on the border. Some representations exclude and marginalize non-nationals or non-residents while others welcome them and show solidarity with

cross-border citizens. Thus, we understand that intense local mobilization is necessary to reestablish the culture of ensuring universal human rights such as health in the region of the trinational border. Ethical values that apply to social life and to public health systems of the border region need urgently to be formulated. The consolidation of the right to health in these locations seems to be far from understanding health as a right to life, as expressed by the Universal Declaration of Human Rights.

Collaborations

All authors contributed to the development of this research and its writing, as well as approving its content before submission to the Journal.

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