

Integrality in Brazil and Venezuela: similarities and complementarities

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Abstract *This study aims to compare Primary Health Care (PHC) in Brazil and Venezuela, considering its characteristics as to integrality. It has a qualitative approach, using documental analysis, semi-structured interviews with key informants and field diary notes. We observed the three realms of integrality inherent to the health work process: comprehensive and holistic care, the individual viewed as a complex being with multiple needs, requiring the connection of various health knowledge; continuity of care in institutional micro-policy with interprofessional articulation, in order to consider individual care; continuity of care in macro-policy, when a shift to other levels of care is needed; intersectoriality was also included, when the needs of an individual and community require a cross-sectoral coordination, with action on determinants and conditionants of the health-disease process. It is worth highlighting the natural tendency to include a comprehensive community medical training. We conclude that those countries strengthened by democracy draw their integrality practices closer, as well as the construction of social and health policies for underprivileged populations to achieve equity.*

Key words *Integrality in health, Primary Health Care, Comparative study*

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Introduction

The term *integrality* has several concepts and interpretations. There is a line of thought that brings denominations geared to health policy or governmental responses to certain health problems, with articulation of prevention and care actions. A second meaning concerns the organization of health services, and a third refers to health practice itself as comprehensive and holistic care¹. The term *integralidade*, *integrality* or *integridad* is defined by the Virtual Health Library (Decs/BVS) as:

The fundamental principle of public health systems that ensures to the citizen the right to be served from the prevention of diseases to the most difficult treatment of a pathology, not excluding any disease, with priority for preventive activities and without prejudice to care services. Integrality presupposes health care and sectoral management that recognizes the autonomy and cultural and social diversity of people and populations².

This paper addresses all the meanings given to the term “integrality”, mainly as a proposed organization of health systems and services maintaining the continuity of care to individuals, family and community. In Brazil, primary health care is predominantly operationalized by the Family Health Strategy and recognized as a guiding and coordinating strategy for the Brazilian health system, corroborating with the implementation of the principle of integrality³.

This is the level of care of the SUS with greater resolubility of health problems of the population, and greater power of organization and direction of the system as a whole. Since its inception as a Family Health Program, the Family Health Strategy originated as a strategy for the reorganization and strengthening of PHC in the SUS, including expanded access, qualification and reorientation of health practices⁴.

Comprehensive or holistic care translates the vision of individual care in a particular and specific way and as approach to the individual as a whole in his biopsychosocial needs. Leonardo Boff⁵ brings the integral care vision as a search for the balance between body, mind and spirit, and summoning the doctor (body), therapist (mind) and priest (spirit) to work together for the totality of human being.

Other Latin American countries structure their public health systems and services based on principles and guidelines similar to those adopted in Brazil. Venezuela's health system is in transition since 1999, when the new Constitution of

the Bolivarian Republic of Venezuela was approved. The public sector is made up of the Ministry of Health, the Venezuelan Institute of Social Security (IVSS), the Institute of Social Security of the Armed Forces (IPSFA) and the Institute of Social Security and Welfare of the Ministry of Education, Culture and Sports (IPASME)⁶.

In the 1990s, the health services of the Venezuelan states were decentralized (17 of the 23 states are decentralized), contributing to the fragmentation of the system, since it did not occur in agreed and integrated fashion. The establishment of the *Misión Barrio Adentro* in 2003 gave rise to a process of transformation of the health-welfare network, initially in primary health care, based on a Comprehensive Care Model, which has since been implemented in parallel and in a non-integrated way with the current traditional model.

As in Brazil, two healthcare paradigms coexist in Venezuela; one oriented to the traditional and fragmented system, and the other directed to the integral practices of care and health care. In these twenty-six years of SUS, health policies and practices were formulated in order to include the principles of universality and equity, but we can affirm that integrality remains one of its greatest challenges⁷. Thus, we noted the relevance of investigating similar experiences in Latin America, such as Brazil and Venezuela, in order to compare PHC in these countries as an objective of this paper, observing its characteristics regarding integrality.

