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Health promotion in primary care: effects and limitations in conservative neoliberalism

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Abstract *This article aims to understand and analyze the effects and limitations of Health Promotion in Primary Health Care (PHC). We conducted genealogical, qualitative research with 23 PHC workers. The analysis originated the following datasets: effects of Health Promotion practices performed in PHC and difficulties and limitations in conducting the practices. The results show that the main impact of Health Promotion is reducing medicalization and adopting Expanded Clinic elements in the care provided. The main difficulties arise from the poor public policies due to the fiscal austerity measures adopted in recent years. Strengthening the collective nature of health demands and their responses is a possibility of resisting in the face of the authoritarian neoliberal rationality currently prevailing in the Brazilian State.*

Key words *Health Promotion, Public Health, Primary Health Care, Genealogy, Neoliberalism*

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Introduction

In its Brazilian presentation, Health Promotion (HP) was established as a synthesis of the conceptual aspects of the movement that originated in Canada and Collective Health in Brazil in the 1970s[1]. Different practices emerged in HP, generating heterogeneous knowledge and actions.

At the same time, we can identify the adoption of different political strategies in HP practices, whose characteristics range from a so-called conservative stance to critical, radical, and libertarian perspectives. Thus, from a conservative perspective, HP would direct individuals to take responsibility for their health and, by doing so, reduce the financial burden on health care. Under the reformist mode, HP would be a strategy to create changes in the relationship between citizens and the State, emphasizing public policies and intersectoral action, or even be a libertarian perspective seeking deeper social changes[2].

Health Promotion in PHC follow the heterogeneous nature described above. Actions aimed at individual behavior changes and risk control coexist and hold a hegemonic position in this knowledge-power field, with practices aimed at improving the Social Determinants of Health (SDH). The latter, with less strength and expressiveness[3]. The SDH are factors in which life takes place, ranging from the most individual aspects, such as age and genetic factors, encompassing social and community relationships, public policies, and ultimately reaching the macro conditions of a country[4].

Strategies for governing the population have existed since the emergence of Nation States in the 15th century. Throughout history, they have been changing and becoming increasingly complex to enable the regulation of the population and the modulation of individual behavior to meet the needs of capitalism in its different phases. The set of techniques operated on the people was called biopolitics, and governmentality is its primary operating strategy from the 18th century[5].

The Brazilian re-democratization process, with the struggles for social rights in the 1980s, was anchored in a new political reason called democratic governmentality[6]. It was a historical period of promoting citizenship, evidencing democratic governmentality as machinery put in place legitimized by the 1988 Federal Constitution[7]. This rationality was accentuated in subsequent years with the Brazilian State's broad creation of public policies[6]. The technical, political, and legal bases of the Unified Health System (SUS) are built in this context. Health Promotion became a public policy in 2006, showing the different influences mentioned above in its text.

Authors[7,8] maintain that democratic governmentality is rooted in neoliberal rationality. While social rights are guaranteed for the population, the price paid for this guarantee lies in the need to be governed in a democratic regime. However, extreme competitiveness, solely individual responsibility for life issues, self-management, and self-exploration emerge precisely from the supposed freedom in this set of ideas.

Neoliberal rationality is defined not only as an economic doctrine but a normativity that can structure new governmental rationality, reaching all social relationships and dimensions of life[9,10]. It presupposes State regulation favoring the market (guaranteeing the best conditions for competition) and negligible investment in social policies[10].

This sedimented rationality, accompanied by economic crises, legitimized adopting fiscal austerity measures in different countries, especially in recent years. In Brazil, it is argued that a new political reason has been adopted as of 2016. The democratic neoliberal governmentality seems to have given way to a conservative neoliberal rationality[7,8], in which investing in social policies is reduced to the extreme, directly affecting SUS and its services. In this context, Health Promotion practices tend to be weakened in all settings in which they have a leading role, including PHC. Thus, we proposed research to understand and analyze the effects and limitations of Health Promotion practices in PHC.

