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Integrality in the population's health care programs

A integralidade na atenção à saúde da população

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Abstract *This article examines integrality as one of the doctrinal principles of the Brazilian State Health Policy - the Unified Health System (SUS) - whose aim is to offer health care as a right and as a service. Integrality is the foundation around which managerial activity practices are organized and whose main challenge is guaranteeing access to the health care system's most complex assistance levels. We developed an analytical reference grounded on three dimensions: service organization, knowledge, the practices of health workers and government policy formulation with input from the population. Managerial practices are fertile ground for integrality and are the political arena in which public managers of different government levels, private service providers, health care workers and organized civil society participate. Integrality in health care can only occur through the democratic interaction of subjects involved in the creation of government responses which are capable of contemplating the differences expressed in the health care needs.*

Key words *Integral care, Health services management, SUS, Brazil*

Resumo *Este artigo discute o princípio da integralidade do Sistema Único de Saúde no Brasil, a partir das práticas. Integralidade é o eixo organizativo de práticas de gestão das ações, que tem na garantia do acesso aos níveis de atenção mais complexos seu principal desafio. Desenvolvemos um referencial analítico ancorado em três dimensões: organização dos serviços, conhecimentos e práticas de trabalhadores de saúde e políticas governamentais com participação da população na sua formulação. As práticas de gestão são campo de construção da integralidade, constituindo arena política na qual participam gestores públicos de diferentes esferas de governo, prestadores privados, trabalhadores de saúde e sociedade civil organizada. Integralidade na atenção à saúde da população é fruto da interação democrática dos sujeitos implicados na construção de respostas governamentais capazes de contemplar as diferenças expressas nas demandas em saúde.*

Palavras-chave *Integralidade, Gestão de serviços de saúde, SUS, Brasil*

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Introduction

Integrality is one of the doctrinal principles of the Brazilian State health politics - the Unified Health System (SUS) -, whose aim is to join actions that realize ***health as a right and as a service***.

To prioritize integrality in health politics means understanding its functioning based on two reciprocal movements developed by people involved in health organizational processes: overcoming obstacles and implementing innovations in health services, in the relations among the several SUS managerial levels, and among these and society[1].

Both movements can be considered the main constituent links in integral care offered to the population, which summarizes questions considered relevant for its conceptual and practical appropriation in Collective Health. And these issues are forthrightly, and often contradictorily, related to economic and social policies adopted in Brazil during the last decades. These policies exclude many people, concentrate wealth and erode social life[2], exponentially increasing demand for public health actions and services.

If, on one hand, the organization of our society, based on capitalism, has favored a lot of progress in production relations, mainly concerning the increasing sophistication and technological improvement in different fields, including health, the same does not apply to social relations. These reveal people's diffuse and growing suffering, who is routinely subjected to serious inequality patterns, expressed by tough individualism, by stimulus to wild competitiveness and by people's negative discrimination with disrespect to gender, race, ethnicity and age questions.

Out of this process's way there is the Federal Constitution, which creates and establishes SUS directives, provides basic elements for Brazilian actions and healthcare logical reorder, in order to warrant the necessary actions towards better living conditions of all citizens.

Despite the health sector's historical shortage of financial resources and the institutional normative culture to carry out federal policies, it is possible to identify the emergence of innovative and successful experiences, in several Brazilian states and municipalities[3,4,5].

In such experiences, one can identify some integrality attributes, as far as they reveal the field of practices as especial places where several healthcare institutional innovations take place. Innovations which are daily built by continuous democratic interactions of those involved in and within health services, always permeated by emancipating values[6]. Values based on the assurance of autonomy, on the exercise of solidarity, and on the recognition of free choice of the kind of healthcare one desires. Perhaps this acknowledgement may help us regard ourselves as collective beings "resulting from our intersubjectiveness", who live in public spaces still lacking an alloted and socialized political action - the health services[7].

