Discourses and polarities concerning health promotion in the Brazilian health system

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Kind L, Ferreira-Neto JL.
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Salud Publica Mex 2013;55:427-432.

Abstract

This paper presents theoretical reflections on health promotion in the Brazilian public health context. Some characteristics and problems of the international debate are highlighted, but our focus is the position of health promotion as it is discussed in the Brazilian health system. We follow the foucauldian perspective of biopower and resistence to discuss the selected texts and documents related to health promotion that were considered relevant for the purpose of this investigation. Health promotion is discussed as a field of discourses, practices, knowledge production and power. We concentrate our analysis on the debate proposed by collective health researchers on the repercussions of the Lalonde Report in the international Health Promotion Charts, and on the connexion between health promotion and the Brazilian health system. The discussion demonstrates that health promotion work requires constant attention and significant effort from managers, technicians, and health system users, and that each step forward reveals new challenges and calls for new actions.

Key words: Health promotion; power; collective health; Unified Health System; Brazil

Kind L, Ferreira-Neto JL.
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Resumen

Este artículo presenta reflexiones teóricas sobre la promoción de la salud en el contexto de la salud pública brasileña. Se destacan algunas de las características y problemas del debate internacional, pero el enfoque se centra en la posición de promoción de la salud tal como se discute en el sistema de salud brasileño. Se sigue la perspectiva foucaultiana del biopoder y la resistencia al discutir los textos y documentos relacionados con la promoción de la salud que fueron considerados relevantes para esta investigación. Se discute la promoción de la salud como un campo de discursos, prácticas, producción de conocimiento y poder. El análisis se concentra en el debate propuesto por los investigadores de salud colectiva sobre las repercusiones del Informe Lalonde en las cartas internacionales de promoción de la salud y en la relación entre ellas y el sistema de salud brasileño. Se concluye que el trabajo de promoción de la salud requiere de una atención constante y un esfuerzo significativo de gestores, técnicos y usuarios del sistema de salud. Cada paso adelante revela nuevos retos y pide nuevas acciones.

Palabras clave: promoción de la salud; poder; salud pública; Sistema Único de Salud; Brasil

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Received on: June 11, 2012 • **Accepted on:** March 13, 2013
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Brazilian health field has been modified by health promotion policies and related debates. On the 1970s, the basis for a health reform in Brazil were established by a set of political, social and institutional processes that culminated in the idealization of the Brazilian National Health Care System, the *Sistema Único de Saúde*, widely known by its acronym, SUS. According to Stralen,[1] one of the most remarkable effects of the Brazilian sanitary movement was the configuration of a new knowledge field, named "collective health".

The ideological basis of the collective health field are summarized by Pego e Almeida,[2] who describe it as a confluence point of distinct areas and objects of knowledge that had created an opposition to biomedical hegemony in public health. The authors affirm that an academic group from the Medical College at the Universidad Nacional Autónoma de México (UNAM) –that afterwards were consolidated with the creation of Preventive Medicine Department at Universidad Autónoma Metropolitana, Xochimilco–, had connections with Brazilian sanitarists involved with the critic of the medical centered model for public health, standing for a theoretical perspective that included social determinants for the understanding of health-disease problems.

In the late 1980's, both, sanitary movement and the collective health field started to analyze health as a social production, determined by the living conditions of the population. Established as a proposition during the 8th National Health Conference, the SUS was approved in Brazilian National Constituent Assembly, and health was preconized in National Constitution of 1988 as a "right of all and a duty of the State". The Law 1.080 legitimated the new health system, in 1990.[3]

With this historical background, health promotion ideas have evident synergy with the implantation of the SUS, although it took two decades to the approval of the Brazilian National Health Promotion Policy, in 2006.[4] However, health promotion was previously a subject of academic discussion in Brazil.[5-7] Some authors sustain that health promotion has a twofold dimension.[7,8] Political evaluation of health promotion proposals presents two main points. The first one have a progressive inflexion, considering that the new health promotion project "represents an effort of updating commitments to common welfare, social equity, and democratic principles of the public health 'tradition'".[8] The second point considers that health promotion discussions reflect neo-liberal, individualistic views, focused on regulation and supervision.

It is not our goal to provide a connection between these positions highlighted in health promotion debates. Our analysis intends to transform the dichotomy mentioned by the authors[7-9] into bipolarity, understanding that this field has no substantial character, but it is rather marked by polarities of forces and tensions. We consider health promotion as a field of discourses and practices, of knowledge and power, simultaneously intersected by regulatory and disciplinary dimensions as well as by participative and emancipatory ones. We argue that analysing health promotion field based on dichotomised categories – such as clinical versus political, psychological versus communitarian aspects, individual versus collective instances, and regulation versus autonomy –, can obscure an accurate comprehension of what happens in current health promotion practices.

