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## REFLECTIONS CONCERNING INTEGRALITY BETWEEN HEALTHCARE AND AGRARIAN REFORMS

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**ABSTRACT:** This reflective essay aimed to discuss agrarian and healthcare reforms from the perspective of the integrality of healthcare delivered to settlement families. Through this study, we determined that both the agrarian and healthcare reforms were intended, from their conception, to reduce social injustice, achieving the integrality and well-being of individuals and their families, whether in the context of agrarian reform, focused on landless individuals and their families, or in the context of healthcare reform, focused on individuals and families in general. Uncoordinated and disconnected actions, based on economic interests, were observed in both contexts of political and social reforms, contributing to the exclusion of the rural population from the scope of healthcare, especially depriving them of integral actions.

**DESCRIPTORS:** Comprehensive healthcare. Healthcare reform. Rural settlement.

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## REFLEXÕES ACERCA DA INTEGRALIDADE NAS REFORMAS SANITÁRIA E AGRÁRIA

**RESUMO:** Trata-se de um ensaio reflexivo com o objetivo de discutir as reformas agrária e sanitária do ponto de vista da integralidade da atenção à saúde das famílias assentadas. No desenvolvimento desta reflexão identificou-se que tanto a reforma agrária quanto a sanitária apresentaram, desde sua concepção, o desejo por diminuir as injustiças sociais, alcançar a integralidade e o bem-estar dos indivíduos e famílias, seja no contexto da primeira, voltada para os indivíduos e famílias sem terra, ou da segunda, voltada para todos os indivíduos e famílias em geral. Entretanto observou-se nestes dois contextos de reforma política e social ações desintegradas e desarticuladas, pautadas em interesses econômicos, corroborando para a marginalização da população rural no âmbito da atenção à saúde e principalmente da integralidade desta.

**DESCRIPTORIOS:** Assistência integral à saúde. Reforma dos serviços de saúde. Assentamentos rurais.

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## REFLEXIONES ACERCA DE LA INTEGRALIDAD EN LAS REFORMAS SANITARIA Y AGRARIA

**RESUMEN:** Se trata de un ensayo reflexivo que tiene como objetivo discutir las reformas agraria y sanitaria, desde el punto de vista de la integralidad de la atención a la salud de las familias asentadas. En el desarrollo de esta reflexión se identificó que tanto la reforma agraria como la sanitaria, presentaron desde su concepción el deseo de disminuir las injusticias sociales, alcanzar la integralidad y el bienestar de los sujetos y familias, ya sea en el contexto de la primera, destinada para los sujetos y familias sin tierra, o de la segunda, destinada para todos los sujetos y familias en general. Por lo tanto se observó en estos dos contextos de reforma política y social acciones desintegradas y desarticuladas, pautadas en intereses económicos, corroborando para la marginalización de la población rural en el ámbito del atendimento a la salud y principalmente de la integralidad de ésta.

**DESCRIPTORIOS:** Asistencia integral a la salud. Reforma de los servicios de salud. Asentamientos rurales.

## INTRODUCTION

The concept of integrality is very complex and has been discussed by various authors in many healthcare settings. Coupled with universality and equity, integrality composes the triad of the doctrinal tenets of the Unified Health System (SUS), expressing one of the main goals of the Brazilian healthcare movement and one of the pillars of the three levels of complexity of health services, prevention, promotion and recovery.<sup>1-2</sup>

Nonetheless, countless limitations are observed in relation to universal access to health services and the development of integral healthcare delivery, especially if we consider the social and economic differences in Brazil.

We propose a reflection concerning some conceptions of integrality and invite the reader to consider the history of the Brazilian Healthcare and Agrarian Reforms to identify the existing relationship between integrality and the Healthcare and Agrarian Reforms.

Some questions are suggested to initiate a discussion about these issues. Was the Healthcare Reform able to develop or achieve its objective to reduce social injustice, and achieve universality and integrality for the entire Brazilian population? Did the Agrarian Reform achieve its objectives to end social exclusion, reduce social injustice and ensure the well being and health of rural workers?

