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Practices in Community Health Toward Equity: Contributions of Brazilian Nursing

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Although Brazil stands out as the eighth largest economy in the world, this country is burdened by huge social and economic inequalities. One of its greatest contemporary challenges is the construction of social policies, including healthcare, that seek to adjust social, economic, and cultural distortions. In the light of this scenario, Brazilian nursing has an important role in the defense of health with equity and quality of life, taking on a caring-based practice. However, to respond to these challenges in a propositional way, the nursing profession needs to reconsider its role and its purpose. **Key words:** *Brazil*, *equity*, *forecasting*, *health-disease process*, *health inequalities*, *health and public policy*, *nursing care*, *nursing education*, *social inequity*

THIS ARTICLE reflects the views of the authors who make up the Nucleus of Studies and Research on Education and Nursing Practice (NUPEPE) of the School of Nursing of the Federal University of Minas Gerais (UFMG), in Brazil, and it reflects their daily experiences in the practices of teaching, care, and knowledge production. It discusses practices in community health, supported by life quality indicators of the Brazilian population, emphasizing nursing contributions toward social justice. We present here the current situation involving inequalities and inequities in health in Brazil and Latin America with regard to the economic aspects, access to and distribution of health services, as well as the scenario of education of health professionals. We propose the methodology of future scenarios building as a means of managing problems of social inequality, and we promote the contribution of nursing in maintenance of health with equity and quality of life, taking on a caring-based practice.

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SOCIAL INEQUALITIES AND INEQUITIES IN LATIN AMERICA AND BRAZIL

When discussing social equity, it becomes necessary to consider the context in which inequity takes place, as well as its causes and determinants. In Latin America, the data of Gross Internal Product (GIP) have been used as indicators of the inequality that exists among the region's population groups, which has arisen from policies that privilege the production and unequal distribution of wealth. Such policies have important repercussions for less privileged populations.

We analyzed the categories of equality and inequality, considering them to be notions that are always relative of the general conditions of production and reproduction of a determined population.[1] The relativity of these concepts can be exemplified by Brazil's situation, as the eighth largest economy in the world, with a GIP of 1 803 917 million international dollars,[2] yet burdened with considerable social and economic inequalities,

as shown by its rank as 69th in the worldwide Human Development Index, calculated by the United Nations Development Program (UNDP). By this index, Brazil lags behind 13 other countries of the Caribbean and Latin America, including Uruguay, Argentina, Chile, Cuba, and Mexico, and ahead of nations such as Venezuela, Peru, Paraguay, Jamaica, and Haiti.[3]

The national income distribution also reflects these social and economic inequalities. Currently, Brazil has the 10th worst income distribution in a list of 126 countries and territories in the world, and has the 3rd worst of Latin America, behind only Haiti and Bolivia. Moreover, the most affluent 10% of the Brazilian population appropriate a slice equivalent to 45.8% of the national income. On the other hand, the poorest 10% of Brazilians receive only 0.8% of this income.[3]

Brazil also presents great regional inequalities: whereas the southeast region has the most developed economy and society, the northeastern region has a poverty rate that involves 44% of the population, which impacts severely in the maintenance of the misery in the region. It is important to emphasize that the regional disparities in Brazil are not caused by scarcity of resources but by the persistent inequality in the GIP distribution.[4]

Educational data can also be used as indicators for the analysis of inequalities and inequities in Brazil. The country has a great debt with respect to the access to and permanence of children and youths in the educational system. The illiteracy rate in Brazil is nearly 12%. Educational indicators point to an inadequacy at all levels, and the illiteracy rate among people older than 15 years reaches 13.6%.[3]

Despite Brazil's income concentration, which reveals a situation of extreme inequality, the overall quality of life has improved in the last 20 to 30 years, as has its life expectancy, currently reaching to 70.4 years. There has also been a marked reduction in infant mortality, at the current rate of 27 deaths of infants younger than 1 year for each 1000 successful births. Health education and the relative control of infectious-parasitic diseases have also improved, along with the eradication of smallpox and polio. All of these improvements result from a greater participation by the socioeconomically disadvantaged in the production and circulation of goods.[2]

It is important to consider that the nursing profession in Brazil has had a relevant participation in improving the sanitary conditions of the country, acting in primary health and assisting women, pregnant women, children, adolescents, and aged people. However, it is necessary to increase actions toward the reduction of the inequalities and iniquities in a propositional way, especially in the health sector.

