

Crisis as potentiality: proximity care and the epidemic by Covid-19

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La crisis como potencia: los cuidados de proximidad y la epidemia de Covid-19 (resumen: p. 15)

Clarissa Terenzi Seixas^(a)

<claseixas@gmail.com> 

Emerson Elias Merhy^(b)

<emerhy@gmail.com> 

Laura Camargo Macruz Feuerwerker^(c)

<lauramacruz@gmail.com> 

Tiago Braga do Espírito Santo^(d)

<tbes81@gmail.com> 

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^(a) Departamento de Enfermagem de Saúde Pública, Faculdade de Enfermagem, Universidade do Estado do Rio de Janeiro (UERJ). Faculdade de Enfermagem (FE), Boulevard 28 de setembro, 157, Vila Isabel. Rio de Janeiro, RJ, Brasil. 20551-030.

^(b, e, f) Curso de Medicina, Universidade Federal do Rio de Janeiro (UFRJ). Macaé, RJ, Brasil.

^(c) Faculdade de Saúde Pública, Universidade de São Paulo. São Paulo, SP, Brasil.

^(d) Departamento de Enfermagem Médico-Cirúrgica, FE, Uerj. Rio de Janeiro, RJ, Brasil.

This article aims at questioning the privatizing hospital-centered biomedical model from the point of view of the response to the Covid-19 epidemic, which focuses on hospital care and hard and light-hard technologies. In this context, we argue that the governmental political project of defunding the public health system and other social policies severely aggravates this scenario. Putting under the spotlight the experiences of other countries, we present 'Proximity Care' as a territorial-based construction centered on light technologies for the production of highly complex care. Proximity Care appears under various shapes in the Brazilian National Health System (SUS) and has been presently underused. We show its potential for the creation of living networks of existence and the possibilities that it opens to reconfigure not only the model of coping with the epidemic, but also that of the post-pandemic.

Keywords: Coronavirus. Brazilian National Health System (SUS). Sociocultural territory. Primary health care services.



Introduction

The first cases of Covid-19, acute respiratory disease caused by the SARS-CoV-2 virus, were reported in Wuhan, Hubei Province, People's Republic of China, on December 31, 2019¹. By January 30, 2020, the epidemic of the new coronavirus had been already raised to the status of Public Health Emergency of International Importance by the World Health Organization (WHO)². This pandemic, with a very high rate of progression, triggered a worldwide effort to stop the spread of the virus. By the time this article is finalized, on June 3, 2020, there are already 6,195,000 confirmed cases in 216 countries or territories³.

This epidemic put pressure on the health systems of all affected countries, both in the so-called central and peripheral countries, producing an evident impact on economic systems, a matter that will not be addressed in this article, but which is known to have health effects. International and domestic news outlets have been showing daily health systems on the verge of collapse^{4,5}, generally expressed in terms of insufficient beds and hospital equipment, as well as health professionals trained to attend all people, with or without symptoms compatible with Covid-19. Such pressure is a result of the specific features of this epidemic: high rates of disease transmission, largely by asymptomatic people - each person contaminated, before adopting social distancing measures in Brazil, an average of 3 to 4 people⁶ - leading to an exponential increase in cases⁷; the severity of an expressive portion of cases, with demands for hospitalization in about 19% of symptomatic cases, with 1/4 of them requiring admission to the Intensive Care Unit (ICU) and use of mechanical ventilation⁸; and a prolonged time of hospital beds occupation.

However, it cannot be disregarded that political confrontation regarding the crisis plays an important role in defining the course of the epidemic and its impact on local health networks, as seen in several cities around the world, with both good and unsuccessful cases. In Brazil, following the example of Milan and New York^{9,10}, contradictory speeches and actions among different government instances and within the federal government itself^{11,12}, concerning the recognition of the severity of the problem and the intensity of measures on population confinement, result in an accelerated increase in the number of Covid-19 cases, putting significant pressure on the public hospital network that was already left to be scrapped, resulting in an increase in the number of avoidable deaths. It should also be considered as well, that the increase in the need for ICU admission in a short period of time is directly proportional to the increase in the speed of progression of the epidemic curve¹³, and this situation has been particularly worrying in Brazil. Wouldn't it be important, then, to discuss what other measures, besides social distance, could contribute to reduce the need for ICU beds?