### Integrality

Integrality is a polysemic concept; a term with ethical, democratic and multi-dimension.<sup>3</sup> Integrality is revealed in the different types of knowledge and routine work practices and experiences of individuals in different contexts, also recognized as an integrating axis among health services when perceived from a systemic view.<sup>4</sup>

Together with universality and equity, integrality constitutes a triple concept of the Healthcare Reform, which encompasses the ideal of citizenship, health as a right of all, and overcoming injustices.<sup>5</sup> It is one of the pillars of SUS defined in the Federal Constitution of 1988; complying with it favors the quality of healthcare delivery, in which is included the coordinated implementation of health promotion, prevention of risk factors, assistance to rehabilitation.<sup>6</sup> It is the only finalistic principle of SUS, as an attribute of what is expected from this system, that is, providing expanded care to groups and individuals.<sup>3</sup>

This pillar should be developed in two dimensions. The first is the result of efforts on the part of and convergence of different types of knowledge from a multidisciplinary staff in the concrete and singular space of health services in an encounter between users and the staff. This includes a commitment to better listen to the health needs of the service users,<sup>5</sup> based on humanization, problematization and interlocution among different types of knowledge and practices in a interpersonal dialogical relationship.<sup>7</sup> At the same time, integrality should also be developed through the coordination of health services, considered at a macro level and in the service network, as an object to reflect upon new practices in order to reorganize the services and work processes in order to establish public policies focused on the complexity of the healthcare service.<sup>7</sup>

Therefore, the delivery of integral healthcare goes through the organizational, hierarchical, and regionalized healthcare structures and achieves the quality of individual and collective healthcare, based on the users of the healthcare system.<sup>8</sup>

Among the meanings of integrality, this can be achieved in the scope of the practices of health workers through abandoning reductionism and fragmentation, and searching for a holistic and enlarged view that continues in the area of health services organization, seeking to more broadly define the perceptions held of groups' needs and the best way to meet such needs. Integrality should be achieved through the incorporation of promotion, prevention, treatment, and rehabilitation at all levels in the purview of health policies and governmental responses to the population's health needs.<sup>9</sup>

Finally, integrality is established in a theoretical-practical relationship of collective health knowledge that permeates the macrostructure seeking the subjective dimension of health service users, perceiving them as subjects of historical, social, and political processes connected to the family context and to the society in which they are inserted.<sup>7-8</sup> It presents a plurality of actions that are not restricted to accessibility but goes beyond therapeutic planning, including the regulation of health public policies, reorientation of the relationship between the State and society, and attention to the subject-user, considering care in all dimensions of the human being.<sup>7</sup>

## HEALTHCARE REFORM AND THE CONCEPT OF INTEGRALITY

The historical movement of health policies is related to the political, social and economic movement of Brazilian society. The actors of the process of public health construction reproduced the logic of capital in all actions. Over the course of history, the conception and practice of health care integrality remained distant from the settings of legislation and practice.<sup>10</sup>

The view of the evolutionary process has always followed the advancement of capitalism, with strong influences from international capitalism. Health has not always been the focus of the Brazilian government, not in relation to the solution of important problems or in relation to the allotment of resources to the health sector.<sup>10</sup>

The trajectory of the Brazilian health policy begins with the construction of purposes of struggling groups, which influence the shaping of the system.<sup>5</sup> Hence, health problems, over a long time in this trajectory, became the focus of attention when they were epidemic and fell out of focus when they became endemic.<sup>11</sup>

Public health activities in 1850 were restricted to the delegation of sanitary responsibilities to municipal communities and to the control of ships and health in ports. The main interest was minimum health control. The empire's political organization was a regimen of unitary and centralizing government.<sup>11</sup>

With the republic, a political and legal organization that is typical of the capitalist state was established. The tradition of political control being in the hands of large landowners imposed standards for the exercise of power according to the primarily agrarian capitalist interests.<sup>10</sup>

The economy in the 20<sup>th</sup> century was agriculture-based destined for exportation, supported on the monoculture of coffee. Accumulation of capital originated in international trade, a fact that boosted industrialization and consequently favored urbanization. In this context, severe diseases such as smallpox, malaria, yellow fever and others emerged and negatively affected Brazilian economic development. To deal with this situation, a healthcare model called *Campanhista* was created to intervene in health issues.<sup>10-11</sup>

Still in the 20<sup>th</sup> century, Oswaldo Cruz organized the Public Health Office, implemented demographic records, and introduced laboratories for etiologic diagnosis. Carlos Chagas restruc-

tured the National Health Department linked to the Ministry of Justice in an attempt to improve health conditions without, however, abandoning political and economic interests. In 1923, the Brazilian Congress approved the Eloi Chaves Law, implementing social security and the Retirement and Pension Plans (CAP'S).<sup>10-11</sup>