EQUITY AND INEQUITIES IN HEALTH

To discuss inequities in health and the development of equity, it is important to consider the data referring to health policies and the availability of access to services.

In this direction, it is necessary to consider that the mechanisms by which socioeconomic variables influence in health, disclose the differences in the structure and the functioning of the society and how the population answers to that.[5]

It is also crucial to reflect on aspects related to professional education, as well as the data referring to the concept of health that prevails in our society. In this context, it becomes important to reveal the role that nurses have on building social equity.

The economic and social differences between population groups in Brazil have important repercussions on life quality and health of the populations. In general, many people have no access to health services. Moreover, we deal with a demographic and epidemiological transition, which gives rise to changes in the population's age level and disease profile. This transition is marked by simultaneous persistence of high frequencies of infectious diseases, malnutrition, and chronic conditions, with resurgence of illnesses considered overcome, such as yellow fever and malaria. In this picture, the

attention is called to the growth of morbidity and mortality resulting from external causes, consequence of the violence that, by its turn, is caused principally by the social inequalities. Circulatory diseases are responsible for about 40% of the deaths among Brazilians who are older than 60 years, resulting from the raise of life expectancy without a significant increase of life quality. The scientific advances in science constitute a relevant factor in the prevention and early diagnosis of chronic and generative diseases and cancers modify the occurrence of these illnesses in the most developed regions of the country that concentrate health units' services with high-technology equipment.[6]

Despite these important modifications in the demographic and epidemiological profile of the Brazilian population, the infectious-parasitic diseases still occupy an important space in the national morbidity and mortality indices. In Brazil, old and new health problems coexist. The country has characteristics that approximate those of developed countries, and it also has epidemiological indicators that are specific to those of underdeveloped countries.[7,8]

Inequalities in health, which are identifiable in the disease pattern and in the access and use of services, reveal a chronic problem that requires construction and execution of more adequate policies.[9] Nurses must act in a propositive way in the discussions about access and service distribution, contributing to diminish health iniquities.

We consider that more equitable health policies result for the most part from sector reform. The political context of social iniquities in health is rarely broached in studies, but is revealed as one of the determinant factors of the persistent inequalities and exclusion in different nations. Despite that, political groups and policies implemented by them predict the equity and iniquity levels in the society and explain the health conditions of its population. Thus, it is undeniable that the construction of equity passes by political definition and constitutes a government strategy.[10]

Historically, in Brazil, health policies are characterized by the stratification of the client population according to their income; moreover, these policies emphasize high technology, resulting in the deterioration of primary healthcare and community health actions. The hegemony of these policies has important repercussions in the cost and quality of healthcare and community health practices, prioritizing hospital, private, individual, and curative care.

The discussion of health as a social entitlement in Brazil, which grew with the movement of health reform in the 1970s, led to an adoption of concepts in the health field that seek to break with the biological model. The Federal Constitution of 1988 incorporated part of the demands of the movement and assured the implementation of Brazilian's National Health System (SUS), one of the most comprehensive social policies in the world. The SUS is supported by the principle of equity, in which the guarantee of health is a government obligation; this principle confirms the universal access to healthcare and incorporates the idea that health is determined by social, economic, and cultural factors.[11] Assuming this constitutional principle has required Brazil to elaborate strategies to guarantee access to healthcare to all Brazilians and to determine how best to accomplish that through the organization, financing, and control of the health system.

Equity, as defined in the Brazilian's National Health System, can be expressed as the provision of equal opportunities of access to health services for all the Brazilian population, independently of social class. However, the sustainability of this system depends on financial support provided by state. An important distortion is that the wealthy population sectors have a large availability of private health services. According to the principle of equity, health services should be distributed according to the necessity and demand of healthcare in the population, independently of social and economic considerations. In Brazil, it is estimated that 38.7 million people (corresponding to 24.5% of the population) are covered

by at least 1 private health plan as a means to compensate for the deficiencies of the SUS.[12]

Nursing participated of the movement of health reform and defends the principles of equity, universality, and quality of health services. Thus, nursing has an ethical commitment in the construction of the Brazilian's National Health System, formulating public policies in the sector and acting in the professional education of nurses that guarantee the achievement of the SUS principles. In this direction, we understand that the models and practices of professional education on nursing are strategies that can add force in building the equity in health.

