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A History of Health Promotion in Brazil

Tracing Brazilian public health up to the National Health Promotion Policy

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ABSTRACT

This academic article revisits the history of Brazil with a focus on the development of Public Health and health promotion. The authors contextualize the weakening of the biomedical paradigm and the epidemiological and sociopolitical changes that favored new health formulations, highlighting the paradigms of Collective Health and Health Promotion as foundations of the Unified Health System, established by the 1988 Constitution and regulated by Laws 8080 and 8142 of 1990. The text presents the objectives and guidelines of the National Health Promotion Policy and traces relevant historical events, from colonization in 1500, through the influence of the American sanitary model in the 1920s, the pension institutes, developmentalist sanitarism, the SESP, and the dictatorial periods, to redemocratization and the Sanitary Reform. It concludes by valuing the social determinants of the health-illness process.

KEYWORDS: *health promotion; public health; sus; national policy; history of health; collective health*

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ABSTRACT: The weakening of the biomedical paradigm, the change in the epidemiological profile, and the sociopolitical and cultural challenges faced in recent decades have made possible the emergence of new formulations regarding health thinking and practice. Among these, the paradigms of collective health in Brazil and of health promotion deserve attention, the former being the one that provides the philosophical foundation of the Unified Health System (SUS). The aim of this article is to revisit aspects of the country's history with a focus on the development of Public Health.

Keywords: Health promotion, National Policy, Historical Facts, and Practical Aspects.

1 - INTRODUCTION

The largest country in Latin America and the fifth largest in the world in territorial extent, Brazil has an area of 8,511,065 km² and a population of 190,732,694 people, according to the 2010 IBGE Census. Until the 1980s the population had a more youthful profile, but over the years the Brazilian population has been aging slowly. According to official estimates, the life expectancy at birth of the Brazilian population gained 2.6 years, rising from 66.0 years in 1991 to 68.6 years in 2000 (IBGE, 2000).

With five geographic regions, Brazil has 26 states and one Federal District. Among these regions there are many contrasts and inequalities in various respects; even so, its economy is the most diversified and has the greatest potential in South America.

In a country where the majority of the population is considered poor, improving the quality of life is hampered by a traditional, corporatist, and excessively bureaucratic

administrative structure, resistant to intersectoral actions and matrix systems, thereby making it more difficult to reduce the chronic poverty entrenched in the Brazilian population.

Changes in the epidemiological profile and the socio-opolitical and cultural challenges faced in recent decades have encouraged the emergence of new views on health thinking and practice. The paradigms of Collective Health in Brazil and of Health Promotion in developed countries deserve emphasis, since both influenced the development of the Unified Health System (SUS), which was adopted by the Federal Constitution of 1988 and regulated by Laws 8080 and 8142 of 1990, leaving a group of public health experts who believed in the importance of the social dimension in determining the health-illness process responsible for managing this system. (CARVALHO, WESTPHAL, LIMA, 2013)

In the Federal Constitution of 1988, the Brazilian State adopts as its primary objectives the reduction of social and regional inequalities, the promotion of the well-being of all, and the construction of a solidary society free of any form of discrimination. Such objectives shape the way the rights of citizenship and the duties of the State are conceived in the country, among them health (BRASIL, 1988).

Thus, to guarantee the right to health it is necessary to ensure equal access for all citizens to the health services offered, as well as to guarantee the creation of new social and economic policies that work toward reducing the number of sick people.

Based on the constitutional definitions, the legislation that regulates the SUS, the deliberations of the national health conferences, and the National Health Plan (2004-2007) (BRASIL, 2004b), the Ministry of Health proposes the National Health Promotion Policy in an effort to confront the challenges of producing health in an increasingly complex socio-historical context, one that demands ongoing reflection on and improvement of health practices and of the health system. (BRASÍLIA, 2006)

2 - THE NATIONAL HEALTH PROMOTION POLICY

The National Health Promotion Policy has as its general objective to promote quality of life and to reduce fragility and health risks related to their determinants — social factors, working conditions, housing, environment, education, leisure, culture, and essential services. (BRASÍLIA, 2006)

And as its specific objectives:

· Incorporate and implement health promotion actions, with an emphasis on primary care.

· Expand the autonomy and co-responsibility of individuals and communities, including the public authorities, in comprehensive health care, and minimize and/or eliminate inequalities of every kind (ethnic, racial, social, regional, gender, sexual orientation/preference, among others).