Methods

We conducted qualitative, descriptive, exploratory, and genealogical field research in the PHC context of a municipality in south Brazil. Qualitative genealogical research identifies tensions, disputes, discourses, practices, and power relationships[11]. Research data were produced through semi-structured interviews with workers responsible for Health Promotion in twelve Health Units (HU), which correspond to 39 Family Health Strategy (ESF) teams and five Family Health Support Centers (NASF). Such Health Units care for approximately one hundred thousand SUS clients. The professional centers (and respective number) of the participants were: Social Service (06), Nursing (05), Psychology (04), Community Health Worker (03), Medicine (02),

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Dentistry (02), Nutrition (01), totaling 23 participants. The interviews were held from February to May 2020.

The workers invited to participate in the research were selected by the "snowball" method, characterized by establishing a non-probabilistic sample using reference chains. Sampling started by contacting key informants, named "seeds", to locate some people with the necessary profile for the research within the participating teams[12]. This procedure was performed to map the workers directly involved with Health Promotion practices. Thus, the key informants (or seeds) participated in the survey by responding to it and provided new contacts with the potential to participate. The interviews ended when Health Promotion practices and narratives repeated themselves, indicating the saturation point, as predicted by the "snowball" strategy[12]. The interviews were audio-recorded and transcribed. Moreover, a field diary was used, which contained the impressions of the researcher who conducted the interviews.

Data qualitative analysis consisted of the following steps: reading the transcribed interviews and describing and analyzing the effects, difficulties, and limitations related to Health Promotion in the research setting. Empirical data were analyzed from the Health Promotion theoretical framework and some Foucauldian tools-concepts. Following the research's genealogical perspective, we aimed to contextualize the study's findings in a chain of historical events and their discontinuities, which enabled the current configuration of the researched setting and presupposed an analysis displacement, encompassing local and more general aspects that influence the composition of the knowledge-power field in the researched background. We also aimed to describe research findings that escape the hegemonic Health Promotion discourses that may suggest methodological, technical-political, and practical possibilities for this field.

This article presents the partial results of the research carried out for the construction of a Doctoral Thesis at the Nursing Graduate Program of the Federal University of Rio Grande do Sul. Data were organized into two sets: effects of Health Promotion practices conducted in PHC; and difficulties and limitations of running Health Promotion practices in PHC. Research participants were identified with codenames, which refer to artistic expressions chosen by themselves at the time of the interviews, to preserve anonymity.

The ethical procedures recommended for Brazilian human studies were observed[13] throughout the study. The Research Ethics Committees of the Federal University of Rio Grande do Sul and the Conceição Hospital Group approved the research under CAAE numbers 16078319.7.0000.5347 and 16078319.7.3001.5530, respectively.

Results

Effects of Health Promotion in PHC

The following effects were identified as a product of Health Promotion (HP) in the researched setting from the respondents' report: partial change of habits; user empowerment; socialization and establishment of support networks; improved quality of life and lower medicalization; comprehensive health care; and income generation.

One of HP's central dimensions is educational practices to change individual habits and behaviors. We found the following reports in the research setting, which refer to educational activities aimed at changing eating habits, sedentary lifestyle, and the proper use of medications:

We realized that people don't change their habits. They report that it is difficult to change because these are cultural things. They must have soft drinks to receive the grandchildren. You have to offer a cupcake when visiting neighbors. So, even having understood the relationships between food and health, they continue with the same habits (Pintura).

Participants in this activity are selected from a list of clients with decompensated Hypertension or Diabetes Mellitus. Although participation in the activity is not mandatory, the health team encourages them to participate. Many even show interest in engaging because of the possibility of interacting and meeting (with the team and neighbors), but only in a genuine desire to change their way of life.

Below is another report of activity aimed at changing eating habits:

We measured [the results] on some occasions. We observed when asking whether they had changed some habits. All had changed at least one habit […] such as drinking more water, eating more vegetables, or stopping eating heavy meals… (Música).

The factor that seems to interfere with the outcome of the practices described above is the objective and motivation of the participants regarding the activity. In the first, clients are unwilling to change their habits, or their life context

is not favorable for this. Moreover, approaches centered on achieving goals established by health protocols may be very distant from these people's life trajectories. Establishing the notion of what will or will not be a risk/threat for someone depends on more than what experts determine with studies and evidence. People build their habits from different influences, which operate in the subjective field and the material aspects of life. In other words, adopting a habit is independent of access to health information. It is complex and conditioned by social, cultural, psychological, and economic factors[14].