It is undeniable that, in face of this landscape, we have witnessed and experienced a movement of real-time reorganization of health services in order to meet this demand as intense as non-homogenic among states, cities and even among different areas of the same municipality⁶. New clinical protocols, establishment of new flows, strengthening of certain modalities of care and structures for health care, in addition to the resignification of functions of different care spaces and their actors are permanent. However, it is worth asking: Which are the bases or models that give foundations to these reorganization movements? Have these changes generated thoughts about the production of health



from different individual and collective modes of existence, or do they only reinforce a conservatism around old concepts? Besides the current stage of “harm reduction” to control the epidemic with measures of social distancing, what strategies could be figured out towards care and protective measures extended to progressive deconfinement?

Based on these questions, we started our reflections in the field of collective health and health as a field of production of life, to analyze the strategies that have been adopted as priorities in confronting the Covid-19 epidemic in Brazil, and on the protagonism that community-based arrangements might assume in the response to the crisis and production of care in the post-pandemic.

To develop such reflection, we performed a non-systematic analysis of the scientific production in response to the Covid-19 epidemic in the first months of 2020, but we also make use of other sources such as epidemiological bulletins, documents from national and international governmental and non-governmental agencies, news reports and public debates broadcasted on the Internet. This reflection is also based on observations and experiences in the territories of production of life, in actions to support services and municipalities in which we are directly or indirectly involved as “Public Policy, Care and Health Education Observatory Network”. This collective devoted to research has been debating in weekly meetings those experiments that are in process, and this article is indebted to those rich exchanges.

Considering the above-mentioned sources, we postulate that in the Brazilian Unified Health System (SUS), the potential capillarity of care modalities closer to people’s life and work territories has been scarcely explored in Covid-19’s confrontation movements. This set of modalities that we will explore later on, will be called Proximity Care.

The hospital as priority strategy to face the Covid-19 epidemic

In general, in Brazil, as well as internationally, the predominant ways to respond to the crisis are focused on social distancing, testing and offering more hospital beds for people with Covid-19, especially ICU. The strategies to reach this last objective in many of the studied Brazilian cities involve: opening of specific beds in public and private hospitals for patients with Covid-19; suspension of scheduled elective activities in outpatient and hospital establishments in order to allow their preparation to receive patients infected by Covid-19; building of makeshift hospitals; acquisition, construction and repair of respirators and other equipment; purchase of inputs; emergency hiring of professionals and training for their performance. Another common measure has been the creation of reference centers for Covid-19 in the municipalities, for screening and first-stage care of respiratory symptoms and in the best-case scenario, testing, while deactivating other services and centralizing the evaluation of suspect cases¹⁴. Such reference centers assume different names and configurations according to each municipal management, with different service offerings, but always obeying a logic of assistance centralization.



This kind of response to the crisis is based on the subjectivation of the biomedical model that has predominantly guided decisions and practices of health managers during the epidemic. This model is based on modern scientific medicine, for which the disease consists of a biological-mechanical failure, which leads to a technicist approach to health care, focused on the incorporation of hard technologies⁽⁹⁾. A conception about health and disease is added around the paradigm of the Natural History of Disease (NHD)¹⁵, which deals with the agent, the host and the environment, in its quantitative aspects, focusing the management regarding the sick body, considering that the adequate treatment, at the opportune moment and during the necessary time, will have repercussions in cure or in the reduction of damages to the bodies. The broader concept of health including singularities, relationships, inclusions and exclusions, values and cultures, which certainly modify the possibility and course of illness, escapes out from this approach.

With respect to Covid-19, a first “design” of the NHD led to focus efforts on the management of severe illnesses, leading to the tacit recognition of the hospital as the best place for its implementation. However, it can already be said that: 1) The intervention model influences the logic of construction of contagions, evidencing that there is a social history of the disease, needed to be taken into account; 2) The hospital has been a privileged locus for the care of severe cases, but also for the transmission of the virus, especially among health professionals, intensely exposed in their work¹⁷.

We consider that, although this response in terms of expanding the supply of hospital beds is important and truly necessary, given the significant number of people who needed care involving hospitalization and the use of hard and light-hard technology, there is much to be done in the territories of the cities. It is worth asking: What has been offered to the approximately 80% of symptomatic patients who have been advised to stay at home? What has been done to guide and support people in their living and working environments to enable their care and protection? How may we quickly identify new cases and their contactors, especially in households and communities with higher rates of agglomeration and precariousness? How to guarantee the follow-up of users in the multiplicity of other health situations that lead them, in normal times, to seek a health service? How can we guarantee the continuity of care upon returning home after more or less long periods of hospitalization, possibly with lingering conditions that require rehabilitation?

