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Health needs: an analysis of Brazilian scientific literature from 1990 to 2004[*]

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ABSTRACT

This paper assumes that the health services' responses to health needs were affected by the regulation of the Brazilian public health system. The study objective is to identify the health-service trends found in scientific publications. Among the 73 publications selected from the LILACS on-line database, 66 (90.4%) did not mention the concept of health needs. Those that did had a reflective stance toward the subject. Health needs as defined in those articles were similar for all individuals, not considering them as members of a social class, a circumstance that defines health-needs characteristics. The results of this study are worrisome because health care delivery has been emphasizing sickness and reinforcing classification practices, rather than enabling emancipating praxis.

Key words: Needs assessment. Health services. Scientific literature.

Introduction

Several studies in Collective Health have addressed the complexity regarding health needs and its effects over health services (Campos, 2004; Matsumoto, 1999; Schraiber & Mendes Gonçalves, 1996; Stotz, 1991).

Collective Health is an interdisciplinary area. It comprises epidemiology (mainly social epidemiology), health planning/administration (regarding strategic planning and health plans), and social health sciences with the aim to interpret and intervene in the health conditions of social groups

and classes, researching health policies and the effects that health services have over diseases and impairment (Paim & Almeida Filho, 1998).

Therefore, though the aforementioned studies focused on different areas (Campos, 2004; Matsumoto, 1999; Schraiber & Mendes Gonçalves, 1996; Stotz, 1991), they proved the same trend: health care services have assigned an operational stance for health needs, which determine the object of health care. Hence, this perspective has been the basis of health care projects and public health policies, associating health needs to the use of a health service, usually medical consultations (Schraiber & Mendes Gonçalves, 1996).

However, the Brazilian Federal Constitution, which institutionalized the Single Health System (SHS) [*Sistema Único de Saúde – SUS*], presents determinants and conditionings regarding the health-disease process, and establishes that health does not improve by merely treating diseases.

Based on this definition of health, answering health needs should imply implementing actions that would affect determinants, and not only disease, since it is the result of the wear over the individual biopyschic body. Therefore, the health-disease concept expressed in the SHS sanctions broad health needs. Hence, the answers should be more complex, surpassing curative praxis.

The implementation of the SHS was an answer to civil society claims in the 1970s. Living in a context marked with exclusion and inequality, the society demanded the State to universalize social rights (Albuquerque & Stotz, 2004; Stotz, 2003).

From the early 19th century until the mid 1970s, State health actions focused on combating transmissible diseases through public health campaigns (Cohn & Elias, 1998). These actions aimed to answer the social need of controlling or combating outbreaks or epidemics.

At the first signs that the military regimen was breaking, especially in the 1970s, the public health system also started to provide individual curative medical care – apart from public health actions – exclusively for formal workers (Cohn & Elias, 1998). This meant that besides controlling transmissible diseases, there was now the social need to recover workers' who had fallen ill.

Today, the health-disease concept expressed in the current Federal Constitution is broader. Health is defined as *a value* established *in the intersection between the logic of economic production and the logic of life reproduction* (Sabroza, s/d, p.4). This should have helped to broaden the scope of what is regarded as an object of health care practices.

This study assumes that health care is implemented to answer the health needs of a particular population, and that, in Brazil, especially as of the 1990s, health services underwent a reorganization of their production process so as to implement SHS principles and guidelines. Based on these ideas, and using studies on health needs, selected from the scientific literature, this study analyzes the effects of that reorganization on choosing the objects of health practices.

Considering this presupposition, the following questions arise: what health needs do the health services perceive? What concept of health need do health services use when implementing health practices?

To answer these questions, this study has the purpose to locate and analyze articles focused on health needs, published in Brazilian scientific serials between 1990 and 2004.

Theoretical considerations: needs, health needs and work process

The theoretical framework of this study is in line with Marxist social sciences. The studied articles were analyzed using the concept of needs developed by Marx and other Marxist authors.

For Marx and Engels (1993) a need is what must be satisfied for life to continue. The satisfaction of one need is likely found in the result of a sequential work process of operations that transform a product, which will be the answer to the need that generated that work process. Therefore, the work process comprises, in one of its moments, the need that originates the process, which, in turn, will result in a product that will likely answer the need. This need will be repeated or extended, thus originating another work process. Hence, there is a circularity between the need and the work process established to satisfy it (Mendes Gonçalves, 1992).

From this perspective, one understands that the purpose of work is, primarily, the improvement of human needs, which, if answered, have the power to improve human essence. For Heller (1986), these are the radical needs, which are not socio-historically determined based on a particular mode of production. They are not needs of social reproduction. Radical needs are those that make human development effective, and are associated with the processes of creativity and freedom.