In the second report, the activity is performed with people who spontaneously seek space; they understood that it would be time to change some habits. The approach adopted considers people's life context and the possibilities for change. Not all habits are expected to be modified, but something ends up being changed and improves health under a singular construction, considering the individual possibilities. This perspective aligns with the Expanded Clinic, a strategy found in the Collective Health framework. In this strategy, subjects in the care relationship gain centrality with their underlying individual aspects, whether subjective or objective factors. This approach enables the care relationship to produce results under shared care plans built from the clients' desires and possibilities[1].

Regarding empowerment, we can identify an example of how it can be made in the report referring to the group of pregnant women:

Women are strengthened for issues related to their "delivery" [sic]; they become more attentive to the onset of labor signs and breastfeeding issues in baby care. With access to this information, women and their families are more empowered to question biomedical behaviors that often disrupt the birth process through normal delivery and breastfeeding (Ovelha, our emphasis).

Empowerment underlies the Health Promotion theoretical-methodological framework. It is widely disseminated in its field of action and has multiple meanings[1]. Attention is paid to using this concept as a strategy to delegate responsibility for individual care to clients, as they are "taught" care methods through the transfer of information. The informed choice that occurs from the premise that subjects can decide about their health per their desires and priorities can be understood from the neo-subject notion, according to which free choice is not an option but a rule of conduct in neoliberal ideas. By being free to choose according to their will, people assume to the same extent all responsibility for that choice[10]. On the other hand, empowerment can be established as a tool to produce effects that go against neoliberal rationality. As information is shared in health services, which allows questioning established practices and guarantees the rights (as in the case of pregnant women, the choice of childbirth, refusal of invasive procedures, and the presence of a companion), empowerment takes on another meaning, inscribed in historical feminist struggles. A good question to assess the effects of empowerment and the direction in which it is being operated is to identify how much such effects impact the correlation of forces in the existing power relationships in health services, changing outcomes in the decisions taken in these relationships.

Socialization and the establishment of support networks can be identified in the report of the interactive group, which exists in almost all HU surveyed:

We are constantly referring older adults to the group because their lives improve; they are less sad, manage to communicate, and make new friends after losing loved ones. Thus, they need to have other relationships and build new networks (Criatividade).

Another effect of Health Promotion was generating income through the production of handicrafts in the interactive group:

They meet other people here and create bonds. They go on trips that they would not be able to do with their income with the money generated by the handicraft produced (Artecriativa).

The constitution of community support networks is a Health Promotion[15] operational framework strategy. The organization of spaces that promote the construction of support ties indicates that such health work identifies and transforms the vulnerabilities of residents into motivation for developing and strengthening individual and group potential[16]. Again, attention is paid to the risks of neoliberal rationality attacking such spaces to the extent that governments and health services may consider them replacements for social protection policies to provide primary conditions of life; in other words, community support and solidary relationships are beneficial and necessary for maintaining health. However, they do not relieve the State of its responsibility to provide public policies to create environments conducive to health.

The improved quality of life – and the consequent declining medicalization – were identified in reports referring to Integrative and Complementary Health Practices (PICS):

Meditation offers a quality of life. We have reports of people who felt less pain and started to use less medication after meditating (Pérola).

A study points out that using PICS can strengthen and weaken medicalization in health according to the practices used and the professional or worker operating such activity. However, in PHC, the authors maintain that using PICS leads to lower life medicalization[17], promoting health and quality of life.

On the other hand, comprehensive care is produced from an expanded view of health, which can be identified both in the Children's Group, which seeks to promote health without medicalization, and in the activities of the Health at School Program, which reach other dimensions of life than just illness, such as learning, through intersectoral partnerships, for example:

We followed the children through the group and identified situations that needed early intervention. Intervening in situations that can generate trauma in the child is something crucial. We work in partnership with the school, which helps in these situations (Mandala).

When we can follow up on the demands, PSE actions impact the child's learning possibility. The learning process will be favored when we identify a visual acuity problem, and that child can access the glasses (Cinema).

