

Psychology and social policies: A historical overview of psychological practice in Brazilian Public Health*

Psicología y políticas sociales: un repaso histórico sobre la actuación del psicólogo en la Salud Pública brasileña

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ABSTRACT

This article examines the evolution of public health policies in Brazil after 1985, when the democratic transition process began at the end of the military rule, and their impact on the professional practice of psychologists. Brazilian social policies of this period and the construction and development of the Unified Healthcare System – SUS (the Brazilian National Health System) are reviewed, as the context for the discussion of the inclusion of psychologists into public health. Issues such as the suitability of traditional clinic models of practice to public health services, questions concerning the academic training and the limits imposed by social policies for the practice are discussed.

Keywords

Health Policy; Political participation; Professional practice

RESUMEN

El presente artículo analiza la evolución de las políticas públicas de salud en Brasil pos-1985 – período en que se inicia la transición democrática en sustitución a la dictadura militar – y su impacto en la práctica profesional de los psicólogos. Las políticas sociales brasileñas del período y la construcción y el desarrollo del Sistema Único de Salud son revistas en el contexto de la discusión de la inclusión de los psicólogos en salud pública. Tópicos como la adecuación de los modelos clínicos tradicionales para el campo de salud pública, cuestiones relativas a la formación académica y los límites impuestos por las propias políticas sociales para la práctica profesional son discutidos.

Palabras-clave

Política de Salud; Participación política; Práctica profesional

The National Health System: background, the New Republic and its aftermath

A historical analysis of the evolution of Brazilian health policies reveals that they reflect a government intervention, common to all other spheres, established as targets of Brazilian social policy (social security, housing, education, employment and income, among others). If the Vargas administration (1930–1945 and 1951-1954) was marked by the institutionalization of legal framework and administrative infrastructure for health, the military dictatorship adopted a model of expansion and state control of health services, while favoring foreign participation in the internal market, encouraging the growth of the health insurance and drug industries. Even during this period, the Brazilian health system exhibits characteristics of unequal access, centralization at the federal level, parallel action, separation between curative and preventive action and health promotion, as well as concentration of resources on medical-hospital care. Healthcare policies essentially became a project of exclusion, which did not consider popular movements or requirements of other policies in the sector. Changes made, primarily in regard to the separation of public health and medical care, culminated in a precarious, low-quality, non-universal healthcare service, obliging the middle class to seek care in the private sector in the form of health insurance (Donnangelo, 1975; Luz, 1979).

At the end of the 1970s, the healthcare model advocated and encouraged during military regime began to show signs of collapse and crisis, as a result of several specific factors: ineffectiveness of the dominant medical practice in changing the morbidity-mortality profile, primarily in relation to preventive measures; overlapping and lack of control and coordination in the face of reduced government efficiency and effectiveness due to high degrees of centralization and fragmentation within both ministries (Health and Social Security and Assistance) responsible for healthcare policy (Teixeira, 1995; Vasconcelos, 1997). During this same period, universities played an important role

in studies that exposed healthcare conditions and fostered ideas for reform. Given their essential nature of breaking with the existing order, universities became the focal point for contesting the authoritarian government. Departments of Medicine were pioneers in implementing alternative social policies to those imposed by the military regime, through Community Medicine programs or by occupying technical and administrative positions in the Ministry of Social Security. During this period, debates point to the need for public investment in primary healthcare infrastructure, which was virtually nonexistent in rural Brazilian cities, whose populations suffered primarily as a result of poor living conditions. Malnutrition, diarrhea, malaria, dengue fever, Chagas disease, among others, were the main causes of death.

The establishment of the “New Republic” created the conditions to reform the government’s social policies, preaching the redemption of social debt. The transition period was an interchange in which the country went through a restructuring phase in its political foundations, due to the occupation of elective positions by left-wing politicians, reorganization of civil movements and the acknowledgment of the failure of military governments. Thus, it is from the beginning of the Geisel administration, marked by the II National Development Plan and the establishment of the Ministry for Welfare and Social Security (MPAS) that public policies acquired characteristics that influenced those transformations seen in the 1980s. Here, we witness the rise of democratic ideals, defended by the first civil-democratic government after 20 years of military dictatorship (Vasconcelos, 1997).

All the progressive movement in the health sector after the resumption of the democratic process was called the sanitary reform. It is the milestone that distinguishes the liberal medicine period from the movement towards enhanced public health care. The so-called democratic transition period propelled movements, culminating in healthcare restructuring and a halt to privatizations that hitherto predominated within the sector.