A slogan like “social distancing”, the most effective strategy to slow down contagion, has repercussions in Brazil through different ways in different segments of the population (not even counting the effects of political divergences). In a scenario of great social inequality that implies precarious working conditions, income, housing, basic sanitation and transportation for large sections of the population, the call for individual adherence is not enough; specific policies would be needed to extend the protective effects to this segment, which already concentrates the largest share of deaths by Covid-19¹⁸. But we see the opposite, as they let us see the difficulties to get federal emergency assistance¹⁹ and very limited initiatives to offer adequate spaces for the isolation, at least, of the symptomatic cases.

⁽⁹⁾ The concept of hard technologies (related to the management of equipment and drugs used in therapeutic interventions), light-hard (intervention based on well-structured knowledge such as clinical and epidemiology) and light (which allow the production of relationships involved in the worker-user encounter through listening, interest, building links) can be found in Merhy and Feuerwerker¹⁶.



More than ever there is a need to debate, with different segments and collectives, their habits of life and unique ways of existence in their networks of connection, understanding how they leave a mark on their experience in the pandemic²⁰. By not recognizing the singularities and diversities, biomedicine transmutes the social, relational, and practical issues of daily life into a set of measures, guidelines, protocols, adopting as a model a certain reference of whatever home, family and relationships among its components are, often quite distant and even out of touch with the singular ways of composing the daily lives of most people.

The extensive offer of proximity care: advantages that we are not using the way we should

Other actions must also be built to take care of both those who are and who are not sick, considering that the process of confronting Covid-19's epidemic goes beyond the hospital walls, and that it is also done in the territories of people's life and work, besides what has already been discussed in relation to social distance. It is necessary to invent other forms of care that incorporate the technologies of care in new work processes, as well as those that combine with new ways of "being" in the territory, with the previous ways of epidemiological surveillance: monitoring of cases, interfering in their distribution in the territory, as well as measures for rapid containment of outbreaks in neighborhoods, with identification of communicators of each known case, allowing their isolation. It is necessary to form support networks to help those precarious situations that are present in the territories, as has already happened - spontaneously - in some places, due to the fact that there is no short number of those forgotten and chronically neglected by public policies. It is necessary to build other rationales for the organization of the community health care offers that may go beyond what has been proposed. Furthermore, it is needed to prepare the deconfinement in a coordinated way with residents, commercial establishments, associations, schools, and other actors.

In this sense, we put our hopes in the potential that proximity care offers have, a potential that has been little explored in the management of this crisis, as a possibility to face the epidemic in the micropolitical production of daily encounters, surpassing the limits of subjectivation of the biomedical model that has also marked community-based offers. The so-called "proximity care", a proposal that has gained its name in some European regions and countries, such as France, Italy and Spain, has been defined in general terms as care carried out as close as possible to the citizens of a given territory²¹⁻²³. In certain regions of Northern Italy, the so-called "proximity services" are used, being defined as social services that, by their nature are closer to the daily and domestic life of the users, such as care for the elderly or the chronically ill²⁴.

This concept, in practice, goes beyond a notion of proximity in geographical terms, of physical delimitation of areas of scope. These are devices that have been proposed to be close to the daily problems of community experiencing in an active way, bringing us closer to an understanding of "territory" as a landscape of human actions in relation, as proposed by Santos²⁵. This conception of territory is also close to that proposed by Seixas²⁶, inverting the emblematic notion of the sociologist Michel Maffesoli *le lieu fait*



lien (it is the place that makes the bond), to reverse it as *le lien fait lieu* (it is the bond that makes the place), from an understanding that the encounters that are established in people's daily lives give meaning to the territory.

Understanding the concept of how the authors of this article have thought about it and become pregnant in recent reflections, the potency of proximity care, in its various local modeling, stems from a bet stating that teams are so much more capable of thinking of adequate solutions, in a way that is shared with the various actors, whenever they have a greater proximity and knowledge of the problems that the people of that specific community face, their needs, demands, but also their potential. It is important to emphasize that the knowledge mentioned here is not only about what professionals acquire in their professionalization, but also about a singular production that happens in act, in the encounter, the fruit of a symmetrical intersection between these actors and the unconditional adherence to the life of the other as ethics. It also derives from the real possibility of creating bonds, allowing the production of community care projects, shared with the residents, therefore having a larger meaning in the lives of those people²⁷. This is because there is the power of building care technologies in their various dimensions, greatly expanding the benefit that the use of relational light technologies opens up in the construction of bonding, accountability and horizontal sharing in the production of care for oneself and the other.

