



## BROADCASTING AS A MECHANISM FOR CONSUMER PARTICIPATION IN THE CONTEXT OF DELIVERY HEALTH CARE

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### ABSTRACT

**Objective:** to understand the perception of managers of health units on the use of community radio (CR) as a mechanism for expansion of consumer participation and control process in the context of delivery health care. **Methods:** study with descriptive exploratory design and qualitative approach based on interviews with managers of counties analyzed under four themes: (1) CR environment and popular use, (2) CR as space communication and health education, (3) design on the model of health care, (4) consumer participation in health services. **Results:** from the management models adopted, there is a tendency to exercise a instructional health education. Proposal that uses normative paradigm to health care and intervention. This model of care and education is far from the perspective of understanding of Health as historical product. The educational approach adopted emphasizes the importance of measures of health hygienists, naturalizing approach on the social determinants of health-disease process.

**Key words:** health communication; consumer participation; delivery of health care. Health services administration; social networks.

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## INTRODUCTION

A contemporary challenge of the National Health Systems is to reconcile the principles of promoting health<sup>1</sup>, fundamentally structured on the development of the autonomy of communities to the precepts of preventive medicine, developed from the theory of populational risks<sup>2,3</sup>.

Basis of traditional epidemiology, the theory of populational risks substance the National Health Models called on cost / benefit or cost / effectiveness<sup>4,5</sup>. This logic establishes investment priorities by advocating public health policies without dialogue with the expectations of community participation with relation to their health care<sup>6,7</sup>.

Thus, questions arise about the impact of political models structured in National Health Systems in stimulating social equity in the population's access to health services<sup>8-12</sup>. Particularly, in care models of decentralized management aware of the perspective of equality, cultural diversity and socio-historical tradition of the populations should be contemplated and based on principles of health promotion<sup>11</sup>.

From this point of view, rather than a spatial distribution of goods and services, the proposals decentralized with universal and/or fair access conduct to a review and discussion on the construction of citizenship and its relationship with the state. Issue that goes beyond the Brazilian reality and finds resonance in political projects of other countries and refers the evolution of proposals for public health in countries with liberal and neoliberal economy<sup>13</sup>, where we can notice the restructuring of the state apparatus and reordering of state-society relation<sup>13-15</sup>.

Paradoxically, regardless of health policy, countries with a neoliberal vocation live with the shrinking of public space in the administration of other social sectors such as education, culture, leisure, safety, sanitation, housing<sup>14,16</sup>.

It should be noted the Brazilian Unified Health System (SUS), which proposes match community needs and ex-

pectations to the concrete possibilities of system designed to operate with limited human, material, technological and financial resources<sup>17</sup>, but by its paradigmatic principles propose the equality, universality and integrity<sup>18-20</sup> of health care, this in its contemporary<sup>15</sup> meaning.

Therefore, in order to broaden the perspective of social participation, in agreement with the positive concept of health<sup>21</sup>, the planning and implementation of health policies should incorporate among the guidelines of the health decentralized management<sup>20,21</sup> the social and cultural values of the communities<sup>22</sup>.

In this sense, the community radio (in Brazil, there are more than 3500 of these small power stations, authorized by the Ministry of Communications) as a vehicle of mass communication, can operate as an element of dialogue and interactivity<sup>23</sup>. A system of mediation between public managers and the population restricted in their coverage area.

That said, we start from the assumption that community radio can become a basic mechanism within the processes of community participation in the SUS<sup>7,23,24</sup>. Thus, not only for being a vehicle of transmission, but a strategy of/for cultural change in complex societies<sup>22</sup>, the use of such equipment in the context of decentralized management of health services can contribute to expanding the exercise of social control in managing to : a) function as a mediation between management and population health and b) ensure the social rights advocacy and improvement of living conditions and health of the population.

So, the objective is to understand the perception of managers of health units on the use of community radio (CR) as a mechanism for increasing the participation and social control process in the context of decentralized management of health.