Methodology and techniques

This was a qualitative research involving the study of multiple cases where Brazil and Venezuela stand as comparative analysis units. Yin⁸ considers that the same study may contain more than one single case and the set of cases will be a multiple case project, and this is the type of study we used in this research.

This paper was a partial analysis of the original research entitled “From Institutional Policy to Care Processes: Comparative Studies on Health Promotion Practices in the Family Health Program (PSF) Teams in Brazil and their counterparts in Canada, Cuba, Colombia, Chile, Peru, Portugal and Venezuela” (*free translation from the Portuguese title*), conducted at the Center for Public Health Studies (NESP) of the University of Brasília (UnB). It was approved by the Research Ethics Committee of the Faculty of Health Sciences (FS/UnB), under project N° 084/12 ana-

lyzed at the 6th ordinary meeting on July 03, 2012.

The analysis of the current national normative framework, semi-structured interviews and the observation of the context at the time of the data collection through field diary notes were used as data collection technique. Regarding semi-structured interviews, the participants of the research in Venezuela (Chart 1) were key informants managers of State Public Health Services in PHC; they were developed by multi-professional teams linked to “community health workers” or similar function. Research participants were identified according to the following acronyms:

In Brazil (Chart 2), the research participants were professionals and managers of the Family Health Strategy teams awarded at the III National Show of Family Health Production, the III National Contest of Family Health Experiences held in 2008. Award-winning experiences with emphasis on health promotion were selected. The Brazilian units of analysis were identified according to the following acronyms.

Results and discussion

Comprehensive care: individual and holistic

With regard to politics, Venezuela’s constitution establishes the right to comprehensive care, as well as assigns to the State the responsibility to provide such service similarly to the 1988 Brazilian Constitution, as expressed in the following statement:

“Our Constitution says that every Venezuelan has the right to comprehensive health and that the State is responsible for this compliance. This is what the Constitution says.” (MS) “Health is a right of all and the duty of the State”⁹.

From the viewpoint of integrality as comprehensive and holistic care, which represents care of the individual in all his/her needs, whether biological, psychological or social, we observe the relationship of Venezuela’s participants with PHC, as shown in the statements below.

When we talk about primary health care, we’re talking holistically. We cannot take anything else into consideration. (MBAI)

Comprehensive/holistic care is found in the Venezuelan PHC as a pillar for the organization and delivery of primary health care. The *Misión Barrio Adentro I*, the organizational structure adopted for PHC in the most vulnerable regions, is comprised of Cuban medical professionals and Venezuelan doctors with a background in Community Integrated Medicine and multi-professional team working in the perspective of this holistic care of individuals, families and the community.

In Brazil, we identified statements that translate integrality into the holistic vision where, in the work process, professionals visualize individuals as a whole, part and reflection of a context. Inferences are as follows:

We now see individuals as a whole. We know about their insertion in the home and work environment. Thus, we see the importance because, until they reach specialty services, primary care will have to provide this care, and often this care does not require only a specialist’s demand. Thus, the specialized back-end support strengthens the issue of monitoring the continuity of care. (FLOR)

Then [in the case of TB, for example] we do it and bring the individual and the family; we have already done this: this is active search. Then we ran an x-ray in all of them – communicators – and ran a smear test. [...] Thus, we do these things. (ONPA)

The difficulty of seeing the individual as a multifaceted being, reflecting a number of determining factors (individual, family, environmen-

Chart 1. Research participants in Venezuela.

Acronym	Work location during research
MS	Ministry of Health
MBAI	<i>Misión Barrio Adentro I</i>
APS	Primary Health Care / Ministry of Health
TICS	Technology, Information and Communication on Health

Source: Research data.

Chart 2. Research participants in Brazil.

Acronym	Municipality during the research
AMP	Amparo/SP
CAMP	Campinas/SP
FLOR	Florianópolis/SC
JPPB	João Pessoa/PB
ONPA	Outilândia do Norte/PA
VAC	Vacaria/RS

Source: Research data.

tal, social, economic, educational, among other factors) hinders professionals' work in providing a truly comprehensive care, favoring the continuity of the care, a process that begins with the incorporation of principles such as reception, establishing links and accountability, which are principles of a Comprehensive Care Line.