This paper presents theoretical reflections on health promotion in the Brazilian public health context. It is a part of a study on group practices as a health intervention strategy, and its empirical data is widely discussed by Ferreira Neto and Kind.[10] Some characteristics and problems of the international debate are highlighted, but our focus is the position of health promotion as it is discussed in the Brazilian health system. We follow the foucauldian perspective of biopower and resistance to discuss the selected texts and documents related to health promotion that were considered relevant to this investigation.

As Foucault defines it, discourse is "a good which puts, from its very existence, the question of power, a good which is, by nature, the goal of a fight, and of a political struggle".[11] Exploring health promotion as a set of discourses and practices can indicate the liberating possibilities of health promotion proposals, remembering these processes are often hard to separate. Considering the health promotion field as marked by polarities of unpredictable forces and tensions, we believe in the importance of analyzing the diverse forms health promotion practices have been taking in the Brazilian health system.

Biopower: assuming life as a political object

On his discussions about biopower, Foucault describes a transformation that had happened by the end of XVIIth century, in which the right of the sovereign to kill has been replaced by a power that generates and orders life. In his words, "the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death".[12] This power over life, called biopower, was developed during the XVIIth and the XVIIIth centuries and had two distinct bases: the first referred to a political anatomy of individual bodies, and the second marked by the biopolitical regulation of

population (the measurement of birth and death rates, health, demography, and wealth income).

In his article *The birth of social medicine*,[11] the notion of biopolitics was initially constructed as a strategy. The public health control of XVIIIth century European medicine was defined by its biopolitical goals. Foucault further developed this idea when he discussed biopower.[12,13] He noted the emergence of a medical approach at end of the XVIIth century which had as public health as its major function "with coordination agencies for medical treatments, centralised information, standardized knowledge, and which gained the appearance of a health campaign and medication for the population".[13] In his analysis, Foucault concludes that different contexts produced different domination techniques through the knowledge and power related to them.

However, life management through domination techniques does not occur completely; life "constantly escapes them".[13] The forces which resist will be supported by what the power invests: life, understood as fundamental needs (including the body, health, and happiness).

The concept of resistance has a long trajectory in the work of Foucault, in his constant worry in highlighting places of confrontation in domination practices. In *History of Sexuality I* Foucault says: "[where] there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power".[14] Some authors had analyzed foucauldian notion of resistance, indicating the main criticisms it had received.[15,16] Muckelbauer[16] claims that resistance, in foucauldian terms, does not relate to a free subject versus specific technologies of repressive power. Put differently, resistance implies "specific deployments of power versus other deployments (…) [it] is simply the convergence of multiple and conflicting powers".[16] In the book *History of Sexuality II*, resistance appears as a matter of liberty / autonomy / invention from the idea of "the arts of existence".[17]

Although the view of Foucault is occasionally seen as a theory of confinement, of power and domination relations, freedom has been strongly presented in the last few years of his work. Freedom resides in the bet that historically constituted experience is not under the commands of necessary determination, but of contingence. His analyses are put against an "idea of universal necessities in human existence (…) that accentuate the arbitrary character of institutions and show us which space of liberty we still maintain".[18] As a result, freedom is defined as an ethico-political practice of inventing new ways of subjecting and new forms of coexistence.

Health promotion: elements of the international debate

The contemporary debate on health promotion emerged in the 1970s from the Lalonde Report.[5,9] The document defined the health field importance in relation to four points: human biology, (natural and social) environment, lifestyle, and health assistance organization. The initially pluralistic analysis of the Report ended by generating actions centred on changing lifestyle and producing a *blaming the victims* process, with consequent depoliticising of the problem. Through unilateral emphasis on lifestyles, the state establishes processes with broader socio-political reach to the individual level. That fact generated great criticism from scholars and researchers.[19-21]

Discussing the direction of biopower in health and medical jurisdiction beyond simply treating illness, Rose[22] warned about a movement "to the management of chronic illness and death, the administration of reproduction, the assessment and government of 'risk,' and maintenance and improvement of the healthy body". By the end of the XXth century, biopolitics focus is less on the illness and more on our abilities to manage, remodel, and modulate vital capacities of the people, to promote a "policy of life itself". This process accentuates health promotion, according to the author, that argues:

> "[We] have seen an intensification and generalization of the health-promotion strategies developed in twentieth century. […] Every citizen must now become an active partner in the drive for health, accepting their responsibility for securing their own well-being".[22]

Self-care appears as a disciplinary element increasingly emphasized both in public health programs and private health guidelines. "Lose weight", "avoid fat food", "stop smoking", "practice safe sex", and "exercise regularly" are some of the orders that fill our daily lives and go beyond health promotion policies, almost as an inheritance from the Lalonde report with its emphasis on healthy lifestyle, moving from the sick body to the "body species" of everyone.