The expanded concept of health, comprehensive care, and intersectoriality are the underlying HP assumptions of its operationalization strategies[15]. Coordinated actions between different public administration sectors, in which the demands generated are provided for, can positively affect people's lives, offering a comprehensive approach by the health sector, provided that they can meet the identified needs.

Difficulties and limitations for conducting Health Promotion in PHC

The difficulties and constraints reported by the respondents regarding conducting HP in PHC refer to changes in the care model and lack of legitimization/prioritization of the HP in the PHC teams' work process; poor public policies; lack of infrastructure and physical space; lack of user participation in activities; complex dialogue and articulation with other sectors; and territory violence.

Changes in the care model and the lack of legitimization/prioritization of HP in the PHC teams' work process are pointed out in the following reports:

The lack of 100% coverage of PHC teams in the city limits us because we identify demands with the PSE actions that end up not being followed up because the student does not have a reference Health Unit (Cinema).

Loss of the care model based on the Family and Community Health model. We have the loss of the ACS who worked with this articulation between the team and the community. Hence the importance of reviving the [Local Health] Council as a place of defense for the Health Unit itself (Capoeira).

The Family Health Strategy (ESF) model was elected in the first editions of the National Primary Care Policy (PNAB)[18] as a priority strategy for the organization of PHC in Brazil. Initially, adopting this model was strongly induced in the municipalities. After the publication of the PNAB in 2011[19], the Ministry of Health increased financial incentives for expanding and qualifying the number of ESF teams. Moreover, other strategies were made available to the municipalities, such as the *Requalifica UBS* (PHC Unit) program to improve the physical structure of the Health Units; the health gyms program to create physical activity spaces close to the HUs, and under the coordination of the Family Health Support Centers (NASF), which are also a PHC qualification strategy in the country since 2008[20]. Furthermore, we highlight the teams' territorial linkage and the Community Health Workers' (ACS) linkage to a specific number of clients/households in that territory.

The care model used in the ESF should prioritize health promotion, prevention, and rehabilitation actions, focusing on promotion in the teams' work process. The performance in the territories and the link provided by the ACS work organized the teams' actions according to community needs. Moreover, it allowed debating these issues in the territories, seeking a collective confrontation of the problems and holding the State accountable.

However, we observed a massive weakening of the State's role in conducting public health policies and the emergence of a conservative or authoritarian neoliberalism[8] in recent years, which has led to adopting fiscal austerity measures, which, by withdrawing public investments from the social area, reduce its capacity to act. The reflection of such measures can be seen in the publication of the 2017 PNAB, in which aspects such as the team territorial binding, the number of ACS, and the financing of services are more relaxed[21]. Furthermore, the non-accreditation of

new NASF teams also limited the work of PHC teams, especially regarding Health Promotion practices.

The NASF teams are staffed by professionals who are not part of the minimum ESF team (namely, Medicine, Nursing, and Community Health Workers). Their work is based on the principles of matrix support and Continuing Education. These teams' support to the ESF teams has a significant pedagogical dimension. It expands the scope of the ESF's activities, including Health Promotion, along with the territories for which they share the responsibility. We emphasize that the setting in which the research was conducted still has active NASF teams. Most workers interviewed are NASF members and responsible for most reported HP actions. Another professional center responsible for driving many HP actions is the ACS. Thus, we can relate the weakened NASF teams and the lower number of ACS in the teams to declining and disqualified HP actions in the territories where such measures are being adopted. This situation tends to be generalized in the country since the primary way of maintaining these services depends on the funding offered by the federal and state governments[21].

Another aspect pointed out as a difficulty refers to the secondary space occupied by Health Promotion in the organization of the teams' work process:

Care activities have a protected space. Things could be more spontaneous for others, such as Health Promotion and Health Education. They remain in this limbo of "if I have time, I'll do it"; "if I feel like it, I'll do it". This situation overloads workers because you must always convince yourself it is essential (Dança, emphasis in the original statement).

We identified the marginal place of Health Promotion actions in the teams' daily work. Care activities have well-established routines and institutional guidelines, including goals and indicators. Prevention occurs more frequently and is intended to prevent specific diseases and conditions. On the other hand, Health Promotion demands more comprehensive actions, requiring workers' time availability and participant involvement. HP has less and less space regarding care activities with the changes in the care model adopted.