The conception of some professionals about integrality in PHC reinforces the realm of users as beings made of different aspects and integrated with each other. Achieving comprehensive health care starts with reorganizing work processes in PHC, redefining practices in order to establish bonds, reception and autonomy that recognize the subjectivities inherent to health work and singularities of individuals, allowing a user-centered care¹⁰.

In Brazil, we also see a perspective that holds the user responsible for the predominant care focused on healing, where difficulty in offering comprehensive care is justified by the fact that the population is accustomed to the traditional medical-centered approach and people expect this type of care by professionals, as per the following statement:

This is the situation. The demand for treatment is huge, so I think that comes first. Now, we perform promotion daily... health education, promotion ... but the burden, the greater demand is treatment. (CAMP)

Studies show that the fragmented provision of services in PHC hinders access and compromises the quality and integrality of care provided. Reception is an important tool in the construction of comprehensive care favoring improved access and the shift from a paradigm focused on disease and treatment to an individual-focused care¹¹.

Integrated care in the micro-policy of health services

When we looked at the organization of health services in its institutional micro-policy, from the viewpoint of integrality, we noted that Venezuela had a characteristic similar to Brazil, where reception is a risk classification of users, which guides necessary individual care, as shown in the following section:

At the primary care level, we perform what is called classification of patients. What is this procedure about? Group 1 is for apparently healthy people; Group 2 is for people at risk; Group 3 is for sick people; and Group 4 is for people with sequelae. This is very complex, if we were to see the level of the comprehensive health concept. (MBAI) In Bra-

zil, participants brought other meanings to the articulation of integrality in the institutional micro-policy, as in the following statement, which brings the interference of access in the construction of a comprehensive care practice:

[...] I think there are still things that the SUS doesn't do. It would be great if we only could get it him to do everything, such as oral health, because there are things that the SUS does not yet cover. Let us say, some treatments are not performed by the SUS. (AMP)

We identified the superficial multi-professional relationship woven in the institutional micro-policy, mainly in the way professionals communicate. Venezuela has not yet moved towards computerization of individual health information of the users, although it considers it as an important step in the consolidation of the National Health System; it brings States' decentralization as an obstacle to the implementation of changes like this.

There's nothing automated right now. It is in the making. If we do not automate, we cannot control anything, because we are few. All is printed; it is all about printing now. We say this has to be vertical, horizontal, but there has to be a communication network that unifies the system. For example, we are trying to see that the number of Venezuelan identities, that is, all information that is inserted there, all medical and non-medical data can be accessed through the network at any point in the country to find out each individual history... Medical records. However, it is a long-standing discussion... It is something that is very complicated, because whenever it is public, someone who is not unique... (MS)

The local information network strengthening is still ongoing in Venezuela. Information systems linked to ministerial programs and missions are not yet consolidated, so that there is an institutional demand for agreement and definition of these structures, such as the information below:

All health programs lack information systems. So we enjoy this moment, when we made the diagnosis, we first took on the task of defining the conceptual framework so that everyone would be involved there. The task is a bit tricky, but it is not difficult because many people must converge to articulate and involve the whole process. There we are now. We are defining the conceptual framework to see what will be the information system that will support each of the programs and then what will the main timeline be. (TICS)

In Brazil, since 2011, the Ministry of Health has been working on the consolidation of the SUS National Health Card System, for use by

each citizen, in order to consolidate a trend of unification and single record. It aims to identify users of health services and actions; it allows the registration of users with national coverage and territorial base; it ensures technological security regarding the integrality of the information and confidentiality; it links users to the SUS and allows access to their own information¹².

Integrated care in the health services' macro-policy

Health macro-policy involves different health facilities, with varying technological densities. In the SUS, Health Care Networks (RAS) have been referred to as users traversing these health facilities for the implementation of integral, singular and comprehensive care.