It is worth mentioning that among the considerations provided in this law was the condition that this benefit not be extended to rural workers.<sup>10</sup> The CAP'S were organized per company and depended on the workers' ability to organize and mobilize; workers also had to pay for the costs of these CAP'S. The Getulio Vargas' government, aiming to extend this benefit to all the categories of the working class, replaced the CAP'S with the Retirement and Pension Institute. It was administered by the State and offered, in addition to retirement and pension, funeral services and physicians.<sup>10-11</sup>

It is clear that by the end of the 1950s, medical care and welfare assistance were not relevant for the State or among its main objectives. Actions and measures were not totally effective and always excluded some group or part of the working class, as happened with rural workers.

The Ministry of Health and the National Department for Rural Endemic Diseases were created in 1953 and 1956, respectively, but Law 3087 enacted in 1960, called the Organic Law of Social Security, aimed to unify the general regimen of Social Security including all workers, in agreement with the Consolidation of Labor Laws, but still did not include rural workers.<sup>11</sup>

Only in 1963, with the creation of the Rural Workers' Assistance Fund (FUNRURAL) through Law 4214, were rural workers incorporated into the social security system. In 1967, the National Institute of Social Security (INPS) was created and later originated the National Institute of Medical Care and Social Security (INAMPS).<sup>11</sup>

These changes always characterized a dubious period between healthcare and social security, with a medical curative, individual and specialized practice, giving assistance without transformation in a system whose priority was the capitalization of medicine, its private production at the expense of public healthcare.<sup>10</sup>

At the end of the 1980s, health policies were included in a context of deep economic crisis, especially in the financial aspect of the social security system. In this context, the processes of re-democratization and health reform were strengthened in

Brazil. We sought then to understand the health-disease continuum in close relationship with the population's living and working conditions. Therefore, healthcare reform was reformulated with a view to break with the traditional corporate order and to reverse the tendency to privatization in the sector's policy.<sup>10</sup>

The Constitution of 1988<sup>12</sup> provides that health is a "right of all and a duty of the State", ensuring, through social and economic policies, reduced risk for diseases and other injuries, in addition to universal and equal access to actions and services aimed to promote, protect and recover health. In this sense, SUS, instituted in 1990 by Law 8080, and which is the result of all the relationships described in the history provided and in health reform, defines health more broadly, though keeping the Constitution's principle: "[...] the determinants and conditioning factors of health include, among others, food, housing, sanitation, environment, labor, income, education, transportation, leisure, and access to essential goods and services: health levels express the social and economic organization of a country."<sup>13:1</sup>

The view of health that refers us to the reform of healthcare models presents the need to collectively and socially construct health practices that take place through a dialectic process, where distinct practices are involved, linked to the political and technical dimensions. These dimensions, once combined according to their cost-effectiveness relationship, result in healthcare practices focused on the needs of individuals, families and communities.

Longing for the afore described care model defined in the health concept that expresses Law 8080, the Brazilian healthcare system has undergone, for two decades, a process of change that was initiated in the 1980s with the Healthcare Reform movement. Nonetheless, even today, we seek to create conditions for the healthcare system to effectively and permanently reach individuals and become more humane, supportive, and more importantly, more resolute. In other words, we are determined for the system to implement integrality provided as a principle of SUS.

Healthcare reform intended to print on healthcare delivery a more integral practice and perspective, using integrality and the construction of social justice as principles, but such a goal has

not always being evidenced. On the contrary, what is actually apparent in the entire history of the SUS is a frayed system and incomplete healthcare reform.<sup>14</sup> Universal access to services, professional coordination, and problem-solving capacity are not actually implemented in Health Units, which expose users to a fragmented, unqualified and unjust healthcare delivery.<sup>15</sup>

Among the various reasons that may have led to this sense of incompleteness is the inheritance of a health network focused on curative actions, on medical work, and on the division of tasks driven by an economic model and by the interest of the State, which has not always targeted prevention of diseases and health promotion.

Such a fact currently presents a challenge for the integral delivery of healthcare, since work has been traditionally organized in an extremely fragmented manner, also hindering universalization.