## METHODS

Exploratory study of descriptive character that uses qualitative approach and refers discursive clippings of intervi-

ews with managers of Basic Health Units (UBS) and the Family Health Strategy (ESF) in Brazilian municipalities. The study was approved by the Ethics Committee of the Faculty of Public Health, University of São Paulo (FSP/USP) in 2006.

The choice of the territorial basis for the research is justified by the characteristics: a) be a dormitory town, b) be a pole of attraction for migrant families, particularly those of northern and northeastern regions of the country, and c) have community radio aware of their possibilities of partnership with the SUS.

The results and discussion are organized into four thematic areas, in accordance with the guidelines of the interviews, namely: (1) community radio as the setting for popular use, (2) community radio as a space for communication and health education, (3) concept on the model of health care, (4) social participation in the context of decentralized management of health services.

## RESULTS AND DISCUSSION

It can be noticed in the mentioned thematic axes, difficulties from some managers in receiving, in the context of institutional culture, popular processes and resources which advocate social rights of the population.

### (1) Community Radios as a popular usage environment

The key informants generalize considerations on the programming of the radio now with a bias of product without creativity and so boring, at times as the fruit of sensationalism.

*"I think it's interesting I think it's nice (...) I think it has the right time. Not to make it boring (...) (...) To know how to do it (...) to hold the attention, but I think it works. Because the radios that will be made here are by people from the community. So it can be done, but what we see are critical at inopportune times or without an understanding of how the system works" [Speech of key informant 01]*

In this sense, it can be noticed in their perception, a tendency of the listeners to choose the musical entertainment at the expense of public interest information which, eventually, the radio might be transmitting.

*"(...) I think it [community radio] is important as it conveys the information in both directions. Both the institution for the population as the population for the institution. It is still an important communication channel to disseminate opinions, the only thing I fear is (...) not to fall into sensationalism. " [Speech of key informant 03]*

Either way, the discourses attribute negative value judgments to communicative actions created and/or managed in a popular environment.

### (2) Community radio as a space for communication and health education

Robert Putnam<sup>25</sup> attributes to the community communication the strategic role for the development of citizenship. In the scenery set up by Putnam, communication emerges as an integral element of experience and community initiatives, basis of the sense of social solidarity and social and political participation.

An important aspect of this issue, pointed out as central among contemporary educators, yet not perceived by the key informants in question, is the enhancement of historical, social and cultural components, and associative life as part of educational processes.

*"(...) I think so, it is of great interest of health to have the radio as a means of communication. If we do not have a television, that is what a person wants, the look, everything ... Radio is another service that is very important, I think the health guys have to have a moment here. (...)" [Speech of key informant 01]*

In this context, the radio is perceived as a means of communication capable of "reporting health and/or disease information." That said, it is clear that the educational process is understood as to speaking of disease and it is not noticed

in the discourses, the concern to adjusting the communicative action to the cultural characteristics of the population.

*"(...) Why not use the radio to talk about the diseases and means of prevention? Look: dengue does exist, that is the point! It is a means of communication that has to exist, it will help us, won't it?" [Speech of key informant 02]*

It should also be pointed out the distance, as perceived by the managers, from the principle of cultural transduction. That is, minimizing the recovery in the educational process of local communicators, able to lead in his group language the health information indicated as necessary by health professionals.

### **(3) Conception of the health care model**

With respect to the adopted model, it is observed in the speech of the managers, the tendency for traditional exercise (instructional or formal) of health education. Proposal that comprehends and advocates health actions in the logic of traditional models of intervention.

This model of care moves away from the perspective of the concept of Health as a historical product. The educational approach adopted by managers highlights the importance of health hygienist actions, naturalizing ideas about the social determinants involved in health-disease process.