In healthcare organization experiences, it can be noticed that the SUS can also be effectively built in users' and workers' everyday life[8], by offering different equity and integrality patterns, made up by management, healthcare and social control practices. Health, as citizenship right to and as life defense, requires us a comprehensive analyses, so that it can be identified as a category which holds movable and progressive standards, and the health system, its organization and the practices within it must be able to follow it, and even to always make new possibilities possible, in a renewed movement of integrality and equity[1].

Then it becomes necessary to apply all possible combinations of technical, political and administrative forces in each different place - according to the users' needs[9]; as indicated by technical studies and planning, and also in conformity to the workers' practice[8] - to dynamic arrangements that, in every progress, are able to pressure and to organize conditions for a new successful step.

In this sense, in order to understand integrality in people's healthcare, we propose the analytical reference developed by Ferla ***et al.*** [1], and we correlate it with different studies on integrality healthcare practices. In their analysis, the authors adopt three dimensions: one related to services organization; one concerned with knowledge and practice of health workers; and the third one concerns State politics formulated along with people's participation. Each dimension can be synthesized as follows:

Services organization dimension: integrality prioritized in the (re)organization of services

This dimension concerns the need for assuring access to all different levels of technological sophistication required in each situation, so that assistance can be successful.

Within the context of the consolidation of SUS, it has been observed that integral healthcare practices are associated with at least two

more principles that orientate the system: universality and equity.

In fact, for Cecilio[9] these three principles form "a triple, entwined concept, almost a sign", and fiercely express the struggle for citizenship, justice and democracy, consolidated in the ideal of the Brazilian Sanitary Reform. The magnified view of the idea of integrality defended by the author would comprise all integrality, equity and universality proposals, thus configurating "the pure essence of public health politics"[10].

So as to reflect on integrality and equity, Cecilio[9] considers health necessities as "analyzers". According to Cecilio, listening to needs increase intervention's capacity and possibilities, on the part of health workers, concerning the problems of those people who demand health services.

The author bases his ideas on Stotz[11], for whom such necessities, although socially and historically determined and built, can only be apprehended within their individual dimension, which expresses a dialectic relation between individual and society. So, in the articulation of micro and macropolitics, integrality, to be fulfilled, does not depend only on the services' single space [9] - even if these satisfactorily play their social role - but also on the articulation between services, and sectorial and intersectorial actions. This happens because, depending on the moment the user is living, the health technology he needs can be either in a primary healthcare unit or in a more sophisticated service[12]. Or it can even depend on the cooperation among other State sectors[9].

Therefore, the population's access to all levels of technological sophistication would be condition and starting point for the construction of SUS's integrality principle. At the same time, access only would not guarantee integrality, since this principle depends on other factors to become real. Among these factors, there is the creation of links between users and staff, improvement of the population's living conditions, and the establishment of the user's autonomy in his attempt to have his needs met and to have his health necessities fulfilled.

It is important to notice that, as we place the Sanitary Reform movement within the context of the struggle for democratization - carried out in the political scene since 1970 -, one observes principles and directives of the 1988 Brazilian Constitution: the institutionalization, according to Mattos[13], of the "criticism which has nurtured the dream of a radical transformation of the prevailing health concept in healthcare system actions and practices". Once again, integrality is highlighted as this notion exceeds the condition of a mere directive, to reveal itself a real "banner" which forms a major "image-objective". It can be translated as a societal project permeated by justice and solidarity ideals.

However, the universalist legal and institutional outline of that time already reflected a counter-hegemonic position in the scope of the international debate about health policies implemented by developing nations. Situation then was marked by structural adjustments and progress of neoliberal politics, pointing out a smaller and smaller State participation either in economic politics or in the provision of social actions and services - here including health politics.

It must be clear that integrality is one of the main divergences between Brazilian health politics and the formulations of international agencies, such as the World Bank. The situation is expressed on the fact that there is an agreement with several other directives defended by us, such as political-administrative decentralization and social control - although integrality remains a non-consensual issue. This fact would be enough to justify the importance of an extensive reflection on the senses of integrality[13]. So the struggle for the qualitative change in health politics towards the construction of a health system with universal access, equity and good-quality services now resembles resistance to public policies adopted in the last decade[10].