Considering the possibilities built up in these encounters in the territories, it is understandable that proximity care goes beyond the boundaries of the health sector and the formal knowledge nuclei of professional categories. The meanings of care production in the territories always demand an ethical-political commitment to the perspective of building the existence of other local actors. But what health services have this "proximity" that we need, especially in times of Covid-19 in Brazil, and probably in post-pandemic times as well?

SUS has a large network of services distributed in a heterogeneous way throughout the national territory, vigorously built for many years, but intensely neglected in the last two federal governments, mainly based on Constitutional Amendment 95 (EC 95)²⁸, on the new National Primary Care Policy²⁹ and its normatizations, and on the "new" Psychosocial Care Network³⁰. Among the non-hospital outreach care offers, we highlight, due to its capillarity and territorial base, Primary Health Care (PHC) including the Family Health Support Centers (Nasf), Home Care (AD), Psychosocial Care Centers (CAPs), Street Clinics (CR), among others.

Despite all the problems and challenges, these devices, by operating close to the homes of people with multiprofessional teams, as well as by incorporating workers such as community health agents and endemic agents, have the chance to implement local forms of care at an intensity that few health systems in the world have, with potential to impact the processes of illness in the various territories where they are inserted.



Since the beginning of the pandemic, it was proposed that parts of these teams should be diverted to act at the emergency services that attend respiratory symptoms. Associated to this, they were also called to perform telephone monitoring of diagnosed cases of Covid-19 (many times relying on the professionals' own telephones) and to direct those with respiratory symptoms to seek services spontaneously to the non-hospital reference centers or to the Emergency and Walk-In services; or guiding them to return to their homes, operating as access barriers³¹.

At the same time, we have observed a demobilization guideline of this network in its routine actions of care to its ascribed populations, restricted to acting in a limited way and following, seldom at a distance, some of its actions, such as vaccination campaigns, renovation of prescriptions, care of pregnant women, distribution of materials for dressings, and accomplishment of some services. With the justification that their presence in the territory would put them in the condition of "disseminators of Covid-19", and with the argument of protecting them from contamination, the workers were initially oriented to halt mostly all home visits with a few exceptions.

Part of this setback was justified by the lack of personal protective equipments (PPE) in sufficient quantity for these professionals to work in the territory. However, this has also been reported in hospitals³², but has not prevented, in some local networks, the relocation of professionals from community-based services to hospital services. This movement is all the more worrying after data showed that the chances of contracting Covid-19 increased significantly in a hospital environment, both among health workers and among people hospitalized for other causes¹⁷, raising the question: exactly why the fears of acting and contaminating are justified?

This perspective of the disease as an exclusively biomedical phenomenon constituted of a NHD and devoid of its social history, engenders the understanding from which it is thought that the proximity care offers do not have the necessary technologies to approach patients in the midst of a pandemic, such as: imaging and immunodiagnosis exams, places for isolation, more intensive intervention beds and advanced life support

Thus, being isolated and distant from the population, and deprived of their place in care, the teams from the territories watch the mushrooming of cases of respiratory symptoms in their areas of coverage; meanwhile, catastrophic data expressed in numbers of deaths indicate the strategic misconceptions of several orders in the coordination of actions among the three spheres of government confronting the pandemic in Brazil.

Added to the lack of coordination of actions, there is a reinforcement for the adoption of old hospital-centric and medical-hegemonic practices in which priority is given to the care of serious cases, with no room for problematizations of their adequacy. It is assumed that there are no dimensions in the "pandemic" that are susceptible to other actions able to be created and offered in the territories.

Although the discourse on the centrality of Primary Care in health care at SUS²⁹ has been current for a long time, little has been questioned about the devices for its effective strengthening and the dispute of values with the medical-hegemonic model. The latter freely presides over professional actions dictating the way of understanding health, interdicting new models of building relationships, recognizing the need for shared construction and bringing care closer to real life in different territories. Moreover, underfunding, focalization and management practices have contributed to its weakening over time. That is, an installed precariousness in full implementation. Thus, isolated primary care, understood as a mere gateway, has not developed the necessary complexity of care technologies, nor the devices for their construction in living networks³³.

Despite this, there is much life and accumulated power and potential for amplifying the connections of workers in these services with the life that pulses in the territories. At the present times, their active presence among the population would be crucial, reaffirming the potency of proximity care as an integral part of the set of tactics to defend life and prevent further deaths.