The crisis in the healthcare model surpassed institutional boundaries and social movements, al-

ready reorganized by this time, clearly demonstrated their dissatisfaction, through proposals to reverse the course taken by the military. One of the most significant experiments along these lines was the Action Program for Internalization of Health and Sanitation (PIASS) of 1976. It sought to assimilate guidance on primary healthcare, increasing basic outpatient services to populations excluded from access, primarily in the Northeast of the country.

The creation of the Brazilian Collective Health Association – ABRASCO, in 1979 strengthened the role of research centers and provided a platform for the organization of academic research, criticizing the healthcare model and proposing its reorganization (Barros, 1997; Rêgo, 2002). Such initiatives were strongly influenced by international events, particularly the 1st International Conference on Primary Healthcare, sponsored by the World Health Organization (WHO) and held in Alma Ata, Russia in 1979. This conference established the goal of “Health for everyone by 2000”, assigning the responsibility of comprehensive healthcare to governments (Dâmaso, 1995).

During the 1980s, the financial crisis in welfare reached alarming proportions, leading to the creation of a National Program for Basic Healthcare Services (PREV-SAÚDE) and the National Council of Welfare Administration (CONASP), whose goal was the expansion of basic healthcare by establishing a National Network of Basic Healthcare Services. Based on these plans, the policy of Integrated Healthcare Actions (AIS) was implemented, seeking levels of institutional coordination that would enable more efficient and effective actions (Noronha & Levcovitz, 1994).

Integrated Healthcare Actions established the infrastructure for the network of basic healthcare services, broadening the extent of outpatient capacity. This network was fundamental to the development of universalization and decentralization policies. Despite its importance, it was unable to dismantle the parallelism of actions, managerial multiplicity and centralization of decisions. In spite of difficulties, in 1986 the VIII National Health Conference (VIII CNS), centerpiece of the sanitary reform movement, was held. Its final report propo-

sed the progressive nationalization of the system and implementation of the National Health System (Sistema Único de Saúde - SUS) for all Brazilians (Vasconcelos, 1997).

Several points were highlighted at the Conference; however, the creation of SUS under Government responsibility for provision, finance and management, guided by a healthcare concept based on the material living conditions of people, was undoubtedly one of the major advances resulting from reformist efforts. The final Conference report also contained the core ideological concept, translating expectations regarding the Government’s role in relation to health and adjacent policies that should guarantee these conditions. Thus, at the VIII CNS, the definition of healthcare in contrast with dominant clinical-biological knowledge is based on social determination of the health-disease process and relies on Government for its provision.

The right to health signifies a State guarantee to dignified living conditions and universal and equal access to services that promote, protect and recover health, on all levels and across the country, allowing individuals to fully develop their individuality. (Ministério da Saúde [MS], 1987, p. 382)

Health, according to the new concept proposed and in the broadest sense, “is the result of nutrition, housing, income, environment, work, transport, employment, freedom, access to and ownership of land and access to healthcare services” (MS, 1987, p. 382).

Following the VIII CNS the emphasis on decentralization gains strength and, thanks to the political direction taken by the centralization/decentralization debate, on June 20, 1987 President José Sarney, through decree 94.657, established the Unified and Decentralized Healthcare Systems – SUDS (MS, 1987).

Parallel to the development of SUDS in the Executive setting, within the Legislature another movement attempted to include the principles of sanitary reform from the final report of VIII CNS in the new Brazilian Constitution. The

political coalition surrounding the proposed sanitary movement encompassed, in addition to its representatives, an alliance between progressive left or center-left parliamentarians, the trade union movement and some sectors of the popular movement.

This intense mobilization served as a form of political pressure that led to a change in federal law. The primary result was the inclusion of a specific chapter in the 1988 Constitution dedicated to health, where it appears as

(...) an universal right, and responsibility of the Government, guaranteed by social and economic policies aimed at reducing the risk of disease and other infirmities with universal and equal access to actions and services for its promotion, protection and recovery. (Constituição da República Federativa do Brasil, 1988, art. 196 and 197).

The National Health System

The SUS model, considered one of the most democratic in the world, has its roots in the restructuring of Cuban healthcare policies after the 1959 revolution. Regulated on September 19, 1990, the introductory provision defining the SUS considers it as a set of healthcare services and actions provided by public federal, state and municipal institutions and organizations, direct and indirect administration and foundations maintained by Government Authority. The role of private initiatives is in complementary participation (Lei nº 8.080 de 19 de setembro de 1990, 1990).