On the other hand, for Cecilio[9], the concrete way to articulate actions considered integral defines the ethical level of programming and assessing health assistance, dimensions that are found in health planning's and management's hard nucleus. Then comes another challenge: how could this concrete way be realized? First of all, we understand that the concrete way to articulate requires the collective construction of innovative technologies and tools within daily healthcare practices and management. Such practices will concern negotiation of different pacts and agreements among sectorial policies instances and civil society. In other words, a dynamic innovation process in public management.

The idea of innovation in public health management arises from the comprehension of its organization in two main directions: type and content of politics (new policies) and management of these policies (new management forms, new decision processes, and new forms of services provision). From this viewpoint, innovation would include new agents in the formulation, management and provision of public health services[14].

In this context, solidarity can be incorporated as an institutional device, a new practice, once it represents a democratic value that acquires the sense of social action, and potentializes the responsibility of the agents involved in health politics formulation and implementation, where integrality would be priority. And, as priority, integrality leads us to the solidarity of knowing health workers' practices, and evokes the analysis of another dimension, as follows.

Dimension of health workers' knowledge and practices

In this dimension, we have conceived the ability to create the welcoming reception and to integrate health services. Integrality is here understood as a process of social construction, which has in the idea of institutional innovation a great potential for its achievement, since it would allow the creation of new ***institutionalities*** patterns. These can be regarded as experiments that can provide more horizontal relations among their participants - managers, health professionals and users - concerning the production of new knowledge based on the practice of healthcare agents.

Healthcare is here understood not as a health attention level or as a simplified procedure, but rather as an integral action with meanings and senses which consider health the right of being - being in the sense given by Heidegger: being-there (cf. Abbagnano [15]). We could think the right to being as respect to differences, its relations with ethnicity, gender or race, or even consider people with disabilities or pathologies, and their specific needs. Or on the organizational and political levels: for instance, to ensure access to other therapeutical practices or ensure that the user will actively participate in deciding the best medical technology he will use. In relation to health facilities, we have already identified the characteristics of a welcoming place.

It means treating, respecting, welcoming, caring for the human being during his suffering, which, to a large extent, results from his social fragility [2]. This statement is frequently found in other researches carried out by our group (cf. www.lappis.org.br), where integral action is also conceived as people's "among-relations" - "***entre-relações***", according to Ceccim [16]. That is, integral action as effect and repercussion of positive interaction among users, professionals and institutions, represented by attitudes, such as respectful treatment, with quality, welcoming reception and link production.

With these senses, it is possible to quantify integrality within this dimension, as a political device that criticizes knowledge and power instituted by everyday practices which enable people in public spaces to produce new social and institutional health arrangements. Such arrangements are often marked by conflicts and contradictions, in an arena of political contest which defends health as everyone's citizenship right, and not just a right of some. So integrality is conceived as a plural, ethical and democratic term. The dialogue is one of its constituent elements, because its practice results from the conflict among several social voices that, when efficient, can produce polyphony effects - in other words, when these voices can be heard[17]. However, the dialogical function does not always produce polyphony effects (according to Bakhtin [18]), but monophony ones, when dialogue is covered up and only one voice is heard. That is, when integrality does not mean efficient practices, there is only one voice, one side, one without the other, only one can decide on the health he desires.

As social construction and practice, integrality gathers substance and expression in the field of health, as far as this perspective tries to overcome the traditional way of making politics using models which require ideal conditions and then can never be fulfilled[19]. Rather, it is a kind of policy-making that subordinates practice to technocracy with its disciplines external to the health area, and that finally splits up work processes, sometimes producing negative asymmetry, caused by knowledge and power relations in everyday services. But such everyday practices, when taken as source of creativity and criticism, can potentialize emancipating actions of scientific knowledge - which is imprisoned by the method that legitimates and authorizes it - and of society as well, so that the latter can discuss which knowledge must be granted and by which sources. As a matter of fact, some historians called attention to the role played by practices in modern human knowledge production, which has been ever considered as a place for checking ideas, never for coming up with ideas[20].