However, improving human needs is no longer the primacy of work in capitalist societies. This change took place as human work became subsumed to work tools, allowing activities to be performed without the outcome guiding and subordinating the worker's will (Antunes, 2000).

With the preponderance of capitalism over social formations, a new social need arouse – the production of surplus and profit. This new need became the purpose of work, and thus determined the work and social relationships that were once broader and solidary (Antunes, 2000).

According to Heller (1986), social needs consider the society as a homogeneous group of abstract subjects. Different from what the term suggests, a social need does not regard the need of every individual, rather it is defined based on the needs or interests of a few. Therefore, for Mendes Gonçalves (1992) a social need, in the capitalist production context, is the expansion of the capital at the expenses of the development and improvement of the workers' human needs.

That is how the hegemony implied in the capitalist mode of production caused intense changes on fundamental aspects of the society's structure

– particularly in human relationships established through work (Mendes Gonçalves, 1992).

In this mode of production, workers exist to answer the needs of expanding production and proceedings, as opposed to producing wealth to improve the development of their own needs (Marx apud Mendes Gonçalves, 1992).

Individuals in different social classes have different needs, since they have different access to the products that would answer those needs (Heller, 1986). Therefore, the individuals' needs are needs of social reproduction (Mendes Gonçalves, 1992). Social reproduction is

> the social life group characterized by the forms of working and consuming, by the relationships that human beings establish among them to produce social life, by the form they distribute and exchange the socially produced assets, by the institutions that they generate, and by the level of awareness and organization they achieve (Campaña, 1997, p.133).

Based on this perception, it is understood that the different health-disease patterns or characteristics in the individuals' biopsychic bodies have their origin in the material conditions of everyday life, i.e., on the profiles of social reproduction in which they develop as social beings.

This interpretation of the health-disease process was reviewed and systemized in the Collective Health theoretical framework through the studies by Engels - in 1845 – and Virchow – in 1847 – who associated the origin of diseases with the material conditions of everyday life. This material condition is determined by the division of classes and by the concentration of income and power by the dominating class (Waitzkin, 1980). Therefore, for Collective Health, it is essential to consider the process of social reproduction of the different social groups in order to characterize the different health-disease processes that affect individuals.

Two facts should be considered: the health-disease concept is capable of electing the object of care (Mendes Gonçalves, 1992), and there is a corresponding work process for each need. Therefore, the health work processes, based on the SHS, should answer the broadened needs, identified as health-disease process determinants and conditionings, toward the needs concerning the improvement of human essence.

In summary, from this perspective, answering health needs means to take the needs of individuals from different social classes as the object of the work process. Moreover, public health policies should be directed toward the universal right (Campos, 2004).

Methodological Procedures

This study is a bibliographic research, performed using the LILACS (Latin American and Caribbean Health Sciences Literature) electronic

database to locate articles published in Brazil after the legalization of the SHS (1990).

The DeCS Health Science Descriptors [*Descritores em Saúde*], created by the BIREME virtual library [*Biblioteca Regional de Medicina*] were used (basic needs [*necessidades básicas*], determination of health care needs [*determinação de necessidades de cuidados de saúde*], needs assessment [*determinação de necessidades de saúde*], and health services needs and demands [*necessidades e demanda de serviços de saúde*].

To ensure access to the material, only articles published in serials were selected - dissertations and theses usually are of difficult access.

Of the 82 titles found, the 73 articles that presented an abstract and focused on health needs were selected.

First, the abstracts were categorized according to the authors' profession and the health care scope (hospital, outpatient clinic, primary care). Next, the abstracts were grouped according to the study object and objective. Thus, three categories were established. The first, **supply/demand of actions at health care services**, consisted of abstracts that associated health needs to the use of health care services. The second, **health care service administration/planning**, comprised the manuscripts that presented health needs as instruments for planning health services and actions. An the third, **health needs**, consisted of the abstracts focused on health needs in both the abstract and operational stance of the concept, from the perspective of organizing health service production or work processes, with the aim of broadening the health care object.

Presentation and analysis of the results

Regarding the categorization according to the authors' professions, most articles were written by physicians (59; 80.8%), eight (11%) were produced by nurses, and six (8.2%) were written by authors with other professions (three economists, two administrators, and one dentist).

Regarding the health care scope, of the 69 abstracts that referred to this subject, most (38; 55%) concerned the hospital environment. The minority referred to primary care (12 articles – 17.5%).