PROFESSIONAL EDUCATION: CONTRIBUTION FOR EQUITY

Equity in healthcare calls for a commitment to the transformation of the political, economic, social, and cultural relations, including the professional education of nurses. Nursing has developed alliances with sectors of the organized society that can overcome the inequalities that engender injustice. Nursing is part of this political project of the sectors of the Brazilian society with interests that are revealed also in its political organization and educational models.

Brazil has almost 1 million nurses whose roles fall into 3 different categories according to their level of education: "assistential" nurses (more or less equivalent to licensed practical nurses), registered professional nurses, and professors of nursing. These workers are ubiquitous in all health services. In Brazil, the professional nurse's education is regulated by the National Council of Education, which in 2007 administers 626 schools and faculties in public and private institutions.[13] Despite the substantive nursing workforce and the increase of nursing schools in the last decade all around the country, the distribution of these nurses remains uneven and not sufficient for the territorial dimensions of Brazil—8 million square kilometers and approximately 188 million citizens,[2] remaining concentrated in the more developed regions and cities. In the same way, the distribution of nursing schools concentrates in the regions of higher density population and income concentration of the country, following the GIP distribution and reaffirming the regional inequalities (Fig 1).

The distribution of nursing schools and faculties reflects the shortage of nurses in the northern and western regions of Brazil, regions with lower population density but with major social problems. The greater number of nursing schools in the southern and southeastern regions suggests that more prospective students migrate to these regions and remain there. This generates an overpopulation of nursing staff in these regions and a shortage of professionals in the others, thus drastically affecting health services.

Nursing staff migration is a worldwide phenomenon with impacts for the sector workers, and for the organization and functioning of health services. The international migration of nurses has been intensified since the 1990s as a reflection of the reductions and a subsequent shortage of nurses in northern hemisphere countries. The developed countries actively recruit healthcare professionals from less affluent countries worldwide, which then in turn have a shortage of personnel for their health services. When comparing the migration of nurses around the world, we verify that Brazil still does not have a significant participation in this process. As of 2003, Brazil had lost 2.8% of its nurses to the United States, but Guatemala had lost 34%, Honduras 32.2%, Panama 46.8%, and El Salvador 60%.[14]

However, by offering great labor advantages, many companies are recruiting nurses from Latin American countries, mostly for Canada, the United States, and European countries such as Portugal and Italy.

Thus, facts show the need to lead studies that analyze, monitor, and evaluate the phenomenon of the internal and international migration of nurses, considering it can contributes to solve the inequalities and inequities in health. To attain such purpose, those studies must involve a fundamental