However, Rose notes that calling for individual responsibility of health cannot be calculated only as an act of blaming and depoliticizing individuals. This new emphasis also brings a new "choice, prudence, and responsibility, to experimentation, to contestation",[22] an area of logic which presents new polarities of power and resistance.

Another point of view is provided by Kickbusch and Payne.[23] They point out that the early debates

on health promotion neglected the trend of Western societies of privatizing health promotion. A "wellness revolution" took place during the last three decades along with the movements of health education and health promotion. Led by the private sector, in recent days such revolution is followed by an explosion of different media – TV, press, internet, books and so on –, that reveals the function of health promotion "as a product in a growing private market of a health goods and services".[23] Therefore, in contexts where there is contrast in population's access to healthcare market, healthy individuals become healthier, leaving those who do not have purchasing power to their fate.

In another paper Kickbusch[24] suggests that the fundamental discussion is no longer the medicalization, but "the debate envolves around privatization and comercialization, *empowerment* e participation, social inclusion and exclusion, public and privation". The inflection of contemporary biopolitics calls for new forms of resistance that strengthen health management in the field of social rights, and problematizes the omnipresence of the always-engaging private enterprise.

In addition to the criticism highlighting lifestyle, another element attacked in the Lalonde report was advocating a group of interventions involving issues such as tobacco addiction, alcoholism, drug use, physical and leisure exercises, and eating habits, thus creating a universal conduct pattern, producing a "new collective morality". [21]

The first International Health Promotion Conference in Ottawa in 1986 also tried to balance the focus of individualist promotion by highlighting community elements and offering the following definition: "Health Promotion is the process of enabling people to increase control over, and to improve, their health".[25] As Carvalho[20] has noted, this conference curiously had little user and community group participation, being "sponsored above all, by State techno-bureaucracy, health professionals, health leaders and academics". This is one of the most problematic elements in health promotion political analysis. On one hand, its discussion seems similar to other social movements whose rhetoric challenges State regulation. On the other hand, its origins reside in the government public health management "rather than directly challenging the state" like the other social movements.[21] We can then understand that the idealized bearer of emancipatory intentions alone does not assert an unequivocally liberating character to health promotion practices. Since the set of social forces is diverse, the well-intentioned correction and interpretation of the Health Promotion Charts does not guarantee an ethical-political direction of actions performed in its name. Health promotion as public policy stands on a dangerous ground. If it must guarantee State regulatory function in its health system management, it must also allow and encourage spaces and actions of individual and collective autonomy and empowerment. This is the ongoing effort of building health promotion politics in a country whose health system was managed at the height of academic and popular social movements.

Health Promotion and the Brazilian National Health System (SUS)

The Brazilian National Health System (SUS) originated from a confluence of social movements that emerged in the second half of the 1970s during the Brazilian military regime. After two decades of military regime, political transition to democracy began in Brazil. It was a long process, as observed by Stralen,[1] with wide participation of organised civil society. In health sector, a complex network of social and institutional actors created de conditions of possibility to the emergence of Brazilian Health Care Reform and the movement of public health specialists known as sanitary movement. A variety of events and different political forces took place in health arena preceding and alongside Brazilian democratization processes. Identification of all of those social and institutional actors, events and political forces is outside this paper's scope. Nevertheless, during those years the idea of health as a right of all citizens was engendered within public health apparatuses, forcing its inclusion on the constitutional text on the late 1980's.

The Brazilian health system is a product of redemocratising the country, affirming itself as a health project of its citizens and not just as simple social service assistance. The complex system "has the responsibility to articulate and coordinate promotional and preventive actions, such as cure and rehabilitation".[26] The Brazilian National Health System organizes and regulates public and private institutions on municipal, state, and federal levels, and is based on organizational commands and principles. It is based on the principles of *universality*, which guarantees health access to all citizens, *integration*, which presumes continued assistance to individuals and groups, and *equity*, which considers the priorities and evaluates social inequalities when offering actions.

Pasche and Hennington[27] assert that the history, movement, and founding points of SUS in Brazil, and those belonging to health promotion are connected. They affirm that the arrival of health promotion in Brazil coincided with the movement to reorganize the national health system. Later, with the consolidation of SUS, the emergence of promotion would occur "in a critical

context of the health field *status quo*, presenting itself as a strategy to transform the health services, practices, and guidelines".