After 20 years of Health Reform, great difficulties still remain in terms of access to health services and the continuity of care. Such difficulties are related to problems in the organization of services, the absence of a regionalized and hierarchical network, poor regulation and inadequate referral and counter-referral mechanisms.<sup>16</sup>

## AGRARIAN REFORM AND THE RURAL POPULATION'S ACCESS TO HEALTH SERVICES

The agrarian issue has always been present in the Brazilian development process and has evolved in innumerable manners and gone through various phases.<sup>17</sup> Some authors consider that the struggle for land in Brazil begun with the occupation of the Portuguese and is marked by the end of slavery with the threat of the slaves themselves becoming owners. Land no longer was acquired by possession and, therefore, began to be sold. Hence, this issue may be seen as a historic pendency in Brazil.<sup>17-18</sup>

The emergence of peasant leagues from the Northeast is observed at the end of the 1950s, which boosted the struggle for agrarian reform. In the 1960s, the military government promoted the modernization of *latifundia*\* instead of providing incentives to small farmers, which favored migration of these farmers to cosmopolitan centers.<sup>17-18</sup>

\* T.N. *Latifundia* refers to great landed estate that belongs to one single person, family or company and is characterized by insufficient exploration of resources.

At the end of the 1970s, conflicts in the country intensified, giving rise to occupations and social movements in favor for the struggle for land. The Movement of Landless Rural Workers (MST) stands out in this context.<sup>17-18</sup>

This excluding economic model speeds up the need for an Agrarian Reform Program and landholding interventions that give rise to the settlement project of the National Institute of Colonization and Agrarian Reform (INCRA).<sup>18</sup> Agrarian Reform is a package of measures aimed to promote better distribution of land by changing ownership and use, generating social justice, progress and well being for rural workers and economic development for the country.<sup>19</sup> A rural settlement is a family-based associate business unit, autonomous and managed by workers, that aims to promote the economic and social development of all the settlers.<sup>19</sup>

In this context, Brazil implements in the 1980s a policy to establish settlements in various regions in the country. Thereby, through INCRA, rural settlements are supported by its credit policy, which finances the implementation of significant resources for housing, sustenance for the settlement family during the first year, in addition to funding the costs of production and providing credit for production investment with terms and grace periods<sup>18</sup>

The Constitution of 1988<sup>12</sup> provides a special chapter for Agrarian Reform, stating that it is the role of the federal government to expropriate – given social interest and seeking agrarian reform – a rural property that is not performing its social function (chapter III, article 184). However, it also establishes mandatory payment of the expropriated property prior to expropriation (which has hindered the process). Additionally, so-called “productive properties” could not be expropriated due to social interest in implementing rural settlements. These aspects negatively impacted Agrarian Reform.<sup>18</sup>

There are currently in Brazil 8,763 settlements and approximately one million settled families.<sup>20</sup> It is the family itself who organizes and performs productive activities in the settlements. Defined as family farming, the family owns the production means and at the same time works on the productive property.<sup>18</sup>

Even those promoting settlements acknowledge that Agrarian Reform does not only mean access to land, but a set of actions aimed to assist families to produce, generate income and also access essential rights such as health.

Scientific production in Brazil is still insufficient to explain complex relationships between the determinants of health and the health conditions of the rural population. A study organized by the Center of Agrarian Studies and Rural Development (NEAD) addressed the access of the settled population to health services. It was conducted in 16 Brazilian cities and observed that such access is still insufficient, considering the poor medical care provided to these families, the unfinished projects and care programs, inactive health units, lack of health workers, and difficult transportation for patients who require ambulatory medical care and/or hospital care, among others.<sup>21</sup>

It is important to note that access to health services does not only mean the entrance of users into the system, but the possibility of meeting the needs that led individuals to seek the service in the first place, which may occur at the primary care level, as happens in the Family Primary Health Care Unit (UABSF) or at other levels.

The Rural Assistance Program (PRORURAL) was created in 1971 through the FUNRURAL. It promoted the right to retirement and expanded access to health services, including medical surgical-hospital care and dental treatment, for rural workers.<sup>10-11</sup> However, access was only possible in health institutions linked to the FUNRURAL; rural settlements, which did not exist at the time, were not included.

In 1980 INAMPS enabled access for rural workers in any of its healthcare facilities, which increased access for these workers, especially in hospitals.<sup>11</sup> At the same time access improved, health policies were still unequal, both in terms of quantitative and qualitative access to those living in rural areas, compared to residents of urban areas, outlining a process that was consolidated in the 1980s and that was called “excluding universalization” of health policies.<sup>21</sup>

Discussions concerning the health of the rural population have drawn the attention of managers and politicians since the 1970s and 1980s, a time when Agrarian Reform was not yet established, as there were few rural settlements.