Following rational logic, the SUS should attend to user needs, prioritizing segments of the population or a healthcare agenda defined by the Federal Government, respecting regional differences. Broad objectives guiding SUS actions refer to the identification and dissemination of conditioning and determinant factors in health, the creation of healthcare policies designed to promote the aforementioned goals on social and economic levels, offering care through health promotion, prevention and recovery (Cordeiro, 1997).

After 21 years of existence, SUS was undoubtedly an advance in the construction of policies aimed at social justice and is established in government organizations, seeking the integration of a wide-ranging healthcare network. Despite this effort, the historical context of its implementation and development was substantially unfavorable (Campos, 2007). Notwithstanding its innovative and democratic goals, relevant aspects of the model are either not implemented or disparaged. Electing the candidate supporting neoliberal proposals allayed the implantation of SUS, initiating a phase of stagnation in reformist proposals, crisis in healthcare and Government incentives for reform according to principles of the neoliberal agenda. This dismantling of the government framework generates a crisis in healthcare models, transforming proposals for the sector so as to encourage participation by private initiatives through tax incentives, subsidies and contracts, compromising the already inefficient operations of the SUS. This scenario appears to invert with the resignation of Fernando Collor de Mello and the inauguration of Itamar Franco as president. From then onwards, basic healthcare expands considerably, both in resources and infrastructure (Lei nº 8.142 de 28 de dezembro de 1990, 1990). Nevertheless, SUS was not accessible to all citizens, primarily for those most in need.

Those still unable to access SUS belonged to the so-called risk category (populations bordering on poverty and extreme poverty). Thus, although idealized as a single Brazilian healthcare system, accessible to everyone, whether rich or poor, the SUS never achieved its goal. In an attempt to reach this population group, The Family Health Program (Programa de Saúde da Família - PSF) was created in 1994.

Considered a strategy for reorganizing basic healthcare, the PSF became a gateway into SUS, focusing on the so-called areas of risk: extremely poor and rural communities (Oliveira, 2005). In 1994 and 1995, more than 1,000 family health teams (ESF) were created. However, as is customary in Brazil, constitutional reform adjusted reformist projects to neoliberal thinking and the reorganization strategy for basic healthcare competes for

funding with human resource training and management, substantial investments in high complexity areas, and with poor administration of municipal services. Between 1998 and 2002, ESF expanded the offer of basic healthcare, but faced difficulties in guaranteeing universality and comprehensiveness. In 2007, the PSF covered 56.8% of Brazilians, which promoted its transformation into a strategy for organizing and strengthening basic care as the first level of healthcare in SUS. In 2010, the family health strategy had 31,974 ESFs covering more than 100 million Brazilians in 5,285 municipalities. Infant mortality fell by 60% when compared with 1990; SUS became a leader in public funding for organ transplants and excellent in immunization programs; SUS cared for 184 thousand HIV-positive individuals and began distributing free blood pressure and diabetes medication in 2011. Nevertheless, challenges remain in the form of struggles for democratic policies versus Government unaccountability for its provision.

In an attempt to increase the scope of primary care activities, Support Centers for Family Healthcare (NASF) were created in 2008, widening the scope and resolution of SUS, sustaining the family health strategy in the service network, and the territorialization and regionalization process within primary healthcare (MS, 2008). The NASF should act in conjunction with ESF, sharing healthcare practices and providing support in their geographical jurisdiction. For the first time, mental health actions emerged as a priority within primary care in non-specialized units. Alternative healthcare practices were also offered more systematically in the NASF, revealing a further attempt at health actions less centered on medical specialties. Since this scenario is recent, the Ministry of Health is still developing guidelines for the operation of NASF teams and work procedures are still in the design phase. As such, an accurate evaluation of the impact of this new device on the set of Brazilian institutions and healthcare policies is currently not available.

In a general assessment of the evolution of SUS, particularly during its implementation, Campos (1997) highlights three forms of providing healthcare services in Brazil: a neoliberal

bloc, hegemonic in concrete structural relationships, but with a degree of dissonance regarding sanitary law; a healthcare project subordinate to SUS, with a legal basis, but not effective in terms of social practice; and a third, rationalizing project, which applies the underlying concepts and terminologies of SUS, but in practice remains a neoliberal supporter.

Despite the growth in neoliberal production of healthcare services in the country, the effects of social movements from the 1980s are still being felt. These proposed a health model in line with democratic principles strongly advocated by progressive and left wing sectors during the New Republic. However, pressure to downsize the Government was evident in public health. Campos (2007) states that there are still problems and dilemmas, since its implementation has occurred heterogeneously, with inequality in meeting the needs and use of services. Not to mention difficulties regarding funding, administration of the system and employment in healthcare. As such, one cannot currently state that the SUS represents Brazilian government policy.