We somehow find similarities and differences between health promotion proposals and the construction of SUS. Castro and Malo[28] consider that "SUS and the International Health Promotion Movement have synergic principles". We can notice this approximation from the planning of the key Brazilian Health Reform event, the 1986 8th National Health Conference, at the summit of political and ideological health reform project planning. Nevertheless, the event organization and participation marked the beginning of Brazilian Reform: popular participation from various groups of society. While the previous conferences were more related to State bureaucracy and interest groups, the 8th Conference was preceded by ample discussions in state and municipal conferences with four thousand delegates "of almost all social forces interested in health issues" bringing "the emergence of new political subjects, freedom to dissent and government of the citizens".[29] In addition, it presented a dimension of resistance for both the present biomedical and private health models as well as the authoritarian and exclusionary organization of Brazilian society. Foucault thought that life seen as an object of biopolitical management would support the forces of resistance. As a result, life became the object of political struggles of XXth century social movements: "the right to life, to one's body, to happiness, to satisfaction of needs [...] was the political response to all these new procedures of power".[11]

The 8th Conference deliberations have some similarities to International Health Promotion Conferences. First, health is defined as a social production

> "[…] resulting from the conditions of food, habitation, education, income, environment, work, transportation, employment, leisure, liberty, access and ownership of land, and access to health services. Above all, it is the result of social organization forms of production which can generate major inequalities in levels of life".[30]

This definition clearly emphasizes the importance of social environmental aspects and services organization at the loss of more individual, biological, and lifestyle aspects mentioned in the 1974 Lalonde report. The context of socio-political transformation in the country was undoubtedly a relevant factor.

It is important to emphasize that unlike the international Health Promotion Charts, the 1986 Proceedings of the 8th National Health Conference,[30] the 1988 constitutional text,[31] and the 1990 law number 8 080,[3] were the results of highly participative and plural social processes, fruits of broad social consensus.

The state-independent social movements in the 1970s suffered a reflux in the following decade and became institutionalised through participative councils and non-governmental organizations (NGO) in managing public policies in partnership with the State. Furthermore, with the advent of the New Republic, numerous health movement leaders began occupying federal, state, and city health management positions. Unlike the beginning of the health reform, the current scenario has its own formal legal base and institutionalised administration.

In the course of institutionalised actions, the Health Ministry approved the National Health Promotion Policy in March 2006, with the goal of "promoting quality of life and reducing vulnerability and health risks, related to determinants and constraints; ways of living, work conditions, habitation, environment, education, leisure, culture, access to essential goods and services".[4] The policy reaffirms the precepts of the Ottawa Charter, and highlights that "health promotion occurs in the articulation of individual/collective, public/private, state/society, clinic/political, health/other sectors (…)". The notions of risk and vulnerability strengthen the document, which recommends actions to improve population living conditions. The supposed connection between individual and collective actions identifies national health promotion politics as a biopower strategy. A disciplining regime of behaviour and individual conduct, for example healthy diet and physical exercise, is created and expressed in a biopolitical regulation. At the same time, it accentuates individual and collective autonomy and co-responsibility, which includes public power while strengthening the importance of social participation.

In the National Health Promotion Policy and its referred texts and documents, we can see effort to guide actions producing social participation and autonomy. However, its governmental origin embraces the impasses inherited from the past, social forces now institutionalised in the State management machine.

Final considerations

Health promotion is a guideline created in a first-world context due to preoccupation with inevitable, increasing health costs. Its proposal of regulating the process through system organization, emphasising basic health, and stimulating healthy lifestyle produced new biopolitical practices associated with disciplinary body practices. Consequently, this focus on the body has simultaneously

provided spaces of resistance and experimentation, with gradients of invention and autonomy. In addition, later international conferences intended to balance emphasis of lifestyle with community empowerment as the main goal of health politics.

Upon its arrival in Brazil, that debate faced a health system produced in the middle of social movements with strong popular participation. There was a gathering between the notion of health as a social production and as a citizen right. The direction chosen by the health movement to develop a regulatory legal apparatus as a strategy of political resistance showed that certain politically-oriented regulations can be created as productive spaces of autonomous practices. These advances cannot be considered definite achievements however, because they carry new dangers from their own successful institutionalization. The increase of bureaucracy and control means the detriment of autonomous and innovative processes.

Thinking of health promotion in terms of health policy simultaneously requires dealing with regulatory dimensions characteristic of any public policy and with emancipating dimensions of individual and community empowerment. As we have seen, this is not a simple process and it requires constant attention and patient effort from managers, technicians, and system users, in which each advance brings new dangers and calls for new actions.

Declaration of conflict of interests: The authors declare not to have conflict of interests.

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