Other precarious intersectoral policies directly related to health besides the poor public health policies also weaken the actions that can achieve the SDH:

The weakened network of services, health, social assistance, and education in the territory limits the possibilities of thinking comprehensively about the territory and the possibilities of producing practices and meanings in Health Promotion. When we must look at the most urgent, we cannot do Health Promotion. We stay in the line of treatment (Bacurau).

Fiscal austerity measures, legitimized by Constitutional Amendment No. 95[22] in 2016, already show the signs of the devastation of the Brazilian social protection standard. The effects so far observed in the short time reflect a disastrous downgrading of the living conditions of Brazilian citizens, nullifying historical achievements[23]. In health, dismantling the Unified Social Assistance System (SUAS) affects the full approach to situations identified in the territories and the reach of HP. Consisting of intersectoral policies, including SUAS policies, the Social Protection Network is essential to expand the approach of the care provided by health teams in the territories to achieve the SDH minimally and, thus, produce comprehensive care. This fact can be exemplified by the weakened Reference Social Assistance Centers (CRAS) in the researched teams' operational territories due to the substandard work bonds of professionals working in these spaces, the lack of minimum working conditions (telephone line and internet, for example), and the few possibilities to offer inclusive policies for the population served.

Also, besides the difficulties, limitations regarding the physical space to perform the activities were reported in almost all US:

Our main difficulty is the physical space. The group had to be interrupted because we needed somewhere to do it. Now we get a community space to do the activity (Pérola).

This limitation is inscribed in the poor health services, whose physical structure would need renovations and investments to expand and improve ambiance. Along the same line, public spaces also have weaknesses:

We have a space issue to do the activity. We usually walk in the neighborhood's squares. Some have an irregular surface, which is terrible. We also have the safety issue. We are afraid of robberies (Movimento).

The team and the community endeavor to solve issues that would be the responsibility of the Public Administration. Accompanying neoliberal rationality, the State exempts itself from its obligations and delegates to health workers and clients the search for alternatives, according to their possibilities, which is not always the most appropriate and safe[23].

The lack of participation in the activities was also pointed out as a limitation.

The most significant difficulty is participation. Making people participate in a group to change lifestyles (Música).

The problem is getting people [to participate]. Some people always go, but they are few. We do not give due value to social participation spaces (Teatro).

Poor participation in health promotion spaces can also be understood as a reflection of the expanded neoliberal rationality that, as we described earlier, builds subjectivities that people need to face their problems alone, without identifying their collective dimension[1,10].

Another hardship refers to the realization of intersectoral actions:

Sometimes it is difficult to get a good articulation with the school. Be able to sit together and plan activities in a shared way. It seems we cannot have the same goals and give the same importance to the activity (Nataraja).

In intersectoral action, the lack of communication and the discontinuous articulations between the stakeholders and sectors are pointed out as the most fragile aspects of intersectoral action. Planning inconsistent actions with the population's health needs can lead to overlapping actions in the territory and limit the reach of interventions. On the other hand, intersectoral initiatives were broader when defined as an integrated policy of the municipal government for the construction of interfaces and cooperation between the several sectors[24].

Finally, the issue of violence in territories is a significant difficulty, as it affects both workers and residents:

We were robbed, leaving the group. We were driving, with the computer, cell phone… They took everything! After that, we decided not to carry our resources with us. So, the teachers lent us their resources (Dança).

In the community, we have difficulties regarding parallel power and trafficking. People are afraid to meet and expose themselves (Capoeira).

The violence in the PHC territories can also be understood as a product of the strong onslaught of neoliberal rationality about these places. Abandoned by the State, the most impoverished territories are occupied by parallel power, which imposes its operational rules. The population residing in the communities is left to accept such rules, considering the danger of breaking them up. Likewise, regarding the violence suffered by team workers, the precariousness deriving from the current economic logic can be a predominant factor. By using their resources, such as computers, cars, and mobiles, to enable activities, teams become easy targets and suffer losses, they assume, not to mention the harmful psychological effects for these people.