Gateways of this care network are PHC, Urgent and Emergency Care, Psychosocial Care and Special Open Access Care¹³. As in Brazil, PHC is the gateway to the Venezuelan national health system, as described by the following statement:

So until the community is convinced by the reality that I go there, solve the problem and go back home, and it's easier because it's close, I don't have to drive and get there. I believe that credibility makes the system work; and the system works and you really know it works. I go there and they solve my problem. If it is not solved, they send me to the hospital. At the hospital, they decide to send me to the first level, and I continue with my doctor. (MS)

In Brazil, RAS operate in integrated and agreed fashion with all levels of health care through specialized back-end support.

There are several network spaces integrating the different levels of complexity to discuss monthly. [...] There are moments of meeting between mental health and family health professionals, to discuss cases of care, home visit. [...] Then these mental teams that provide support also gather monthly with the CAPS and the CAPS also contact the hospital, making a line of care. (FLOR)

Then we remove people from the villages to the municipalities of reference. Those cases requiring a more specialized, medium and high complexity treatment come from municipalities and go to a Regional Hospital located in Redenção. [...] They come from all municipalities covered by the District, these patients come to this hospital here in Redenção. (ONPA)

The Comprehensive Care Line (LC) arises from the need to rethink new care models, guided by the principle of integrality, where living work promotes changes in the health work

process. The primary characteristic of LC is the construction of a user-centered care (singular), shifting from the perspective of care focused on disease, professionals or the market¹³.

Intersectoriality

Brazil and Venezuela are similar in terms of intersectoriality in the health sector. Based on similar definitions of the health-disease process, these countries believe that health and well-being of individuals are conditioned and determined by multiple factors of an organic, biological, social, psychological, environmental, historical, cultural, educational nature, among others.

As Andrade said ten years ago, in addition to a multistate and multidetermined health concept, in its daily practice and in pursuit of integrality, the SUS requires multi-professional actions, which, in turn, imply the articulation of the most diverse knowledge towards promoting the health of users, whether in the individual or collective realm. That is, the very exercise of the principles and guidelines of the SUS requires an articulation of transectoral knowledge and practices¹⁴.

States sharing this vision tend to organize their actions and legislations in health in order to contemplate multidimensional care, that is, they allow articulations among the most diverse sectors outside Health. The following statements reinforce these inferences:

Thus, if we are to achieve PHC, we have to involve other institutions than the health sector. For example, our kids are growing 2 inches. This is part of integral health policy. However, it is the direct responsibility of the Ministry of Food. It's a State policy that results in an indicator that says your kids are growing up. (MBAI)

At the level of primary care, they have made progress with other ministries; with the Ministry of the Environment, with the Ministry of Housing... Here we have a Ministry of Municipalities, we also have relationship. At the level of hospital care, there are some networks operating like security agencies, but the rest is under construction. (MS)

There was a partnership with the DLU [who participated in the experiment], which is the urban cleaning department. We forgot about the projects, we do dancing parties with the elderly; once a month, the city bus comes and picks them, they go along, and CRAS provides them with classes of crafts, choir singing. We had this, and we have plenty of activities. (CAMP)

I worked in the school part, visiting schools... There is another way of calling these children,

these schoolchildren, with an ongoing survey. It was annual before. From this year on, it is going to be every two years. Dentists go there to schools of their area there, they do a survey, a pre-screening. They examine all children's mouths and call as well. Thus, it is another form of access to treatment, that fits with the ticket; ticket is used more to call individuals of the district. And there's also school service. (AMP)

There is also a partnership with the Ministry of Social Development (MDS). They provide food baskets via the Ministry of Social Development... Food baskets are distributed, but the instalments that we receive are not monthly, for example. They are ... [...] six (steps) ... twice a year (ONPA)

Intersectoriality in health provides for actions articulated with other social policy sectors, but it was not adopted primarily by managers in the three Brazilian governmental spheres responsible for the implementation of health policies, highlighting actions geared towards an integrality characterized by referrals and counter-referrals in the different levels of health care¹⁵. Integrality encompasses intersectoriality, but still does not have a priority agenda in the health sector:

... integrality is the SUS guideline that has developed the least over the 20 years of its existence, contrary to decentralization and social control guidelines, which were central to the recent course of the sector¹⁵.

