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National Comprehensive Health Care Policy for People Deprived of Liberty in the Prison System: a reflection from the perspective of intersectorality

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Abstract *This essay aims to bring up the debate on access to health in the prison system, focusing on the National Comprehensive Health Care Policy for People Deprived of Liberty (PNAISP) and the intersectoriality proposed by the policy. As intersectoral articulation is one of the PNAISP main guidelines, we aim to reflect on its implementation, considering the Prison Primary Care Teams (EABP) professionals as street-level bureaucrats and the difficulty of access to health by people deprived of liberty as wicked problems. We understand that there are gaps in studies on access to health in the prison system with an intersectoral approach and analysis of the PNAISP with an academic focus and from the perspective of intersectorality. We aim to contribute to this debate within Public Health, addressing reflections on a health policy that affects the prison system.*
Key words *Intersectoriality, Prisons, Health Policy, People Deprived of Liberty, Health Services Accessibility*

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Introduction

Access to health by People Deprived of Liberty (PDL) is a sensitive issue, especially when considering the substandard structural conditions of correctional facilities, and a complex one, as it involves different stakeholders and prison specificities. Entering this theme means, first of all, understanding the context of this population and how public policies, or the lack thereof, affect these people.

Brazil has 748,009 PDL, and 30% – 222,558 people – have not yet been tried; they are provisional prisoners[1]. Moreover, 67% of the country's prison population consists of brown or black people[1], and 75% of the same population has low schooling levels and has not yet accessed high school[2]. Data show that the prison population is not multicultural, and incarceration is a profound inequality-maintaining mechanism[3]. As Santa Rita[4] puts it, the Brazilian penitentiary system works as an instrument of subject segregation and makes certain social groups even more vulnerable.

In this sense, when understanding PDL access to health, we should bear in mind the inequality and vulnerability in the daily lives of these people. The occupancy rate in the Brazilian prison system is 171%, with a deficit of 312,925 vacancies[1]. Overcrowding and unsanitary conditions, with most cells lacking adequate ventilation and light, make prisons disease-spread conducive environments.

The National Comprehensive Health Care Policy for People Deprived of Liberty in the Prison System (PNAISP), established in 2014, aims to guarantee PDL access to comprehensive care in the Brazilian Unified Health System. By establishing intersectoriality as one of its main guidelines, the PNAISP recognizes the multidimensionality of the problems linked to the health of this population. Thus, it reinforces the need for solutions that involve a collective strategy and not just one sector. Moreover, the PNAISP is provided for by the Interministerial Ordinance covering both the Ministry of Health and the Ministry of Justice, which corroborates its intersectoral nature.

Understanding the role of intersectoriality in this setting assumes prison itself and PDL's difficult access to health are wicked problems, that is, dynamic, multicausal, and related to other problems, requiring less traditional and more interactive approaches. Furthermore, it is also to consider that PDL require a comprehensive perspective that does not interpret them as a fractured individual but as a whole. Comprehensiveness is also a PNAISP guideline intrinsically related to intersectoral work. In much of the literature, the complexity of the problems and their several dimensions and causes are directly associated with intersectoriality, which requires a comprehensive perspective as its underlying perspective[5].

However, even when intersectoriality is a consensus and guideline, as is the case of the PNAISP, with the support of an influential group of actors, problems will highly likely arise in its implementation, even more so in a context permeated by power relationships and value judgments, as is the case of the prison system. Thus, this essay also aims to reflect on the mobilization of intersectoral actions by Prison Primary Care Teams (EABP) professionals. When considering that there is no natural tendency towards cooperation between government sectors at the same hierarchical level, between the bureaucracy levels, between the population involved in policies, or between state and non-state stakeholders[6], it becomes relevant to discuss whether and how intersectoriality is present and, consequently, how this can influence PNAISP's effectiveness.

The literature on the issue of access to health in the prison system[7-11] still needs more focus on intersectoriality, even considering PDL's vulnerability. In turn, even with a central role in PDL's access to the health system, the PNAISP still needs to be analyzed from an academic viewpoint.

Studies that work with intersectoriality have consistently gained ground, and this is a challenging discussion[5]. Although the PNAISP brings the concept as one of its main guidelines, its analysis from an intersectoral perspective is uncommon. This essay aims to work with intersectoriality as the central theoretical concept, subsidizing the perspective under the PNAISP.