The study of practices in our research does not aim at making an archeology of integrality, but rather to set out a genealogy in the Foucaultian sense - that is, genealogy as coupling of scholarly knowledge and local memories, which allows the formation of a knowledge of historical struggles, and the use of this knowledge in present tactics[21]. And this outline is almost a map of different criticism to the knowledge instituted in the

health field, mainly the biomedical knowledge. Criticism arising from different spaces and in places we visited during fieldwork. Spaces (corridors, medical offices, hospitals, squares, streets, backyards) and people (doctors, nurses, community agents, patients, families) which, in their daily movements, revealed themselves as ***space-quotidian***, as defined by Milton Santos [22]: reciprocal reunion of fixed and flux, space as a contradictory set formed by a territorial configuration and by production relations, social relations; and finally what guides today's reflection, the space formed by a system of objects and by a system of actions.

Along this trajectory, we did not describe convergences and divergences among kinds of knowledge, based on the positiveness of their discourses; we identified the appearance of other types of knowledge, founding and critical ones. Kinds of knowledge that assume strategic character for the subjects' transformation, for concepts of world acting as political device (and why not?, as power device). We could name it "people's knowledge", local knowledge, discontinuous and not legitimated, knowledge without common sense[21], which do not find refuge in the rational order of our capitalist society, as stated by Madel Luz [2]. In other words, these are types of knowledge economic analyses do not explain, but political, social and cultural ones do.

We draw attention to the necessary critical examination of the hegemonic source of knowledge production, which, founded in modernity, often tends to take us apart from the possibility of making new reflections upon the diversity and plurality of health investigation objects and strategies, especially the ones centered on practices. In this discussion, a very popular saying is implicit - "knowledge without practice makes but half an artist". In this sense, one must make it clear that it urges overcoming the limits of hegemonic theoretical analyses produced and used for planning governmental action. So we will give rise to the empirical knowledge assembled in the disunity between one condition or the other[23] as source of new knowledge on and basis of health practices.

This perspective is supported by Ricardo Ceccim, who stated that knowledge production is made with the truths of inteligence, and not with the truths of the explanatory rational thought[24]. From this viewpoint, we agree that practice cannot be conceived as a mere space for checking ideas, but for coming up with new theories, more powerful ones - in short, a field for reflection, able to strengthen management, thus assigning innovative cross-sections. Innovation in the sense given by Santos[22], such as tensions, ruptures, and the transition of a modern paradigm, reconfiguring knowledge and power.

Exactly in these "cross-sections" there is a certain kind of making and applying government policies, which we call ***shared management***. A way of making policy based on the political and ethical commitment of fully implementing integrality in the population's healthcare.

Dimension of governmental policies formulated with populational participation

This dimension is related to the ability of governmental politics to organize the health system, with prominence to new propositions and development of new decentralized, decisive, solidary arrangements, aiming at the participation of local health systems.

Such capacity refers to management practices that democratically grant the agents involved in the formulation of State policies the main role of meeting the population's health demands. These practices, known as health shared management, can be defined as an institutional space to build up practices involving several health agents, through the establishment of joint and permanent decision devices, on different levels of the system[6].

To realize this type of management, agents' spaces in everyday health services management must change. However, the need for changes must correspond to a need for transformations in sectoral macropolitics. In this sense, one must think again on the SUS's ongoing formation. This perspective, more than allowing the formation of a sectoral micropolitics, can recover the dialectical unity existing between "health and democracy" which permeated the implementation of the Brazilian Sanitary Reform.

So we have correlated the integrality concept beyond sanitary practices strictly speaking, towards the ideal of individual and collective freedom, the subjects' autonomy itself "living their lives their own way" and, therefore, towards the ideal of a fairer and equal society, which defends a reform of the Sanitary Reform, based on integrality principles.

Finally, it can be noticed, from the analysis of innovative experiences for the development of new health technologies, how important decentralization, universality and integral care are, as triple principles that largely express the process of consolidation of achieving the right to health as a question of citizenship. New agents have been

incorporated to the national scene and, with universal access, they allow the appearance of new experiences, centered on integral healthcare[6].