The consolidation of strategies and organizational arrangements that allow the exercise of integrality in the SUS is still a challenge. In PHC, mainly due to its implication in health promotion and actions on determinants and conditionants of the health-disease process, there is greater urgency to configure comprehensive health care services effectively.

Comprehensive Community Medicine Education

In the Bolivarian Republic of Venezuela, Comprehensive Community Medicine courses established by Cuban doctors, part of the Venezuelan-Cuba agreement were created with the objective of training Venezuelan doctors to provide comprehensive care, a health care model set in the *Misiones Barrio Adentro*. This characteristic refers to the Brazilian *Mais Médicos* Program, established with the objective of strengthening Brazilian PHC, taking medical professionals to the most remote and difficult access places to cover a vulnerable population. This program also provides for an increased number of places and

medical courses in the country, as well as curricular reform that includes PHC in teaching-learning programs. This progress is shown below:

UFSC sends its students to us also because it is a fundamental PHC experience for them; they cannot go through university without knowing what is done here, and this has changed because, until recently, it was once a week only with their visit here, but with the change of curriculum, they spend a period immersed here, mornings and afternoons, and you can see what is done. (FLOR)

... the Integrated Community Medicine Program focused on training doctors, with all the medical skills, but which, with greater strength in promotion and prevention, obviously with capacities for diagnosis, therapy and rehabilitation; this was the profile of the doctor trained in his community. (MS)

While in Venezuela the Bolivarian University (comprehensive education with the support of the Venezuela-Cuba Agreement) and the Central University of Venezuela (fragmented traditional medical training) coexist, Brazil is undergoing a moment of curricular transition in the several national universities that are faced with the challenge of including in their curricula community medicine education, preparing future professionals to work in the promotion, prevention, treatment and rehabilitation with the community.

Final considerations

This comparative study on integrality between Brazil and Venezuela brings similarities in the application of this principle in primary health care in these Latin American countries and evidences complementarity.

As for the concepts of the term integrality, they resemble in the three-dimensional view. First is the definition of comprehensive and holistic care, which seeks to provide users with a unique care, addressing the unique needs of each individual, in the organic, biological, psychological, and social realms, among others.

The implementation of an effective comprehensive and holistic care requires an inter- and transdisciplinary action and a configuration of the health work process in the living space of the institutional micro-policy so that users' health needs are included, defining the second realm.

Building on a comprehensive concept of health, as in the SUS, it is necessary to articulate with the most diverse levels of health care, which in Brazil is called networking and line of care,

that is, a third realm of integrality, the continuity of care in the institutional macro-policy. In Venezuela, the *Misiones Barrio Adentro* expand to account for all levels of care, since agreements with traditional structures are not effective.

Intersectoriality holds an important place in integrality, since PHC is mainly focused on health promotion actions that directly affect the conditionants and determinants of the health-disease process. In Brazil as in Venezuela, PHC involves knowledge and practice from other sectors in its health work process under a macro-political perspective.

Medical education in Venezuela is polarized. On the one hand, comprehensive community medicine education and, on the other, traditional medicine. In Brazil, movements toward curricular reform and medical education in family health or community medicine are still underway and mainly motivated by the *Mais Médicos* Program.

In this study, we can highlight that social policies with the *Misiones* (Venezuela) and the Ministerial Programs (Brazil) aimed at the most vulnerable populations have a systemic impact on health work processes, further strengthening primary care as a regulator and coordinator of national health systems.

Collaborations

CTB Santos, IS Barros and ACCLA Amorim participated in the analysis and interpretation of the data; writing the article. DG Rocha participated in the design and execution of the stages of the project, critical review relevant intellectual content. AVM Mendonça participated in the design and execution of the project stages, co-orientation of the essay, critical review of the intellectual content and final approval of the version to be published of the article. MF Sousa: design and execution of the project stages, orientation of the doctoral thesis and the writing of the article, critical review of the intellectual content and final approval of the version to be published of the article.

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