As to the object/objective of the 73 selected articles, 45 (61.6%) were centered on the supply or demand of actions at health care services. Of these, 21 (28.8%) addressed health service administration or planning, from the perspective of rationalization of costs. Only seven (9.6%) articles focused on health needs, both in the operational and abstract stance of the concept.

It is worth emphasizing that, of the 45 studies that addressed the supply and/or demand of actions in health care services, 36 (80%) focused on the supply and/or demand of actions toward diseases. Nine (20%) addressed actions toward family or pre-natal/puerperium planning, i.e., their object

was a specific event in a moment of women's life – pregnancy/delivery/puerperium.

It is also important to stress that the actions described in these 45 studies (100%) addressing the supply and/or demand of actions combined actions or programs recommended by the 1996 Basic Operational Norm – NOB/96 [*Norma Operacional Básica de 1996*]. NOB/96 is the guideline for managing health resources. Consequently, it regulates the SHS financing policies (Brasil, 1996), according to the logic of rationalization of costs – subjected to the cost-effectiveness relation.

The NOB 96 determines that the State shall provide funding for some actions for specific groups, primarily classified by their vital cycle. In agreement with the NOB/96, 34 (75.6%) of the 45 studies that addressed the supply and/or demand of actions in health care services presented actions toward specific groups, and nine (20%) addressed program actions, all of which are described in Law number 3925/98, which regulates the NOB 96 instructions (Brasil, 1996).

Regarding the 34 studies that addressed actions toward age groups, 12 (26.6%) discussed on interventions directed to children (11 regarding children under five years of age). Nine (20%) studies addressed actions directed to women in the reproductive years (four regarding the pre-natal phase and puerperium, and five regarding family planning), while six studies (13%) focused on health care to adult men with occupational diseases. In addition, seven studies (16%) focused on health care for the aged.

Also regarding the 45 studies that concerned the supply and/or demand of actions in health care services, nine studies (20%) addressed program actions toward the prevention or treatment of chronic-degenerative diseases. Of these, two (4.4%) had as their object the actions toward HIV/AIDS-infected patients, three (6.7%) addressed controlling or treating tuberculosis or Hansen's disease, and four studies (8.9%) concerned high blood pressure or diabetes mellitus.

In summary, of the 46 articles concerning the supply/demand of actions in health care services, only two (4.4%) referred to actions not stated in the NOB/96. These two studies regarded actions toward mental health care (schizophrenia and maniac/depressive psychosis).

However, though not stated in the NOB, actions concerning these issues are recommended in the minimal essential plan recommended by the World Bank, with the same logic of rationalization of costs (Misoczky, 1995).

Therefore, all 45 articles (100%) in this group referred to health needs that were determined by the institution, which originate from perceiving the needs of health service users. This result proves that health services have addressed needs as synonymous to impairment care needs, or, in cases of pre-natal and family planning for specific events in a particular life cycle: the reproductive age.

Considering the circularity between needs and work processes, the data apparently indicate that health actions reiterate that health needs are answered by consuming a health care procedure, usually a medical consultation.

Therefore, based on the studied scientific articles, it is inferred that health services still have a trend to identify health needs as associated with sickness, perceived as a biological expression, or, at the most, as the biopsychic expression of an abstract subject.

Of the 73 selected articles, only seven (9.6%) referred to the health need concept. Of these studies, three discussed on the concept using a concrete-operational approach, i.e., perceived as the object of health work processes. Other four studies addressed the abstract perspective of the concept.

Among the three studies that presented the concept using the concrete-operational approach, one is based on the perspective of broadening the object of health care, using the production of health actions, thus privileging *light technologies*, focused on relationships and on the care established by perceiving the service users' needs (Merhy & Franco, 2003). The second study had a reflective stance addressing the health system and defending that the integrality of services at different levels of complexity should be made effective. The study proposes to broaden the comprehension regarding the health need concept and its understanding concerning the demand and supply of actions in health services (Silva et al., 2003). The third study (Soares et al., 2000) extends the discussion and the proposal of understanding the needs beyond health services. It addresses the health needs of the youth living in the outskirts of the city of Sao Paulo, considering the social insertion of their families. In addition, it defines health needs as needs that concern the class condition, therefore defined as needs of social reproduction.

The other four articles discussed on health needs from the abstract perspective of the concept. The conceptualization of two of these studies approached the functionalist theory (Oliveira, 2002; Oliveira & Sá, 2001). The other two were based on a proximity to the conceptual theoretical framework of Collective Health. That is, from a Marxist conception, the studies assumed that answering health needs comprises those regarding the preservation of the individuals' lives as well as those that surpass the former, therefore toward the improvement of the human condition (Mandu & Almeida, 1999; Melo-Filho, 1995).