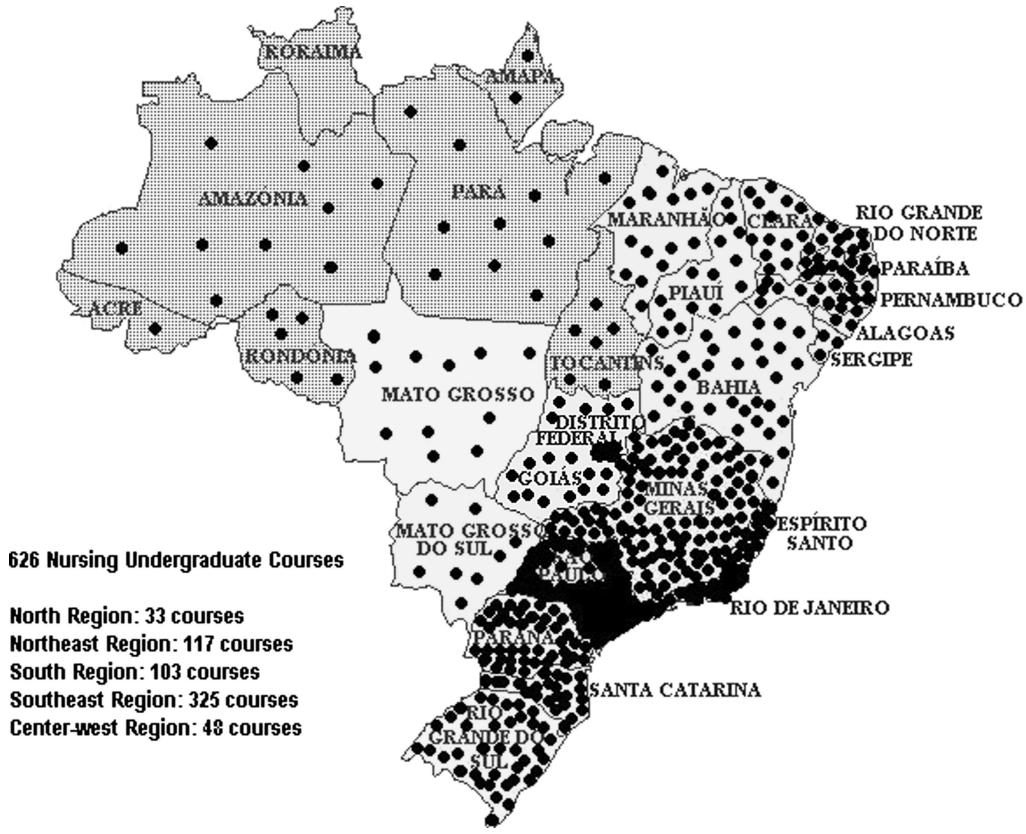

Figure 1. Distribution of nursing undergraduate courses in Brazil, 2007.

partnership among associations, councils, unions, public power, and civil society.

POSSIBLE SCENARIOS

In this scenario of inequality and iniquities, it is important for nurses to use methodologies that allow them to contribute as a political force in social changes.

In a context of high complexity and unpredictability, when the goal is to find strategies for the building of equity in health, it is of interest to consider the construction of scenarios as a methodology so that nurses can lean over on the current iniquities and glimpse possibilities of changes.[15] The scenarios make it possible to point opportunities, draw paths, and offer subsidies for the strategical planning of actions that allow nurses to contribute for a desired future, with reduction of the social inequalities. One cannot know accurately what will happen in the future, but reflect on the possibilities that allow more rational decisions to be taken, in view of which would be the most desirable future and, from this, to look for to realize it.[15]

Many methodologies to "look at the future" are possible. The construction of scenarios is only one of these, but it seems to be the best one when seeking to explore the possibilities from a qualitative point of view of the reality to be transformed. Two excellent studies demonstrate Canadian advances in this type of prospective study: the study developed by Martha Rogers,[16] a Canadian nurse, and the one developed by the Canadian Nurses Association.[17]

Although both studies use the methodology for building future scenarios, they present some differences. Whereas Rogers[16] proposes

the elaboration of future scenarios, desirable or not, using many categories of analysis for the same scenario, the Canadian Nurses Association study,[17] presents only desirable scenarios for Canadian nursing in 2020, analyzing each category ("assistential" model, education, political organization, etc) separately.

To prepare adequately for the future sanitary and social challenges and achieve a desirable and equitable future, the nursing workforce and the other healthcare professionals must take bold measures now.

Every nurse has the capability to influence the future: to create a positive future for the profession, as well as the health and healthcare of those we serve. To make informed decisions and choices, we need to think about the future beyond tomorrow or the next day. We need to explore the possibilities, both good and bad. We need to use our minds, hearts, and imagination to generate images of a preferable future and use our voice, hands, and feet to create our destiny.[16(pVI)]

For Rogers,[16] a future scenario for nursing involves the debate on the potentialities and the possibilities of nursing work. The author describes 4 plausible scenarios for nursing in Canada for the year 2020, on the basis of questions and trends that are present and developing in the health sciences. At the conclusion of her analysis, Rogers provides a space in which readers can build a possible and desirable scenario, on the basis of their knowledge and experience.

If we analyze the current situation of inequalities and injustices in healthcare in Brazil and Latin America, we can identify characteristics of the situation that help us understand nursing care as a resource that might aid in constructing more equitable practices.