· Promote an understanding of the broadened conception of health among health workers, both those in support activities and those in front-line activities.

· Contribute to increasing the resolving capacity of the System, ensuring the quality, effectiveness, efficiency, and safety of health promotion actions.

· Encourage innovative and socially inclusive/contributive alternatives within health promotion actions.

· Value and optimize the use of public spaces for social interaction and health production for the development of health promotion actions.

· Favor the preservation of the environment and the promotion of safer and healthier settings.

· Contribute to the design and implementation of integrated public policies aimed at improving quality of life in the planning of urban and rural spaces.

· Expand integration processes based on cooperation, solidarity, and democratic management;

· Prevent factors that determine and/or condition diseases and health problems.

· Encourage the adoption of nonviolent ways of living and the development of a culture of peace in the country.

· Value and expand the cooperation of the health sector with other government areas, sectors, and social actors for the management of public policies and the creation and/or strengthening of initiatives that reduce situations of inequality. (BRASÍLIA, 2006)

It is managed through a system of spheres of governance — federal, state, and municipal — in which each sphere has specific responsibilities as well as some shared ones, among them the dissemination of the Health Promotion Policy.

Among the main actions of this health promotion policy, the following stand out: the dissemination and implementation of the national health promotion policy, actions related to healthy eating, physical exercise/activity, prevention and control of tobacco use, reduction of morbidity and mortality resulting from the abuse of alcohol and other drugs, and the promotion of sustainable development.

3 - RELEVANT HISTORICAL FACTS IN THE EVOLUTION OF THE HEALTH SYSTEM AND OF HEALTH PROMOTION IN BRAZIL

The history of public health in Brazil begins back in 1500, with the arrival of Portuguese ships on Brazilian territory. Until 1822 colonial Brazil was administered by Portugal, and the State did not intervene directly in health matters, except in emergencies, such as epidemics, in which — among other educational activities — hygiene norms were disseminated.

Until the end of the nineteenth century and the beginning of the twentieth, the political and economic interests

of the ruling classes were intertwined with health policies. With the abolition of slavery and the development of commerce and industry, the cities, which still lacked a solid basic infrastructure, received a large influx of immigrants, thereby increasing the need to expand foreign trade and open the borders to receive workers who would replace enslaved Black people; and with this population growth the cities began to be ravaged by diseases that threatened the maintenance of the workforce and the expansion of both urban and rural capitalist activities. It thus became extremely necessary to find quick and effective solutions to control these diseases.

During this period, liberal medicine served the urban middle class and the dominant sectors of the population. Meanwhile, measures for identifying and detaining sick people of the lower classes in disinfection facilities on the basis of the "sanitary policy" were being set in motion, alongside the beginning of the compulsory collective vaccination movement — a practice that generated great outrage among the population, which opposed it.

In 1920 the American medical-sanitary model began to influence the Brazilian sanitary structure directly and decisively. Geraldo de Paula Souza and Borges Vieira were students in the first Public Health course at the Johns Hopkins School in the United States, and they reorganized the Sanitary Service of the State of São Paulo, reducing the coercive power of the sanitary police to a minimum and emphasizing health education.

In 1930 a period of dictatorship began in the country that lasted seven years. During this period, labor legislation was established in which, replacing the abolished Health Centers, the Pension Institutes were created; these were responsible for providing health care to workers in different productive sectors of society, among other functions.

In the 1940s, with the end of this dictatorial period, the discussion of a new conception of the health-illness process began to broaden, based on the natural history of that same process. It was the era of developmentalist sanitarism, which coexisted with a populist political movement and which allowed the creation of new proposals for work in health. The need to exploit raw materials during World War II, together with the movement to bring health actions into the country's interior, inspired the creation of the Special Public Health Service (SESP), funded by the American Rockefeller Foundation, to serve the interior populations, who were poor and neglected. The aim of these Services was to help the population perceive social and economic obstacles to community development, through new methodological resources for raising awareness (Mello, 1987).