It is necessary to qualify the qualitative and quantitative characterization of armed violence and its consequences based on an intersectoral approach with broad community participation to seek coherent and significant responses. It is also necessary to ensure professionals' protection, safety, and working conditions so that health services are continuously in place in the spaces and supported by the State[25]. Besides these emergency measures, such issues should be debated with the State so that public security measures are implemented, with adequate public policies within the communities, offering opportunities for their members.

Discussion

According to the results, health promotion practices' main effect is reducing medicalization and adopting Expanded Clinic elements in the care provided. We can infer that this outcome is inscribed from the perspective of democratic neoliberal governmentality[5,6], whose main feature is establishing public policies to modulate behaviors, make people live, and, more than that, live under specific parameters so that the capitalist system finds the conditions to develop itself. This description meets the concept of biopolitics[5] used by Foucault to maintain that Western societies have built strategies to enable the advances of capitalism through life and, more specifically, by modulating behaviors (governmentality) throughout history[5].

The results indicate that the main difficulties for HP actions in PHC originate from the poor public policies due to the fiscal austerity measures adopted in recent years. This finding meets the idea of authoritarian neoliberal governmentality[6], developed by Silvio Gallo from the governmentality described by Foucault[5]. Thus, public policies, among them health, are weakened when adopting fiscal austerity measures, dramatically reducing investments in the public arena, leaving extremely vulnerable populations without coverage of health services, so that in many situations, especially in the COVID-19 pandemic, it meant the death of thousands of people. This State reason, called conservative neoliberal

governmentality, aligns with the notion of necropolitics[26], which, unlike biopolitics[5], comprises a set of strategies that operate to cause the death of specific undesirable population groups in the most conservative societies and where capitalism achieves its extreme characteristics of capital supremacy vis-à-vis any life form.

Also, from the perspective of Foucauldian analyses, we find resistance and counter-conduct[5] where there is power. If we can say that, in the researched setting, we see the product of the performance of public policies inscribed in a democratic neoliberal governmentality[6], in this same field, some practices escape this governmentality, expressing the tensions resulting from the actions inscribed in governmentality and those that stand as resistance and counter-conduct. The latter can be described as the actions that tension the biomedical model. We also find practices that tension conservative neoliberal governmentality, which encourages collectivized health demands and seek to debate issues involving the SDH, explaining the importance of preserving and expanding the Unified Health System as a state public policy and other intersectoral public policies that directly affect people's lives.

Final considerations

HP practices reported in the researched setting have their most significant effect as resistance to medicalization processes. They oppose the medicalizing trend that reinforces industry and the health market. However, they fail to reach the SDH due to weakened intersectoral public policies, evidenced by the escalating fiscal austerity measures in Brazil, especially in recent years.

The analyses of this research point out that health promotion assumes a heterogeneous nature, which characterizes it with conceptual polysemy and the multiple practices performed in the studied setting. Some align themselves with the aspect of the behavioral approach found in the oldest and more conservative health promotion currents. Other practices assume the nature of resistance and counter-conduct against the perspective of the absolute medicalization of life and propose expanding the clinic to promote different ways of life. The latter are inscribed and find their technical-operational basis in Brazilian public health, which has an intrinsic relationship with the struggles the Brazilian health movement waged in establishing the SUS.

Structured HP strategies at the macro level and identified in the research setting are characterized and reach the two HP strands described above, the behavioral and the reformist. One focused on changing individual habits and behaviors, and the other proposed structuring public policies favorable to establishing healthy living environments. Although we find, in the discourse of groups and collectivities organized in Collective Health, the identification and desire that significant structural changes in Brazilian society will be operated as imperative for people to have a life of better quality effectively and that this is permanent, without being at the mercy of the government change and economic instability influences, we could not find any historical accounts that point to any investment in this regard, at least in recent decades. At the local level, we see this same setting, perhaps even more fragile, because the reach of health promotion actions identified in the research has a little collective impact. Reviving the collective nature of health demands and the possibilities of real achievements for communities is a possibility to resist neoliberal rationality, which imposes competitiveness, blame, and individual responsibility.

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Collaborations

FC Mattioni and CMF Rocha worked on the design of the study and the preparation, elaboration, and review of the manuscript.

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