It is worth stressing that none of these seven studies was written by health workers. Moreover, though two studies were empirical, they had a reflexive stance. These studies proposed to broaden the object of health work processes, but they did not address any association with health care services, which would make this expansion operational, thus favoring the implementation of work processes guided by the act of making the SHS principles effective.

Discussion

The health system is responsible for changing health needs from self-referred into a code recognized by the system (Stotz, s/d). The same should occur with the care given to these needs (Stotz, 2001). This is the only way for health needs – determined both socially and biologically – to be socially acknowledged. The health system must therefore organize its practices so as to answer health needs. Furthermore, health-disease processes develop in agreement with the social reproduction profiles of individuals that comprise the different social groups. "*In this sense, the more disparity there is in a society, and the more this difference is culturally sanctioned, the more health needs there will be for the different population groups"* (Stotz, s/d, p.3).

Considering this idea, the health work processes – from the operational point of view – should be implemented based on the awareness about the differences among social classes. Furthermore, these processes should see the action of answering health needs as a project.

However, health needs are often referred to health care, represented by the demand and supply of actions in health services (Schraiber & Mendes Gonçalves, 1996). Health service users hope to find an action from the workers; something that would solve or at least mitigate the problem that made them seek that service.

Hence, due to the circularity between needs and the work process (Mendes Gonçalves, 1992), the result of these actions is considered to be the answer to the need that made the user seek the service. Furthermore, this answer reiterates what the users will have to consume in a similar situation, as well as where they should seek for that service. Therefore, the form of socially organizing health actions toward the effective service production and distribution will not only be the answer to the needs, but also an immediate context that will establish other needs (Schraiber & Mendes Gonçalves, 1996, p.30).

Therefore, when health workers blame the population for seeking health service only for medical consultations, they should reconsider their thoughts, since it is likely that this was the only answer offered to the different demands of that population.

For Collective Health, answering health needs should mean to establish work processes that would propose answers to the roots of the problem – the determinants – and to the results – the disease. Furthermore, it should direct public health policies toward the universal right.

It is true that Collective Health, as a field of knowledge and praxis, must answer a network of needs that could pose a conflict, since, in addition to the population's health needs, there is a network of interests. Hence, health care projects are the result of the clash between the needs: the population's health needs, those of the workers, administrators, public policies, program authors, funding institutions, and others (Campos, 2004).

The field of Collective Health has proposed and provided foundations for changes in the organization of health services on the behalf of the care to the population's health needs. However, these changes have not been capable of providing the answers to a large part of the population. Principles that guided the service reorganization, such as the universality and the "*integrality of actions have fought against the proposals to rationalize costs*" (Albuquerque & Stotz, 2004, p.260).

This has caused health care proposals to turn to focal care, feeding the conflict between making the health right and the guarantee for the minimum necessary to survive effective in specific groups. This way, it answers the need to rationalize costs with social policies aiming to reduce the participation of the State (Calipo, 2002).

One example of this situation is the strong encouragement for seeking private health care service. In fact, this service is commonly associated to higher quality care. The idea is to reach a point in which the only people to seek public services would be those with no condition to buy one of the numerous private health plans in the market (Campos & Mishima, 2005). What is apparently an incoherence between the SHS legislation and the models that operate it can be understood in the study published by Calipo in 2002. The author explains how the State has reduced its participation by saying that

> in the health area, the governmental reform has occurred by means of the implementation of the 1996 Basic Operational Norm (NOB/96), the law that creates Social Organizations and the 'Publicization' Program, and health plan regulation. The first two mechanisms introduce changes in health care done by the State, and the health plan regulation provides the norms for private services. (Calipo, 2002, p.125)

In this context, the World Bank has had a central role in defining the use of resources in social policies in countries with peripheral capitalism, as Brazil. They have suggested rationalizing public resources used in social policies.

An example of the unconditional option of this logic is the public health care project in the country – a benefit that the State should promote only in specific conditions, and focused on more vulnerable population groups, i.e., on the poor who are unable to buy any kind of private service.

Misoczky (1995) analyzed the World Bank 1994 report and found that the logic for funding health programs complies, primarily, with a financial cost-effectiveness relationship. Furthermore, the country depends on this relation to obtain further loans. According to this criterion, the population included in the *essential minimum package* should meet the following criteria: children under five years of age, pregnant and puerperal women, people with a debilitating infectious disease (especially STD/AIDS, tuberculosis, and Hansen's disease), or a chronic-degenerative disease – systemic hypertension and/or diabetes mellitus, and/or some psychiatric diseases – like schizophrenia and manic-depressive psychosis.