*"I think health for all is to preventing diseases (...) As I just said the last word. Prevention. I think health for all is to preventing diseases. The healthy is the disease prevention. It is my general understanding (...) I think the most objective thing to maintain health is prevention" [Speech of key informant 01]*

It is observed in the speech of key informant 01 that there is not a dialogue with the precept of the World Health Organization about the design of the health-disease process<sup>5</sup>. There is, however, the expressed concept that prevention is synonymous with health, reducing the dimensions of citizenship and social participation. Besides the difficulty of a reflection of the complexity the theme raises on the

interface with the social determinants of health.

It is also interesting to note that the bases of the reform of the health care system would be in contrast to this model, since national systems, which aspire to have as principle the health promotion must recognize that health depends on access to education, transportation, housing, food, safety, work, leisure among others. Human needs of collective responsibility - as the network of social factors that connote health as common well.

*"(...) Health, uh, a condition that depends on several factors such as their own ..., physical health, the environment interfering with health, then there would be the issues of sanitation, education, information, economic factor that is something much broader" [Speech of key informant 02]*

However, as evidenced in the speeches, despite the commitment of SUS in understanding and facing the social determinants of health, the care model is structured based on individualized educational models and pointed to an approach centralized on the figure of the health workers, losing opportunities to stimulate processes of collective action<sup>26</sup>.

*"(...) Well, then, it is through our health workers, it is through the face to face of the assistants, it is also through the doctors talk about the routine and the eventual, isn't it? (...). It's what I say, every moment is done by our health workers leaving UBS, (...) our work faced with our community, and make the education." [Speech of key informant 03]*

Opinion that legitimates the absence of a collective protagonism on/of the education and health actions for the strengthening of social control in SUS, given the centralization of every educational process in the figure of health workers.

### **(4) Social participation in the context of decentralized management of health services**

Managers, according to interviews, organize their observations around a deficiency in the participatory process. The

desirable participation is seen as a more consistent activity. What is observed as a product of participation are punctual and out of time criticisms to SUS 27.

*"(...) social participation is still small by all .... Perhaps because we come from a time history of repression. That is, they are people who have had their adolescence and youth during the dictatorship. I think this has to do with this inactivity though all are called, people still do not have this culture" [Speech of key informant 01].*

It is worth noting that the speech of the key informant attempts to bring an explanatory level to the participatory deficit, which would result from two possibilities: a) a culture of passivity inherited from previous, exclusionary and repressive political conditions, and b) low empowerment of the population.

*"It should be more effective [community participation]. It is weak, (...) the city council itself is a valid institution, but not valued, at least here in the city, I don't know in the others. Maybe people don't have yet clear the appropriate channel to make complaints, claims and discuss the issues (...)" [Speech of key informant 02].*

Nevertheless, the speeches do not indicate any concerns about the leadership role among the population. First, they refer to the community as an external object to the Health Service, although punctuate the existence of Municipal Health Council as the legitimate agency of the exercise of social control in SUS<sup>27,28</sup>. However, failing to see itself as part of the community, it endorses a distant view that separates the interests of the health services users.

Thus, in general, the results express a low understanding of managers to perceive community radio as a favorable location for the exercise of social control and citizen participation in decentralized contexts of public health management.

It should be evident in this study that the municipal manager breaks the possibility of dialogue advocated by the public management paradigms, agreed with the population, by adopting the traditional biomedical preventionist view as

a model of health care. In this model, there is the risk of transforming the management process in a *referendum* of the determinants of illness and, accordingly, opening the possibility of transferring responsibility to the people by bad living conditions<sup>23</sup>.

It is encouraged, by naturalizing the conditions of health, the decontextualization of the health-disease process of the macro socio-economic model and, therefore, of the social determinants.

Thus, not only the joint committees of the various levels of SUS management, created in order to give transparency to administrative actions, were depoliticized, but also it contributed to the depoliticisation of intersectoral relationships of health<sup>22,27</sup>.

It is noteworthy that urges not to delimitate the reform efforts to a set of technical and administrative health care system in force adjustment, but to take a real change in the way of conceiving the state's role in this process.