Located in the most precarious places of material production of existence, the diverse modalities of outreach care could play a decisive role at this time, connecting with different collectives and organizations, with people's lives, to build protection strategies, identifying situations of extreme precariousness, agglomerations, and triggering intersectoral articulations together with other entities, movements and institutions, solidarity actions to provide strategies to guarantee epidemic safety, food and other guarantees for increasingly impoverished population contingents.

What is the proximity care ableness?

We have seen the difficulty of several countries in facing the pandemic. The USA, widely affected, faces the consequences of systemic inequities in access to health and the weakening of other social policies, by considering health as expenditure and not a public field of economic-financial investment. In Brazil, this same logic is intensified mainly from EC 95.

The Covid-19 pandemic has also put to the test those countries whose health systems proved to lack the capacity to coordinate territorial actions with the network of health services as well as through intersectoral networks, with the incorporation of appropriate care technologies at each moment, in order to limit the consequences of the epidemic in terms of the number of sick and dead, not even counting the economic impact on families. In this sense, the hegemonic hospital-centric biomedical model has proved to be a failure by working alone, isolated from an expanded network and disconnected from the territories of existence. This situation, therefore, opens a great discussion: without a universal health system that articulates care technologies - light, light-hard and hard - into technological arrangements to make Covid-19's confrontation actions more effective, the chances of overcoming the pandemic with lower losses of lives will be slim.



If we look at the Cuban experience of confronting Covid-19, a country that, like Brazil, has a large network of services in the territories of life and work, we see in a blatant way how much we are underutilizing this accumulated power in SUS. With some 1900 cases and less than 80 deaths recorded up to May 20, 2020³⁴, Cuba employed several community-based strategies to fight the epidemic, such as regular visits by students or health professionals to quarantined families to ask about residents' health, their daily activities and verify if they were applying protection measures against Covid-19; early targeting of symptomatic residents to centers installed in each neighborhood; intersectoral mobilization for coordinated actions, broad home testing, etc.³⁵ In addition, of course, there was a very robust state investment in health.

New Zealand, a country that has been very successful in fighting the epidemic, besides adopting early and very restrictive measures in terms of social distancing, has also adopted strategies of massive testing and tracking of contactors in the territories³⁶. Costa Rica, a country that invests an important percentage of its GDP in the health system, had good results in fighting the epidemic due essentially to: the access of the entire population to basic sanitation, broad network articulation of health services, and the work of the Basic Health Care Teams in actively monitoring suspected cases in the territories³⁷. This good performance in facing the epidemic by Covid-19 is also repeated in China, South Korea, Ethiopia and other countries and/or regions with solid community care strategies, corroborating the understanding that the social history of the disease has different paths according to the adopted strategies.

The experiences, as analyzers, point us to the possibilities of building a public dimension, even in a context of precariousness, of a severed, isolated and privatized model.

It is not acceptable to leave the population alone in the territories, at the mercy of conflicting information and left to crafting solutions - sometimes solidary, sometimes confused and solitary - when it may count on all the Brazilian history of original construction of proximity care modalities, which invented matrix-led developments, forums and other elements of such a sophisticated techno-assistance arrangement such as the community health agents. We understand that the pandemic is exactly the moment to take them back to their greatest power, stop their destruction and invest in their maximum functioning.

It would be appropriate to open up the range of options and imagine that the proximity care would have several possible dimensions: one of them takes as an assumption the fact that by making care interventions guided by a social history of the disease, it is possible to change its course and, therefore, the clinical gravity that arrives - or does not even need to arrive - at the hospital.

Another dimension is to understand that caring in the territory is not only about intervening in the clinical picture: it is to circulate in the territories with the proper protection and with a work agenda for the pandemic period, jointly built with different local actors. As already said, but worth reaffirming: a health worker circulating in the territory, if properly equipped, has less chance of being contaminated than a worker caring for serious Covid-19 patients in the hospital. Thus, they can build with the community mechanisms and strategies in which social distancing is also a way



of producing life, and not only isolation and psychic suffering. And that strategies of community construction of self-management of actions can be produced in that same place, in that same territory.

Therefore, it is possible to build an operative capacity of another mode of pandemic care that can change the social and natural history of Covid-19 within our society. Such capacity would not only greatly increase the legitimacy of the teams, but also offer Brazilians a possibility of defense against the epidemic that no other health system in the world has, because of its broad network of capillary proximity care with hundreds of thousands of very powerful workers, avoiding the abandonment of symptomatic cases and contacts, acting more consistently in controlling community transmission, and building other possibilities for social distancing.