The concept of intersectoriality will be discussed below, including in the health field. Then, deprivation of liberty will be addressed, with discussions about the prison-form, prison as punishment, and contextualizing the Brazilian prison reality, including the health specificities of PDL. By showing how prison health appears in the legislation, the text will present the PNAISP as the current health policy that affects the prison system. Implementation challenges will be addressed along with the policy design – formulation – resuming the role of intersectoriality and the importance of intersectoral articulation by the professionals from prison primary care teams (EABP). Finally, this essay aims to present wicked problems, establishing relationships with intersectoriality and access to prison health.

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Intersectoriality

Duarte and Leite[12] associate intersectoriality with the need for social organizations to respond to complex problems. According to Jaccoud[13](p.15), this theme "has been gaining prominence as a relevant public management strategy, especially in the face of complex problems and publics marked by vulnerabilities".

A common ground in the literature is that reality has multidimensional problems that interact and reinforce each other. Thus, they demand solutions that involve not just one sector but a collective strategy involving several sectors, areas, and stakeholders. Therefore, intersectoriality is associated with intersectoral integration. According to Pires[14], it appears in debates when one finds that the real social problems for which public policies are destined are necessarily multifaceted and do not obey the sectoral divisions of public bureaucracies.

Bringing the discussion to the health field, we should point out that intersectoriality has been strengthened as a concept precisely in the health sector between the 1970s and 1980s[15]. The understanding of health began to be related to the quality of life and not just the lack of disease. The Declaration of Alma-Ata formulated by the WHO in 1978 reinforced this comprehensive concept of health[16]. Other stages in public health have also been marked by intersectoriality besides Alma-Ata, such as the Ottawa Charter in 1986 and the Eighth International Conference on Health Promotion, with the Declaration of Helsinki on Health in All Policies (HiAP) in 2013[17].

In Brazil, the concept of intersectoriality also originated in the health field within the health movement in the 1970s, consolidated in the Eighth National Health Conference in 1986[18]. The documents that guide the SUS recognize the multiple aspects underlying the health-disease process, recommending intersectoral articulation[17].

Addressing intersectoriality in health brings to the fore a discussion of the Social Determinants of Health (SDH), through which we can establish relationships between the health of populations and people's social conditions. We achieved an expanded perspective of health[19] when considering the influence of subjective, relational, community, political, economic, and social aspects, which transcends the biological focus and sheds some light on health inequalities. The idea of health promotion is strengthened in this context, emphasizing the need for policies aimed at reducing social inequalities and dealing with relevant aspects for the prevention, treatment, and rehabilitation of individuals and the community. Thus, health promotion is highlighted as an intervention in primary care, which can focus on the environment and lifestyle[20].

Understanding the Social Determinants of Health and the importance of health promotion shows that the health sector alone cannot address all the aspects that influence and determine the health of individuals. Thus, intersectoriality returns to the debate as the primary strategy for dealing with problems and solutions from an integrated perspective. As shown by Franceschini[21], the intersectoral work approaches these determinants as a new proposal to work, govern, and build public policies in a logic of health promotion and improved quality of life of the population, and with the health sector becoming a key stakeholder in the mobilization of other sectors.

From this discussion, we can concretely bring public policies formulated and implemented with an intersectoral approach, that is, think of the logic of articulation with the health sector. The National Health Promotion Policy (PNPS) aims to provide quality of life and reduce vulnerabilities caused by social determinants[22]. Acting from the health promotion perspective aims precisely at encouraging the participation of other sectors and the community, advocating a commitment from several players[23]. Besides the PNSP, the School Health Program is an example of an intersectoral health-education policy, also providing for the participation of other sectors and stakeholders per the organization of each territory[24]. Finally, it is essential to implement public policies that also work centrally with populations marked by vulnerabilities and that, thus, approach the PNAISP concerning complex issues. In this sense, we mention the National Women's Healthcare Policy[25], the National Health Care Policy for Indigenous Peoples[26], the National Health Policy for Older Adults[27], and the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals[28], all public policies that need to transcend the health sector to account for the determinants that influence the health of their respective target audiences.

Deprivation of liberty and the National Comprehensive Health Care Policy for People Deprived of Liberty in the prison system

The prison-form existed even before it was formally established in the judiciary equipment

and used systematically in criminal laws. Along with this prison, not yet defined as a sentence par excellence, the punishment was a scene with punishment, torture, and public execution. Changes in criminal justice in the early 19th century replaced the spectacle of punishment with milder sufferings or a greater description of the art of making people suffer. Institutional transformations, explicit codes, and unified rules of procedure made the prison a fundamental part of the set of punishments. Thus, deprivation of liberty becomes the simple way to justify imprisonment[29].