Technologies are understood, in this study, from the definitions of Mendes-Gon calves[18] and Merhy et al.[19] In the conception of Mendes-Gonçalves,[18] technology is a set of skills and instruments that express the network of social relations in which the agents articulate practices in a social totality. Merhy et al distinguish the technologies involved in the health work process as light, light-hard, and hard. The light technologies involve the relations between citizens, implying bond, shelter, and management; the light-hard technologies refer to structured knowledge that informs the work process, such as epidemiology, taylorism, social communication; the hard technologies involve the technological equipment, such as machines, norms, organizational structure.

Therefore, new perspectives on nursing, with the inclusion and recognition of light technologies in nursing care, add value to nursing, considering they involve:

- the adoption of caring as a historical, cultural, social, and economic practice;
- the recognition of care dimensions in all areas of life and for all the population, promoting the universality of caring;
- the recognition of caring as a central element on nursing aspiring the construction of the social equity;
- nursing care centered on the necessities and demands of the population with strong emphasis in the interpersonal relations and the integrality of caring;
- an end to the determination by other professionals of the nursing role, with progress toward the construction of a nursing care practice;
- an increase in the research on nursing care: concepts, methodologies, groundbreaking experiences, nonhegemonic practices, with knowledge production;
- the inclusion of a caring approach in social and health policy-making as element that direct to the understanding of the social determinants of health.

The inclusion of these considerations may contribute to a greater understanding of the health-illness process in Brazil, which most Brazilians still consider to be solely biologically determined, tending to discount the socioeconomic aspects of the process. This paradigm would permit an extension of analytical approaches to a larger, more generous, and complex perspective of the health-illness relationship, and life history—past, present, and future projections—of people and their

communities. These new conceptions require the development and incorporation of light technologies into the nursing and health work process.

It is also possible to envisage that this understanding of the approaches to equitable health practices will feature the differences and create alternatives to address the needs expressed in the increasing demand for attention in health.

Therefore, the policies and practices that promote equity must focus, as a starting point, on the identification and analysis of the population's contemporary health problems and necessities, but they must always consider factors on which the possibilities of a future with equity are constructed.

With this knowledge, it becomes necessary to reconfigure the work process in health. In a world marked by new relationships of production and finance that create a world order characterized by inequality and injustice, sustained by values that defend political actions that favor the concentration of goods, prestige, and power, care is not protected; it has no defense against these interests and their repercussions in societies. It is necessary to rescue the solidarity that has been forgotten and reconstruct it to overcome the inequalities and the iniquities. Consequently, defending life with quality care asks for an ethical position, considering that the same system that "raised the human existence to unknown degrees of material progress, simultaneously lowered the value of the human being to the most vile levels."[20(p41)]

In this context, caring becomes a prerogative of life defense and a challenge to economic, social, and cultural inequalities and is revealed on the challenges to be faced by nursing:

- The cost of caring: It is not enough to want to achieve caring as the object and essence of nursing. It is necessary to recognize that caring has an ever-increasing cost that must be considered in its accomplishment. It must also be assumed by both government public policy and the private sector to be a responsibility of all nurses—especially the bedside nurses.
- The quality of caring: Considering the demands and necessities of the population, there is evidence to prove that the efficiency and the effectiveness of caring have a positive cost-benefit relationship.
- Caring as a space of interactions and possibilities, of multiple relations, mediated by technologies, interests, and social practices, culturally determined.

The defense of caring is not enough; it is important for society to prove with evidence from both quantitative and qualitative studies, that caring guarantees and improves people's life quality.

Everywhere in the world, politics is demanding evidence as the basis for decision making, and nursing staff must demonstrate that they have a positive and significant influence on the quality of care as well as on its costs, with the result of producing an effect on the policies, finances, and health practices.[21]

The search for evidence is a responsibility of all nurses—practicing nurses, nursing professors, and "assistential" nurses---and of societal sectors that are engaged with the ethical-political project of life defense. It is not possible to transfer this responsibility solely to those who carry out academic studies and who are responsible for policy-making in the health sector.

The use of light technologies in health must be considered as a central category in the construction of a healthcare that seeks equity.

Nursing care has historically been sustained by light technologies. Nursing has traditionally used these technologies and values them, intending to recover interpersonal relations, reassuring receptivity, establishment of bonds, and of the responsibility of the population for the individual and collective health-illness processes. Therefore, the reevaluation of nursing care in all its features must consider not only its historical nature but also the human dimensions in the caring process: beliefs and values of each different group, ethical commitment for life, human emancipation.