It is against this backdrop that psychologists, in a broad move to reorganize democratic forces, align themselves with professional groups acting in segments within trade unions and professional and political areas of the social struggle and, subsequently, join the health workers movement (Bock, 1999; Vasconcelos, 1999).

Psychology in public health policy: a new configuration for the "psychological subject"?

Forty-nine years of regulation portray psychology as a profession still in pursuit of greater social inclusion and political representation. It established itself as a conservative science and practice, belatedly focusing on the construction and/or execution of social transformation. In the history of the profession in Brazil, it seems psychological knowledge was often used for control, segmentation and differentiation, thereby contributing to maintaining and increasing the profit needed for reproduction of capital. A combination of vectors, including action by professional entities, enables significant change in the

profession with regard to public policy (Bock, 2003; Oliveira, 2005).

The movement surrounding changes in the National Health System, mainly from the 1980s onwards, is the first determining factor in the input and nuances of work undertaken by psychologists in the field of public health. Until that time, participation of Psychology in public health had been minimal, and its presence is incipient in psychiatric hospital and outpatient mental health facilities. The clinical care model was hegemonic for the time, that is, practice was centered on private clinics influenced by the spread of a primarily psychoanalytic culture within a process of psychologization and individualization with sociopolitical and cultural implications (Bock, 1999).

The permanent inclusion of psychologists into public health occurred due to their connection and involvement with proposals for psychiatric reform. This was marked by structuring of the AIS, which anticipated the existence of mental health teams in outpatient healthcare units (Arcaro & Mehias, 1990).

For Psychology, there was a glimmer of change in the course of its history towards commitment to the real needs of the Brazilian population, particularly to workers and the democratization of society, in order to expand the market without losing sight of the struggles of workers and civil society. The profession attempts to organize itself around its institutions to debate this and other problems related to their practice. The clinical care model becomes a target of intense criticism and debate for its association with medical practice, severely criticized and opposed by the sanitary movement. In contrast, reorientation of care strategies towards activities of a psychotherapeutic nature became the cornerstone of the care system, providing a wider range of activity for clinical psychologists and further disseminating a culture of appreciating medicine as synonymous with psychological practice (Bettoi, 2003).

In this context, demand for labor grows not only in health, but also in public health, particularly from 1984. To strengthen the participation by psychology in public health, The Federal Council of

Psychology compiles a draft of the main conclusions from discussions held by regional councils and trade unions in the country, whose title reveals part of its content: "The role of psychologists in promoting health" (Bock, 1999). The text indicates directions for psychological care within the public domain and reflects the concern of councils and trade unions regarding defining a working model for psychologists in healthcare. However, the reference for this project was still mental health (Carvalho, 1984).

Representatives of the profession were aware that substantial change was needed for psychology in public healthcare to achieve significant results in improving living conditions among the population. There was a perception that for psychologists

(...) to broaden their scope and social contribution, knowledge of psychology theory is not enough, rather, it is necessary to criticize it, criticize our instruments, our vision of man and the world. Furthermore, one must assume the political dimension of their professional activities and the scope of our interventions. (Bock, 1999, p. 102)

After the excitement of the VIII CNS, the Constituent Assembly is formed the following year, with psychology represented by its entities. The anti-asylum movement gains ground in the country and among psychologists under the slogan "For a society without asylums". This results in pressure to establish a network of replacement services for psychiatric hospitals (Vasconcelos, 1999).

Institutions are incited by criticism of the profession: concentration on clinics, poor diversity of activities, problems in education, restricted market, incipient research and shortage of psychologists in public service. The profession seeks to redefine its social image; however, it reflects professional activity and therefore depends on the type and scope of work contributed to society (Bock, 1999).

During the period in which the neoliberal doctrine is consolidated in the country, starting with the Collor de Mello government (1990-1992), psychologists are still caught up in corporatist struggles. The psychologist as a mental health professional becomes consensus, although, in practice, these services are

only a gateway for psychologists into public health services. Their activities are not restricted to mental health. On the contrary, clinics, general and specialized hospitals and primary healthcare units were locations where psychologists met varied needs, encompassing school complaints and tending to specific groups (women, the elderly, pregnant women, etc.), without focusing on mental health.

Previously limited to outpatient institutions and hospitals, psychologists were absorbed by Primary Healthcare Units, owing to a project incorporating new professional categories for interdisciplinary care, seeking comprehensive and integrated means of achieving goals. This is the major challenge for our psychologists. Rooted in traditional clinical care, they already faced obstacles in implementing the replacement network in mental health due to their inability to incorporate the ideas of psychiatric reform. Although frequently linked with these services, psychologists were unprepared to act on any front whose primary activity was not psychotherapy.