The total nature of the closed institutions symbolizes a barrier to the social relationship with the outside world, where the exit is prohibited[4]. According to Goffman[30](p.11), the prison can be classified as a total institution, that is, "a place of residence and work where a large number of individuals with a similar situation, separated from the wider society for a considerable time, lead a closed and formally administered life". This is not a pure legal deprivation of liberty: the prison recodifies existence and becomes an exhaustive, uninterrupted, disciplinary apparatus without exterior and gap[29].

In Brazil, in the 19th century, prison predominated as a form of punishment based on a model of silence, solitude, and re-education through work. However, it is relevant to observe how the disciplinary practices of the Empire were related to the structure of the slave society[31]. When analyzing this relationship, Koerner[32] shows how a dual logic permeated the punishments, based on the individual's social condition or legal status, with aggravated penalties for slaves. Regarding São Paulo, Salla[33] discusses the great distance between the domain of laws – the formulation of legal devices in incarceration – and of ideas – the discourse that involved the subject of prison sentence among scholars and authorities – with the practices experienced in daily prison routine. The intention of the then Province to focus on correction and work stands out, in a setting of incarceration marked by substandard conditions, with unhealthy places and crowding[33], situations that persist today.

Data from the National Penitentiary Information Survey – INFOPEN 2019 – show that the most common pathologies in the penitentiary system are tuberculosis, HIV, hepatitis, and syphilis, all communicable diseases. In the case of tuberculosis, one of the most prevalent infectious diseases in prison, data from the Health Surveillance Guide[34] show that the PDL are 28 times more likely to fall ill from the disease than the general population.

PDL's right to health is found in the legislation. The Criminal Execution Law[35] ensures medical, pharmaceutical, and dental care for prisoners, and soon after, the Federal Constitution[36] reinforces respect for this population's physical and moral integrity. Moreover, the issue of health in the prison system also appears in international treaties to which Brazil is a signatory, such as the Universal Declaration of Human Rights and the UN Standard Minimum Rules for the Treatment of Prisoners.

The National Health Plan for the Penitentiary System (PNSSP) was launched in 2003 to organize the access of PDL to health services within the SUS. The National Comprehensive Health Policy for People Deprived of Liberty in the Prison System (PNAISP) was established in 2014 after evaluating and redesigning the PNSSP. The policy arises from the need to comply with the principles of universality and equity of the Unified Health System (SUS) concerning PDL. Thus, the general objective of the PNAISP is to ensure the access of PDL in the prison system to comprehensive care in the SUS[37].

Primary Care is the main gateway to the SUS for users and is PNAISP's guiding element. The care level includes actions such as promotion, protection, and maintenance of health, besides disease prevention[38]. By centrally including Primary Care, the PNAISP establishes that prison units become "gateways" and "point of care" so that the work process of health teams is organized by receiving the inflow of people into the prison system and systematizing the continuity of care[37].

The PNAISP provides that health within the penitentiary system is organized by prison primary care teams (EABP), which are responsible for qualifying primary care – health promotion, disease prevention, treatment, and follow-up – and performing territorial articulation – access to urgent and emergency services, specialized and hospital care in the extramural network, whenever there is a need for more complex care[37]. We understand the importance of intersectoral articulation, including professionals with whom health workers are not used to, such as prison agents and police, to implement the proposed actions in the territory.

The EABPs are multidisciplinary teams that can be organized into different compositions depending on criteria, such as the number of people in custody and their epidemiological profiles.

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Type I EABP must have at least a doctor, a nurse, a nursing technician or nursing assistant, a dental surgeon, and an oral health technician or assistant. Type II EABP consists of at least a doctor, a nurse, a nursing technician or assistant, a dental surgeon, an oral health technician or assistant, a psychologist, a social worker, and a higher education professional among the following occupations: physiotherapy, psychology, social assistance, pharmacy, occupational therapy, nutrition or nursing. Finally, Type III EABP has the same profile as Type II EABP, with the addition of a mental health team, which consists of a psychiatrist (or a doctor with mental health experience) and two professionals selected from among the following occupations: physiotherapy, psychology, social assistance, pharmacy, occupational therapy, or nursing[37].

The professionals who make up the EABP can be street-level bureaucrats, the bureaucrats responsible for implementing public policy – in this case, the PNAISP. Street-level bureaucracy acts directly with the policy user and becomes a State-citizen mediating agent[39]. The work of these professionals is influenced by political, economic, and institutional contexts and their references, which involve interests and ideological conceptions, for example[40]. By implementing public policies with their respective values, beliefs, and ideals, street-level bureaucrats transform how these policies were conceived[41]. In the prison system, a space still heavily permeated by prejudice, these individual references, which include moral issues and value judgments, can further influence the implementation of policies.