Since this criterion guides public health projects, the programs are designed by technicians and are not based on perceiving the population's needs. These programs determine social health needs that should concern everyone, or most people living in a specific area (Heller, 1986), but they are actually defined above these individuals' needs. In addition, these needs are determined considering abstract subjects, with no difference regarding the class they are inserted in (Stotz, 2005). Collective Health has been replacing the subject's main role – a product of history, determined by the social structure – with categories like gender, ethnicity, sexuality, lifestyle, and others. This attitude favors a fragmented understanding of the reality (Lacaz, 2001).

Ortega (2004, p.11-2) also addresses this fragmentation. In the referred study, using a Hellerian perspective, Ortega names "*anti-political forms of grouping* regarding these groups formed based on *biological and body* criteria (*ethnicity, gender, health, physical performance, specific diseases, longevity*)", which replace "*political grouping criteria (class, social level, political orientation)"*.

Perfect health became a utopian apolitical value, "*the means and end of our actions"*. One must have good health to live, but must live to be healthy. Hence, ideal subject models were created based on biological criteria founded on individual performance and structured on the discourse of risk (Ortega, 2004, p.14).

According to Stotz (s/d), from a historical standpoint, we now live in an age in which the representation about health and a healthy life has moved from being a social right to that of an individual choice, which depends on individual possibilities. According to this logic, health has become an exchangeable, marketable asset.

From this perspective, the choice for healthy behaviors and lifestyles is a responsibility of the individual. According to Ortega (2004, p.16), the individual's responsibility over his or her own health reduces the pressure over the public system, to a "*perspective of neoliberal government*". While social problems are neutralized, healthy behaviors are associated with marketable values, merchandise for individual consumption.

For Stotz (s/d, p.5), the SHS is facing a dilemma: despite health being a social right, "*guaranteed through social and economic policies that aim*" to produce health and access to a system that would grant health recovery for every citizen, "*the system organized to guarantee this right answers (precariously and with poor solutions) the disease at the individual level"*.

Therefore, providing care in Collective Health means to propose health care based on understanding the health needs that capture the form how these subjects reproduce socially, because these needs result from the forms by which the groups are inserted in the social reproduction, as stated by Campos & Mishima (2005). For these authors, answering to health needs implies on implementing work processes in an intersectorial perspective, based on the recognition of the health needs of different social classes that comprise the territory. Health needs include: **the need for the presence of the State**, presupposing that it should be responsible

for guaranteeing the various services that promote social well-being, and that its absence it closely related to the lack of access to universal rights, represented by the access to the consumption of assets produced at public services; **the need for social reproduction**, since it is the basis of the health-disease process (the different forms of producing and consuming assets in the society); and **the need for political participation**, since it is the instance that allows the discussion and clash between the needs and interests of civil society classes and groups, so that rights can be put before interests (Campos & Mishima, 2005).

As several critical social sectors of the neoliberal State have been restricting social rights, participation becomes fundamental in the process of expanding the public sphere. The clash between the interests of the different sectors in the society is necessary, because it reveals the social conflicts covered by the wear from the current work world, and it allows for the construction of an emancipating project that would oppose resistance to the position of the State, which privileges capital interests.

Conclusions

This study located numerous scientific articles using the theme of health needs. These articles mainly focus on health care in the hospital environment. This means that studies regarding primary health care are scarce, and almost inexistent if considering the Collective Health perspective. The analysis showed that common needs are assumed/determined, considering individuals as a homogeneous group of abstract subjects, disregarding their class – which would actually determine and differentiate the health needs.

It was also observed that the articles did not present the concept of needs, using the common sense term. Since the studies were not based on a concept to propose the object, there is a risk of seeing the object through a perspective that would mask the determinants (Pereira, 2005). This would fatally lead to punctual actions, which rarely answer the needs. If they do, they are restricted to the needs regarding the already installed health problems – at the individual level - or, at most, they answer the interests of specific groups, which are prioritized by public social policies that obtained funding.

The result from analyzing these articles is worrisome, since health care actions have focused on disease, on some diseases, thus performing actions specific to the affected population. This could reinforce functionalist and classificatory praxis, harming the emancipating practice, i.e., a practice that would allow Collective Health – which is part of the base of the SHS logic – to recreate the concept of needs, providing feedback for the praxis, in a dialectic movement.

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