Once again, this means betterment of integrality senses, and widening of its legal definition, i.e., a social action resulting from the democratic interaction among agents in their everyday healthcare practices on different attention levels[6]. It implies rethinking the most relevant questions of health work process, management and planning, in search of a view that conceives new health practices and knowledge. A view that is shared out among subjects, either in the adoption or in the creation new management technologies for integral care.

New management technologies must be built from a democratic and emancipating viewpoint, whose main tools must be social control and political participation. As well as assistance technologies take practices to be their potential transformer in the daily life of those who search and the ones who provide health services, management technologies must consider, in their practices, the potentiality within their own transformation. In other words, management technologies must warrant democratic interrelation conditions of the several sorts of knowledge implied in their formation - such as epidemiology, biomedical sciences, human and political sciences - in order to contribute to the elaboration of richer and more efficient assistance concepts and strategies to face the most serious health problems of the population.

At last, we all know that integrality was formed in a specific context (the creation of SUS) after the sanitary reform and other specific social movements - women's, children's and old people's movements - more than 20 yeas ago. But we also now that, almost 15 years since SUS's consolidation, the ground became fertile and produced important transformations and experiences favorable to integrality, which, in its turn, has been defined as actions in defense of people's lives. This process has been marked by legal and institutional changes never seen before in the history of Brazilian health politics.

Final remarks

In this paper, we tried to present a viewpoint on the way we understand integrality in people's healthcare, based on practices. We understand integrality as an important organizational union of management practices, whose main challenge is to warrant access to the more sophisticated healthcare levels[8]. This challenge requires social and joint action, arising from the democratic interaction among agents in their everyday healthcare practices on different attention levels.

In this sense, management practices are a fertile field to build integrality in a concrete dynamics of the political arena, where public managers from several government levels, private providers, health workers, and organized civil society act.

As we point out the insufficiency of "ideal models" historically used in health management planning, (due to their excessive abstraction, fomalization, inadequacy and difficult assessment of realization in health services), we try to highlight their unability to meet the population's health needs, which are marked by a high level of subjectivity, unpredictability and complexity. So these models have become imperceptible to the "insensitive eyes" of an instrumental rationality - such as the economic one.

We understand then that integrality in the population's health assistance can only come true through the necessary democratic interaction among subjects involved in the construction of governmental answers to the many differences expressed in demands for healthcare.

Collaborations

R Pinheiro, A Ferla and AG Silvia Junior participated equally in all steps of the paper elaboration.