Despite their support and participation in the anti-asylum struggle and systematization and dissemination of new approaches and experiences, as well as professional training courses, these changes had no effect on most professionals and learning institutions, which continued to favor traditional clinical learning. As a result of this type of training and professional culture, psychologists entering the public network found themselves completely inadequate for both new and previous services, tending to continue, within outpatient care, the standard of practice they were accustomed to (Boarini, 1996; Dimenstein, 1998, 2000; Vasconcelos, 1999).

Although it expanded working contexts and situations, it cannot be said that the advent of psychologists in public health was the result of professional awareness regarding their role among the poorest segments of the population (a role that was never clear). The general capitalist crisis, reflected in our country by the failure of the so-called economic miracle, generated a fall in employment levels and a sharp decline in consumption patterns among the middle class – major consumers of psychological services. Privation in the labor market accompanies academic debate concerning the

social relevance of the profession, which, until then, seemed not to consider lower classes as the focus of their attention. Such discussions forced psychology into new areas capable of absorbing its manpower. They did not, however, provide a working model, but rather instituted actions along traditional lines in an attempt to bring psychotherapy to the poorest populations. The search for a workspace made psychologists focus on activities that, in some way, were unique to the profession, setting it apart from others, namely the application of psychological tests and psychotherapy (Bettoi, 2003).

The first outcries for dissemination of psychological practice among poorer sectors of the population were convinced that only the presence of psychologists in institutions caring for these groups would signify democratization of the profession and psychologists themselves. The passage of time, the realization of inefficiency, growing unsatisfied demand and the psychologization and aggravation of problems resulting primarily from material living conditions, reawaken, for some segments of the profession, the perspective of their role and social commitment of the professions.

Only in the 2000s discussions started in the 1980s began to reflect on the psychological practice. Activities are related to the evolution of psychiatric reform, which not only proposed mental health reform, but also created a theoretical/practical entity to subsidize this work. Emerging issues such as expanded clinical practice, therapeutic monitoring, matrix support and humanization, among others, have pointed to professional conduct guidelines. Such is its importance, that matrix support has been used as an important work strategy not only by mental health teams in the NASF, but also by professionals in all centers. However, this does not imply that psychotherapy was banished from healthcare institutions; rather, it has been diluted among other activities, while remaining an important tool in psychological work.

Conclusion

Facts discussed up to this point do not intend to detract from the achievements of several initiatives

to improve work processes within the SUS and, particularly from the contributions of psychology. In essence, the issues raised here highlight obstacles to evolution within the system and psychological practice in the field, due, in the latter case, to resistance to change and lack of clarity in public institutions and among professionals regarding the type of work most suited to the reality of the National Health System.

When considering other processes in the work of psychologists in public health institutions, it is clear that not only isolated aspects such as education or professional culture influence and constitute the profession. The first of these is institutionalization of the profession. By venturing into healthcare institutions, psychologists begin to market their labor power and surrender the “autonomy” inherent to the liberal domain. An employer now controls them with the means needed to execute work programs and projects. Although they maintain some degree of theoretical, technical and ethical-political freedom in their professional conduct, ultimately, this condition depends on means and resources that do not belong to psychologists. Furthermore, norms are dictated by public social policies, institutional power relations, political priorities established by institutions, available human resources, social pressures, etc. All these factors are conditions and vehicles of performing any institutional task; they are constitutive elements of the work process, rather than mere “external” agents influencing professional practice.

Another aspect is the type of demand that psychologists manage in the public health system. The change in patients from higher socioeconomic levels to one that lies within the scope of social issues and their many manifestations is significant not only because of differences in suffering or in environments where actions are developed. It is significant in that psychologists have no knowledge of the population they are caring for, whether in relation to their material or subjective conditions, or in regard to expressions of the social issue. Knowledge of the social reality in which transformative action is to occur is an assumption of the action itself; lack of knowledge

in this aspect contributes, according to Yamamoto (1998) to “... professionals who are no longer the subject of their actions or aware of the effects they can have on social processes” (p. 101).

There is no single, homogeneous work process among psychologists, whether in public health, other institutions or as autonomous professionals. In fact, what determines the work of psychologists in its various aspects are the peculiarities of several work processes, into which they insert their own. This mosaic attributes features, limits and possibilities to professional practice when associated with characteristics intrinsic to the work processes of psychologists within healthcare institutions.

Finally, practicing within public health does not imply the exclusion of clinics and clinical care, but rather demonstrates the relevance of other levels, contexts and modes of practice.

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