It is then necessary to build care networks that unfold in a multiplicity of care technologies based on the territories of people's lives and work, using tools that are much more manageable from the point of view of cost, but mainly with a capacity to interfere effectively in containing community contagion, ensuring a sufficient supply of tests, PPE, information, articulated support with the capacity to embrace, dialogue and share actions.

This is because there are wide capillary communication networks in these communities, they are very lively territories that require to be seen as such. However, these places are subject to high stress by being forced to invent a local policy where the state is absent with effective policies. The groups are organizing themselves, inventing their way of doing surveillance in the territory, looking for networks of movements, and these inventive processes will often be rich and sometimes problematic. Collectives are building their knowledge of how to organize themselves so as not to be exterminated, and they can benefit from the active support of local health services in this process.

These strategies must be combined with effective social distancing measures, with the closure of businesses and schools and the guarantee of basic sanitation with potable water for the entire population, decreasing the person-to-person contagion coefficient and, at the same time, by building a rearguard capacity for those who need interventions with a high density of hard technology.

We consider that it is necessary to take advantage of the SUS, to keep it robust as an indispensable patrimony, precisely in calamities, and to activate it from its potential.

Final considerations

To what extent, and in what directions, has the potential immanent in moments of crisis - of questioning the foundations that underpin our societies and models - been harnessed? "This may be the ultimate question, before the door closes once and for all". This call to action inspired by the current crisis that Achille Mbembe³⁸ delivered to us all at the beginning of April 2020 in a broader aspect - that of our human being on this planet - summons us as actors committed to a model in defense of life, which points out that every life counts.



We then ask ourselves: are we going to face this unprecedented health, ethical and political crisis in the existence of all of us using the same paradigms and conservative models in the field of public health and biomedicine, whose limitations become more evident every day?

Covid-19 is openly showing the exhaustion of all possible limits of the notion of society, putting in check the logics of organization of existences centered on life-market, on the worsening of inequalities and the (no)place that health occupies in this process.

Authors

Helvo Slomp Junior^(e)

<helvosj@gmail.com> 

Kathleen Tereza da Cruz^(f)

<cruz.ufrrj.macaee@gmail.com> 

Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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Este artigo busca tensionar os equívocos do modelo biomédico hospitalocêntrico privatizante com base na resposta à epidemia pela Covid-19, que tem como centralidade o cuidado no hospital e as tecnologias duras e leve-duras. Mostramos, como elementos agravantes nesse cenário, o projeto político governamental de desfinanciamento do sistema público de saúde e de outras políticas sociais. Trazendo a experiência de outros países para a cena, apresentamos os “cuidados de proximidade” como construção de base territorial centrada nas tecnologias leves para a produção de cuidados de alta complexidade, presentes sob diversas modelagens no Sistema Único de Saúde (SUS), que vêm sendo pouco aproveitadas nesse momento. Buscamos mostrar o potencial dos cuidados de proximidade para a criação de redes vivas de existência e as possibilidades que abrem para reconfigurar não apenas o modelo de enfrentamento da epidemia, mas também o do pós-pandemia.

Palavras-chave: Coronavírus. Sistema Único de Saúde (SUS). Território sociocultural. Serviços básicos de saúde.

El objetivo de este artículo es tensionar los equívocos del modelo biomédico centrado en el hospital privatizador a partir de la respuesta a la epidemia de Covid-19, que tienen como centro el cuidado en el hospital y las tecnologías duras y leves-duras. Traemos como elementos agravantes en este escenario el proyecto político gubernamental de desfinanciación del sistema público de salud y de otras políticas sociales. Colocando en escena la experiencia de otros países, presentamos los ‘Cuidados de Proximidad’ como construcción de base territorial centrada en las tecnologías leves para la producción de cuidados de alta complejidad, presente bajo diversos modelados en el Sistema Brasileño de Salud (SUS), que se ha aprovechado poco en este momento. Buscamos mostrar el potencial de los cuidados de proximidad para la creación de redes vivas de existencia y las posibilidades que abre para reconfigurar no solo el modelo de enfrentamiento de la epidemia, sino también el de la postpandemia.

Palabras clave: Coronavírus. Sistema Brasileño de Salud (SUS). Territorio sociocultural. Servicios básicos de salud.