Returning to the PNAISP, all Federation Units adhered to the policy, and, concerning municipalization, following the SUS decentralization principle, 441 of the 927 municipalities with a prison unit in their territory adhered to the PNAISP[42]. Since it was established more than six years ago, it is challenging to find studies that aim to understand how the PNAISP implementation has occurred and its main challenges.

In 2019, 40% of prisons still did not have a doctor's office or multidisciplinary clinical care room. Mortality rates in prison systems, combined with endless numbers of PDL with infectious or transmissible diseases[1], show that there is still a long way to go for this population to access the SUS. The high numbers of contamination and death by COVID-19 within the prison system[43] may be the most current reflection of the challenges in implementing the PNAISP.

In São Paulo, data from the State Public Defender's Prison Situation Specialized Center[44] show that 77.28% of prison units in the state do not have a minimum health team. These data reflect how the State of São Paulo still disagrees with the PNAISP, which is relevant since it concentrates 31% of the country's prison population, with 231,287 PDL[1].

The Prison Health Coordination of the National Penitentiary Department (DEPEN) recognizes that the right to health of PDL is one of the most sensitive among the services implemented in the prison system precisely because of the substandard structural conditions of correctional facilities[42]. We should understand the inequalities that go hand in hand with the PDL besides the poor prison physical structure. Prison can be understood as a place where emotions, conflicts, constant contradictions, and, above all, inequalities prevail. According to Amis *et al.*[45], inequality is a multidimensional issue, and its profound knowledge presupposes understanding its presence in daily life and interactions between individuals.

Inequalities are materialized and problems are not isolated in the daily life of prisons. Recognizing their different dimensions and how they interact with each other challenges the implementation of intersectoral policies, as is the case of the PNAISP. Intersectoriality is one of the policy's general guidelines, along with four other guidelines: comprehensiveness, decentralization, hierarchization, and humanization.

Deprivation of liberty and difficulty in accessing health in prison as wicked problems

When it is defying to define a problem linearly, most likely due to its dynamics, multiple causes, and interrelationships with other problems, one can associate it with a wicked problem. The literature differentiates wicked problems from tame ones; the latter posed as complex problems but easier to define and, consequently, solved[46].

The following characteristics related to wicked problems stand out: they are complex problems to be defined; they have many interdependencies and multiple causes; they tend to be unstable problems; they do not have clear solutions; they are socially complex – which may include overlapping vulnerabilities –; they can hardly be the responsibility of a single sector and single governmental level; and their solutions involve behavioral changes. Furthermore, some wicked problems are also characterized

by a chronic failure of public policies and State action[47]. According to Cunill-Grau[15], these problems have conflicting political objectives and disagreement regarding appropriate solutions, which requires a more interactive and non-traditional approach.

The effects of wicked problems can hardly be solved, much less in simple and linear logic. It is possible, however, to mitigate these effects and their adverse consequences[46]. In this context, the importance of intersectoriality as a possible strategy for wicked problems is resumed.

Thus, based on what was stated in the section referring to deprivation of liberty and the characteristics of a wicked problem, we understand that prison and PDL's difficult access to health can be understood as wicked problems.

Final considerations

This essay aimed to discuss the National Comprehensive Health Care Policy for People Deprived of Liberty (PNAISP), articulating the concept of intersectoriality and giving rise to the idea of wicked problems. By understanding the professionals of the prison primary care teams as the bureaucrats responsible for the daily activities of the PNAISP and direct articulation with users – people deprived of liberty –, we reflected on the influence of their respective values, beliefs, and ideals in their work. Based on the literature and data, the section on deprivation of liberty showed how inequalities materialize in the daily life of prisons and how the problems are not isolated so that recognizing their different dimensions and how they interact with each other are challenges in implementing intersectoral policies, as is the case of the PNAISP. We should reflect on the possible impact of spaces still permeated by prejudice and inequalities, such as the prison system, on intersectoral articulation and, consequently, on policy implementation, reinforcing the wicked problem that involves access to health in prison.

Possible research agendas are indicated here, mainly regarding studies that aim to understand the PNAISP's implementation and its main challenges. From what was stated in this text, we understand the relevance of analyzing the intersectoral relationships in implementing the PNAISP, recognizing that this process can also be influenced by several factors that permeate the bureaucrats implementing the policy, in this case, the EABP professionals. We should analyze intersectoriality as dynamic interactions between users of the policy – PDL – and the implementers – prison primary care teams. Finally, we reinforce the contribution of these possible research agendas in producing data and knowledge about the prison system since these are still very scarce and fragmented. May research and analyses within this theme contribute to a better understanding of the setting and support public policies that affect prisons.

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