In the context of the Brazilian sanitary reform, field of this research, two relevant and overlapping issues emerge. On the one hand, how to conquer the population for the exercise of social control in the many spheres of the SUS, make them aware of their constitutional rights and educate them for the use of health facilities, if the practice of leadership is reduced to the technical component and does not incorporate the social and health policy? On the other, how to treat this issue fairly, ie, equalize the efforts of SUS management to give time and voice to those who do not recognize themselves as subjects of the construction process of SUS?

That said, the question is how one can empower people to understand and assume its leadership role and do not conform to it simply as "beneficiary" of the SUS. The contemporary challenge goes beyond the technical-instrumental and improving management of the Health System. In other words, the challenge goes beyond the administrative approach of medical care (either in the optical preventive or curative) of local health teams to the field of construction

of a democratic society, guideline *sine qua non* of the SUS.

Alvarez and col.<sup>22</sup> lead us back to social authoritarianism in Latin America to describe the set of social relations that govern the discretionary social hierarchy. They emphasize the need to mobilize and repoliticize the debate on the right to health in the perspective of enlarging the participation and the intervention power of the excluded social groups.

According to the authors, behind the instructional and asymmetric approach of the relationship between services and population, emerges an individualistic slant evident in societies with unequal classes<sup>22</sup>.

With regard to the importance of social control for the SUS, the ideas of Putnam, Alvarez et al. alert us to the need for expansion of the principles of participation and democratic control of management - as expectations and standards of sanitary reform - but also make specific reservations about the concrete possibilities of social participation in our country<sup>27,22</sup>.

According to Costa and Lionço<sup>29</sup>, the political principles of SUS (equity, universality and completeness) should be understood as

*"Questioning elements for health policies, which in turn must, toward the charges, the potentialities and specificities of historical circumstances, be reallocated as issues to be worked in each community by managers and workers of the system"*<sup>29</sup>

According to Castiel<sup>1</sup>, Viana, Lima and Oliveira<sup>10</sup> and Santana<sup>12</sup>, adjustments to the neoliberal ideo-political legacy advocate between the lines, under the aegis of equity as principle of social justice, the search for focalization of the system for the poor, breaking the universality advocated in SUS<sup>19,20,27</sup>. That legacy can contribute to the fragmentation of social projects of collective interest in Brazil, such as the discussions lead by managers in the field of management agreements<sup>25</sup>.

Supports this approach the agenda of funding research and studies in

Science & Technology in Brazil, since it has a strong interest in the characterization of social conditions and their relationship to health status of specific population groups<sup>26</sup>.

However, it should be noted that health is not merely a service subject to an agenda that advocates the principles of distributive justice as parameters of evaluation and implementation of actions, services and research in social and health.

In this sense, they hurt both the principles of the Universal Declaration of Human Rights as the Brazilian Constitutional precepts, according to which health is, above all, a universal right based on legally indivisible and intangibles principles that take life as a supreme value and not fruit of technical and legal agendas nor political parties.<sup>5,16,20,21,28</sup>

Therefore, the use of community radio as a space dedicated to health issues can serve as an advocacy tool for human and social rights as well as a management tool from the perspective of interactivity with the public, despite the Brazilian experience does not lead in this direction.

In Brazil, the media of commercial radios has been making effort to characterize the community radios as socially dangerous<sup>23</sup>. In this context, the Public Health should open a space for discussion to problematize complex issues, as is the case of community radios as a democratic, decentralized and collective space. That is, spaces potentially favorable to develop local and regional actions for health promotion and fostering community participation in decision-making processes with respect to individual and common health<sup>7</sup>.

Thus, health managers are not all in tune with the political and interdisciplinary perspective that the guidelines of social participation do not dispense.

Overall, the approach to the population project, defended by the respondents, proved to be traditional in regard to the purposes and routine tools of communication. In all cases, the responsibility of health care was understood as disease care.

These findings highlight the management of health services and their limited understanding of the health-disease

process as well as the use of alternative media, challenges for the realization of the SUS.

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