In the cities there was technical assistance under the responsibility of Social Security, sanitary campaigns to control major epidemics, and the Health Centers and the Santas Casas hospitals offered supplementary medical care aimed at the most marginalized sectors of the periphery. Health education was also one of the health actions, complementing and supporting medical-sanitary actions and helping to make them more effective. Education was regarded as a process of changing undesirable individual behaviors such as ignorance, lack of hygiene, and disobedience of norms and prescriptions based on the values of those who were culturally dominant. During this period, strategies were adopted that favored educational campaigns aimed at specific problems — the so-called "biologization of health," which depoliticized the social, in Cardoso de Mello's words, and later the "psychologization of health," a consequence of the development of psychology, which proposed the adoption of a disciplined routine to achieve good living habits, meaning actions of hygienization, normalization, and domestication. The structural and economic roots of health problems were not even part of the universe of thought of the health professionals of the time, much less included in the actions they carried out. (Mello, 1987; Oshiro, 1988).

From 1964 to 1985, during another dictatorial period controlled by the military government, positive results in terms of economic development were evident, though still with a large part of the population being marginalized. The dark side lay in social arbitrariness, inhuman living conditions, and a health situation in which the "diseases of the rich" were compounded by the "diseases of the poor." The populations excluded from the benefits of development lived under a privatist, curative model of health care; but this type of system, with medical practices centered on cure, had low effectiveness and did not meet the needs of medical care, disease prevention, and health promotion. (Laurell, 1986, apud: Nunes, 1994, p. 12, and Carvalho, 2005, p. 97)

After the social crisis of 1970 and the end of the military dictatorship, a process of redemocratization of the country began. Dissatisfied with the advances achieved by the changes proposed by the preventivist currents, progressive professional groups in health engaged in discussions in search of new paradigms to guide health and education programs, seeking to give a new dimension to public health policies, with a focus on the socio-historical determinants of the health/illness process.

Freire's political-pedagogical approach, Hortência de Holanda's methodological proposals for health education, and the principles and procedures of Carlos Brandão's participatory research are some of the important initiatives that contributed during this period. Such initiatives favored changes in the conceptions and procedures of Community Medicine, since in a way they fed a transformation that superseded the conservative, hygienist, and moralist view. These conceptions were gradually taken up not only by some health technicians who criticized hygienist and

behaviorist education, but were also adopted by the popular health education movements, which supported the sanitary movement then being organized. (FREIRE, 1975; HOLLANDA, 1959, BRANDÃO, 1988)

"The health of the public, whether individuals, ethnic groups, generations, castes, social classes, or populations" is chosen as the object of intervention by Collective Health. Through the historical-structural example, which seeks to incorporate the "historical-social dimension into the analysis while at the same time providing new categories of analysis" (Paim & Almeida, 1998, p. 61; Arredondo, 1992, p. 258, apud Carvalho, 2005, p. 95).

Today, the theoretical framework of Collective Health guides the activities of various Departments of Preventive and Social Medicine at Brazilian universities, playing an important role in the political-ideological support of the Brazilian Association of Collective Health. (ABRASCO, 2004)

In the Federal Constitution of 1988, health appears as a universal right of citizenship, one that results directly from living and working conditions and that lies within the realm of social policies as a "*fundamental right of the human being; the State must provide the conditions indispensable to its full exercise through social and economic policies and the establishment of conditions that ensure universal and equal access to actions and services for its promotion, protection, and recovery*" (Brasil, 1988).

These policies must also guarantee food, transportation, work, income, and leisure to all Brazilians. The inclusion of the social determination of the health/illness process delimits a theoretical and practical field for Collective Health, differently from the earlier movements (Berlinguer, 1988; Brasil, 1988; Westphal, 1992, Carvalho, 2005).

From 1990 onward, the Unified Health System (SUS) became responsible for the health care of 70% of Brazilians and for overseeing the entire private system. During this decade, the government was led by a president who gave his administration neoliberal characteristics, reinforcing a biomedical model through the actions of the Ministry of Health. Policy continued to be the art of integrating preventive and mass actions, with an emphasis on individual curative actions. (Westphal et al., 2004)

Ten years after the 8th National Health Conference, and eight years after Health was incorporated into the Federal Constitution, the law had been won, but full compliance with it — and with its objectives — had not been achieved. (Brasil, 1988)

4 - PRACTICAL ASPECTS OF HEALTH PROMOTION IN BRAZIL.