The projects of individuals and of their cultural and social group must also be considered, such as the bonds established between citizens and professionals. It is reaffirmed, then, that relations between nursing workers and users must proceed valuing subjective relationships, with the use of listening capacities, building spaces where users can speak out and interpret their expectations, creating moments of complicity, in which commitment and responsibility are produced in the context of the problems that must be overcome with confidence and hope.[22]

The incorporation of hard and light-hard technologies in the health practices field has dimmed the brightness of caring. It is important to emphasize that hard, light-hard, and light technologies must be recognized for their potential to extend life and health quality, and they should be used as an instrument and not as a purpose. The recognition of methodologies that systematize the care sustained in the use of technologies emphasizes the need to address the systematization of nursing assistance. This should involve nurses using the daily practice to formulate theories that explain care practice as a cycle of action-reflection-action, and in the affirmation and recognition of nursing science, with nursing care at its center.

The evaluation of nursing and healthcare quality has considered hard and hard-light technologies, resulting in a predominantly quantitative evaluation, despite qualitative studies and evaluations that express light technologies of health and nursing care. Thus, we have identified the necessity of implementing new evaluation models that consider the entire process and that use quality indicators related to the use of light technology.

As means to transform our population's health and life conditions and guarantee equity, nursing, and health practice must develop new perspectives and knowledge on the basis of an education that provides professionals with some technical-scientific ability that relates to the population and encourages an ethical and political commitment to society for the reconstruction of citizens' rights, founded in principles of social justice and peace.

Therefore, we understand that caring, more than merely an act, is an attitude that represents the values and the intentionality of nursing in defense of social equity. Caring is, therefore, the possibility of answering and of making oneself responsible for the other, for their care. This fully engaged level of care consists of touching, speaking, observing, listening, shielding, and establishing bonds, as well as having the capacity to act in complex and unpredictable contexts. The expression of care thus refers to the attention and solicitude for the execution of care practices, administrative actions, research, and education, through an attitude of concern, responsibility, and affective commitment, as well as through the adequate and opportune use of knowledge.[23]

We promote that creating bonds imply to establish clear relations of proximity, with sensitivity concerning the life conditions of the population, allowing the constitution of a relation of reliability between users and workers, which must establish the construction of autonomies. Thus, caring is "to feel responsible for life and death of the patient, inside of a determined possibility of neither bureaucratized intervention, nor impersonal."[24(p138)]

In the context of the recognition of these values, it becomes essential to recognize that light technologies are fundamental for nursing care, and they are expressed in all interactive relations of nursing workers, of professionals with other health workers, and in interactions of those assisted, either individually, or with their relatives or population groups.

The construction of integral and authentic care depends on the opportune and adequate combination of light and hard technologies; it also depends on humanization, with the purpose of recognizing the "place" of patients and their individual needs, as a starting point for any intervention, building possibilities of user-centered care.

All these factors must be considered in the construction of the future scenarios, so

that nursing can contribute for the social equity and the life and health quality of the population.

FINAL CONSIDERATIONS

For Brazilian nursing and of several developing countries in the world, one of the greatest contemporary challenges in healthcare is the construction of adjusted and equitative social policies that seek to adjust social, economic, and cultural distortions related to the (re)organization of health services. Nursing needs to respond to these challenges in a propositive way, which brings the task of rethinking their role and their purpose as social practice historically and culturally determined. This reflective attitude gives nursing some time to prepare herself in the best way possible to face the challenges that lie ahead.

We believe that the use of technologies in health and nursing must be adjusted to recognize that care is an element of life defense. Thus, recovering and valuing the meaning of light technologies in nursing care becomes an ethical-political act of defending life with quality, centered on care of individuals and communities in the exercise of citizenship.

Caring must be assumed as a tool that creates possibilities of a world in which respect for ethics, diversity, solidarity, democracy, and human emancipation is imperative. To face such a complex challenge, the nursing profession should strengthen alliances between society's civil sectors that are committed to care, as a prerogative of life defense with democracy, equity, and peace.

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