Current discussions concerning the health of the rural population was boosted by the 12<sup>th</sup> National Health Conference in 2004, which indicated that one of the main current challenges is to ensure rural populations have effective access to the health system.<sup>22</sup>

Since then, the Ministry of Health has discussed the construction of a Health Policy for the

Rural Population based on the National Plan of Agrarian Reform, the National Health Plan, the National Policy of the Humanization of Management and Healthcare, on the Amazonia Project, Policies to Promote Racial Equality, on the National Policy of Regional Development and on the National Policy of Territorial Planning.

Such a policy should be integrated into a set of public policies designed to raise the living standards of the population through inter-sector actions with a view to generate jobs and income, to promote environmental sanitation, housing, rural electricity, education, culture, leisure, access to land, and safe transportation.

### **CONSIDERATIONS CONCERNING INTEGRALITY IN HEALTH REFORM AND AGRARIAN REFORM**

It became apparent that in recent years, due to the course of the Health and Agrarian Reforms, Brazil has tried to change the current and hegemonic health care model marked by fragmented actions and overvaluation of biomedical aspects. At the same time, an ideological struggle to reduce social inequality has also escalated. The reason is that the Health Reform and re-democratization movements in Brazil have always been associated with social justice and equity.<sup>23</sup>

Nonetheless, we observe in both Health and the Agrarian Reforms that the rural population has always been left outside the main health measures, while integrality and equity have never been achieved. During most of the last century, universality of health rights was ensured only to the social security beneficiaries, maintained by the Social Security Ministry, generating the delivery of curative healthcare, strongly excluding the rural population, and favoring the development of social inequality and differences in access to health services, especially if we consider the large urban centers and wealthier economies.

We note that despite the efforts toward these reforms, they present similar phases; such struggle occurred in a disconnected manner, supported on political and economic issues, and interests focused on an economic model that resulted in uncoordinated political actions. The health services and programs corroborate this situation, which in general, were and still are almost exclusively designed for the urban population.<sup>24</sup> At the same time, the settlement process occurs through fragmented and uncoordinated public policies.<sup>25</sup>

Studies addressing the living and health conditions of the settled population are rare, but the existing ones portray disconnection and detachment from the implementation of integrality. Most settlements present conditions that put the health of the population at risk such as a lack of running water, cesspools, and burned or buried garbage.<sup>24</sup> Health needs can be organized into four large groups: the first comprises living conditions and the second refers to access to health technology.<sup>6</sup> Access to healthcare is linked to living conditions, nutrition, housing, and accessibility of health services.<sup>13</sup> In terms of access to health services, some settlements have family health units within the settlement itself, though in some cases, these units open only twice a week. In other cases, the settlement population needs to seek the health units available in the nearest town.<sup>21,24</sup> This search for services in other health units overcrowd those services causing an excess of clients in relation to the number of personnel and disrupts the organization of healthcare delivery.<sup>27</sup>

These situations are aggravated by the poor referral and counter-referral systems, which as shown by another study, hinders the continuity of care at the different levels of healthcare.<sup>15</sup>

Considering the issues previously discussed, we observed that the rural population, specifically the settlement population, is at a disadvantage in terms of healthcare because it is not favored by the principles of universality nor by the practice of integrality. Such exclusion occurs due to the historical process previously described in which health practices are disconnected and the development of reform is fragmented also due to the configuration of professional and organizational practice of the health services.

Facing this reality and considering integrality as a result of professional knowledge and competence, cooperation between health workers and health services and among the health services and other organizations is needed to structure health services in order to meet the various health needs of the population seeking equity, whether in terms of spontaneous demand (when individuals express their suffering) or in the development of promotion and prevention actions. Hence, health managers and workers, especially physicians and nurses, should work in a coordinated manner in the management of health actions focused on the settlement-based rural population to meet their health needs, taking into account the local and regional histories of each settlement, their social,

economic and cultural formation with the active participation of the community.

Despite its limitations, this paper discusses the importance of health actions and/or agrarian reform actions to be implemented while taking into account inter-sector and interdisciplinary actions so that integrality is not simply a guideline provided by the SUS but its practice and constitutes a battle flag of the reforms presented here.

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