The Brazilian Sanitary Reform, widely discussed from 1986 onward, following the 8th National Health Conference, proposed to Brazilian society concepts and objectives similar to those presented at the 1st World Conference on Health Promotion, held in Ottawa, Canada, in the same year. According to the Ottawa Charter, health was not merely the absence of disease, but also attention to the basic needs of human beings.

Although this Reform did not manage to realize its initial proposals, it contributed to a series of changes and advances that were achieved within the perspective of the SUS, such as: the decentralization of health decisions, which favored the development of a Municipalist Health Movement led by Municipal Health Secretaries and strengthened the participation of the population in health matters, thereby broadening health concepts and practices.

The Latin American Conference on Health Promotion was organized by the Pan American Health Organization (PAHO) and held in Bogotá, Colombia; it brought together 550 representatives from 21 Latin American countries, among them Brazil, to discuss the meaning of Health Promotion in Latin America and to debate principles, strategies, and commitments for improving the health of the region's populations with a view to equity, and it was another important event of this period (BUSS, 1997).

In 1995, the National Council of Municipal Health Secretaries (CONASEMS) met at the Congress of Municipal Health Secretaries of the Americas, in Fortaleza, Ceará. The Fortaleza Charter, drafted at the end of the Congress, mentioned the Canadian Healthy Cities experiences. From then on, various proposals for implementing Healthy Cities Projects were encouraged by the Pan American Health Organization and put into practice in several Brazilian states, such as Paraná, São Paulo, Rio Grande do Sul, Minas Gerais, and Alagoas, among others, supported especially by CONASEMS. The holding of the "1st Brazilian Forum of Healthy Cities" in Ceará in August 1998 also supported these initiatives; the proposal for the Brazilian Network of Healthy Municipalities was even launched (Westphal, Motta, and Bogus, 1998).

In November 2002, the 3rd Latin American Conference on Health Promotion and Health Education was held in São Paulo, a joint initiative of the International Union for Health Promotion and Education, the Ministry of Health, the Pan American Health Organization, and the University of São Paulo. It brought together 1,500 participants who presented 600 papers, recorded in the Proceedings, with Brazilians making up the majority of the event's participants.

In January 2003, with a new government in the country, the structure of the Ministry of Health was again reformed. The new administrators, many of them from the Collective Health movement, proved resistant to Health Promotion; however, since there was an international commitment to implement "A new model of care from the perspective of Health Promotion," they decided to adopt it as a philosophy of care, relocating it to the Executive Secretariat of the Ministry of Health.

The Brazilian group linked to Health Promotion, made up of university professors and program managers from some states, continued to meet under the auspices of the Brazilian Association of Collective Health (ABRASCO, 2004), the largest and strongest professional body, responsible for studies and for providing guidelines to the government on health.

On March 30, 2006, the National Health Promotion Policy was published through Ordinance 687 MS/GM; at that moment the commitment of the current administration of the Ministry of Health to Health Promotion had already been ratified, and the agreement between the principles and guidelines of both had been recognized. For the implementation of this policy, the Ministry of Health defined a Management Committee for the National Health Promotion Policy, composed of representatives of all the Secretariats of the Ministry of Health, the National Health Foundation, the Oswaldo Cruz Foundation, the National Cancer Institute, and the National Supplementary Health Agency, with no members from outside the health sector.

5 - CONCLUSION

Health is a right of the Brazilian citizen, guaranteed by the Federal Constitution of 1988, which presents it as a broad concept, far more meaningful than the mere absence of disease, and which proposes strategies of action for the recovery, protection, and promotion of health. But, although the importance of the system taking responsibility for these actions is explicitly mentioned, health promotion continues to be treated superficially in Brazil, both within the health sector itself and in external, even academic, settings.

The history recounted here allows us to understand more clearly some of the many reasons why the adoption of Health Promotion in Brazil meets with so much resistance. It is therefore extremely important to persist in the challenge of conducting research and studies that evaluate the results of the National Health Promotion Policy and the actions it proposes, based on the concepts and principles established by the SUS as well as those set out in the Ottawa Charter: comprehensiveness, equity, co-responsibility, mobilization and social participation, intersectorality, information, education, sustainability, and others.

The challenge remains of monitoring and evaluating programs, as well as of implementing this Policy more decisively in a country of continental dimensions with so many social differences, demonstrating that Health Promotion is effective in achieving the objectives it sets for itself, helping to form autonomous individuals capable of bringing about changes in the social determination of the health/illness process.

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