References

1. Ferla A, Jaeger ML, Pelegrini ML. A gestão da saúde no contexto do SUS: descentralização, integralidade e controle social como desafios para os novos governos. In: Tavares L, organizadora. ***Tempos de desafios: política social democrática e popular no governo do Estado do Rio Grande do Sul***. Petrópolis: Vozes; 2002.
2. Luz MT. Fragilidade social e busca de cuidado na sociedade civil de hoje. In: Pinheiro R, Mattos, RA, organizadores. ***Cuidado: as fronteiras da integralidade***. São Paulo: Hucitec; 2004. p. 9–20.
3. Brasil. Ministério da Saúde. Secretaria de Assistência à Saúde. Projeto ReforSUS. ***SUS: o maior sistema público de saúde. Experiências Inovadoras no SUS.*** 2002; 1:1.
4. Levcovitz E ***et al***. Política de saúde os anos 90: relações intergovernamentais e o papel das Normas Operacionais Básicas. ***Rev C S Col*** 2001; 6(2):269–291.
5. Pinheiro R, Mattos R, organizadores. ***Os sentidos da integralidade no cuidado e na atenção à saúde***. Rio de Janeiro: IMS–UERJ; 2001.
6. Pinheiro R ***et al***. Novas práticas de gestão especializada e a construção da integralidade no SUS: notas sobre a experiência da 4ª Coordenadoria Regional de Saúde. In: Ferla AA, Fagundes S, organizadores. ***Tempo de inovações: a experiência da gestão na saúde do Rio Grande do Sul.*** Porto Alegre: Casa da Palavra; 2002.
7. Ayres JR. Sujeito, intersubjetividade e práticas de saúde**.** ***R C S Col*** 2001; 6(1):63–72.
8. Pinheiro R. As práticas do cotidiano na relação oferta e demanda dos serviços de saúde: um campo de estudo e construção da integralidade. In: Pinheiro R, Mattos RA, organizadores. ***Os sentidos da integralidade na atenção e no cuidado à saúde***. Rio de Janeiro: IMS–UERJ; 2001. p. 65–112.
9. Cecilio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e eqüidade na atenção em saúde. In: Pinheiro R, Mattos RA, organizadores. ***Os sentidos da integralidade na atenção e no cuidado à saúde***. Rio de Janeiro: IMS–UERJ; 2001. p.113–126.
10. Camargo JR K. As muitas vozes da integralidade. In: Pinheiro R, Mattos RA, organizadores. ***Os sentidos da integralidade na atenção e no cuidado à saúde.*** Rio de Janeiro: IMS–UERJ; 2001. p. 11–15.
11. Stotz EM. ***Necessidades de saúde***. ***Mediações de um conceito (contribuições das ciências sociais para fundamentação teórico–metodológica de conceitos operacionais no planejamento em saúde***) [tese]. Rio de Janeiro (RJ): Escola Nacional de Saúde Pública, Fundação Oswaldo Cruz; 1991.
12. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onoko RT, organizadores. ***Agir em saúde: um desafio para o público***. São Paulo: Hucitec; 1997.
13. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca de valores que devem ser defendidos. In: Pinheiro R, Mattos RA, organizadores. ***Os sentidos da integralidade na atenção e no cuidado à saúde***. Rio de Janeiro: IMS–UERJ; 2001. p. 39–64.
14. Farah M. Gestão pública e cidadania: iniciativas inovadoras na administração subnacional no Brasil. ***R Ad Pub*** 1997; 31(4):126–156.
15. Abbagnano N. ***Dicionário de Filosofia***. São Paulo: Martins Fontes; 2000.
16. Ceccim RB. Equipe de saúde: a perspectiva ***entre-disciplinar*** na produção dos atos terapêuticos. In: Pinheiro R, Mattos RA, organizadores. ***Cuidado: as fronteiras da integralidade***. São Paulo: Hucitec; 2004.
17. Fiorin J, Barros DLP. ***Dialogismo, polifonia, intertextualidade: em torno de Bakhtin.*** São Paulo: Edusp; 2003.
18. Bakhtin M. ***Estética da criação verbal***. São Paulo: Martins Fontes; 1985.
19. Pinheiro R, Luz MT. Práticas eficazes x modelos ideais: ação e pensamento na construção da integralidade. In: Pinheiro R, Mattos, RA, organizadores. ***Construção da integralidade: cotidiano, saberes, práticas em saúde***. Rio de Janeiro: IMS–UERJ; 2003. p. 7–34.
20. Burke P. ***Uma história social do conhecimento: de Gutenberg a Diderot***. Rio de Janeiro: Zahar; 2003.
21. Foucault M. ***Arqueologia das ciências e história dos sistemas de pensamento***. ***Ditos e Escritos***, II. Rio de Janeiro: Forense Universitária; 2000.
22. Santos M. ***A natureza do espaço***. ***Técnica e tempo, razão e emoção***. São Paulo: Hucitec; 1997.
23. Ferla A, Ceccim RB, Pelegrini ML. Atenção integral: a escuta da gestão estadual do SUS. In: Pinheiro R, Mattos RA, organizadores. ***Construção da integralidade: cotidiano, saberes, práticas em saúde***. Rio de Janeiro: IMS–UERJ; 2003.
24. Ceccim RB. ***Políticas da inteligência: educação, tempo de aprender e dessegregação social da doença mental*** [tese]. São Paulo (SP): Pontifícia Católica de São Paulo; 1998.

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