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The universalization of rights and the promotion of equity: the case of the health of the black population

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Abstract *This article takes the field of "health of the black population" as an object to problematize some tensions and possibilities existing around the operationalization of the concepts of universality and equity in public policies and no debate about the right to the city. The question that mobilizes it is: how to articulate the search for the universalization of rights with demands mobilized by specific groups in an unequal society. In order to respond, to approve the debates and the resistances surrounding the institutionalization of the National Policy of Integral Health of the Black Population and its relation with the prerogatives of the Unified Health System. The result is a critique of the universalization/targeting and recognition/distribution and pointing to a dialectical approach. Categories that consider a mediation between singularity, particularity and universality*.

Key words *Universality, Equity, Black population health*

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Introduction

The need of observing, reflecting and intervening on sociocultural aspects of individual and community health production justifies the concern about Health field in subjects related to right to the city. Highlighting, in this sense, the following treatises stand out: Alma-Ata Declaration of September, 1978, in the International Conference on Primary Health Care, in the Republic of Kazakhstan (ex-socialist Soviet Republic); first International Conference on Health Care Promotion, in Ottawa, November, 1986, as well as the "Healthy City" movement, started in Toronto, Canada. Therefore, topics as gentrification, territorial stigmatization, spatial segregation and urban mobility, inter alia, offer a great potential to widen the focus on health, especially in contexts of intense social imbalance.

Since the beginnings of sanitary movement, in the twentieth century, a context already marked by increasing acuteness of urban contradictions in capitalist centers, the importance of mobilizing subjects and resources to face health-affecting collective issues was already recognized. Nevertheless, it is from the second half of the 20th century on that such perception consolidates, bolstering a series of concepts, meetings and treatises[1] that elect the city or, at least, its concerning conflicts, as unsurpassable premises for reflections on health[2].

At the same time, health field issues, such as quality of life, health promotion, mental health, inter alia, are also present in reflections related to the right to the city[3], offering innumerable dialogue possibilities. Furthermore, both fields work on common themes that relate equity and vulnerable populations. In the wake of those discussions, some questions concerning both fields deserve highlight. Namely, is it possible to conciliate the struggle for universalization of rights with *advocacy* for specific policies, focused on vulnerable groups? If so, what issues are implicit in such conciliation?

Although the answer seems obvious, political and theoretic perspectives mobilized around them are not always convergent, bringing forth some tensions that are object of reflection in this paper. Therefore, we take the field (of study and intervention) of black population health as privileged object to think some of such tensions. Even though the topic in question belongs exclusively to the health area, its causal relations – as social determinants of health – are explicitly linked to issues and worries of the literature focused on right to the city, especially in its possibilities of articulating concepts of equality, universality, difference and equity.

Concept politics

Worries about economical determinations on production of urban spaces, especially its harmful effects on health and resident population quality of life have been target of systematized reflection[4,5]. Notably, urban growth and planning were guided by logics that considered, ultimately, not the wishes and well-being of individuals and groups composing cities, but, above all, social and geographic capacity of these spaces to concentrate productive surplus. In such scenario, possible divergences and oppositions of the debate situate themselves more in the proposed prophylaxis than in problem diagnosis. In other words, to some, the unsurpassable class dimension of urban issues would be solvable within liberal marks – from determined social regulation that acts according to the "sacred" right to property and surplus value. To others, the solution would demand an emancipatory revolution, able to democratize the right to rebuild one's space and oneself – following one's own needs and desires. In both cases, the diagnostics, the debates on individual and collective rights to the city have in economic dimensions an element of capital importance.

In the same way, main reflections and vindications around the right to health pass, unsurpassably, through the ways in which State and social life, in a determined time and space, influence individual and collective right to health. If individual right is seen in terms of freedom – of decision and access to information and resources needed for a healthy life – collective right to health is seen in terms of equality – not only legal, but, above all, political and economic[6]. Both of them, however, provide central importance[7] to preoccupation with poverty and social inequality, in opposition to the identity vindications that only afterwards earned space in the public scene, especially along the twentieth century. As exemplified by Marcos Chor Maio and Simone Monteiro[8], while referring to the Sanitary Reform movement trajectory:

[...] *Sanitary Reform movement, a kind of intelligentsia, would be informed by some principles of left-wing tradition, of a nationalist set, which would regard strange a world moved by racial constricts, namely: 1) long-term sociological tradition that operates with the concept of social class to ap-*

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proach social inequalities; 2) left-wing traditions whose socialist and nationalist utopia does not conceive racial actors; 3) moral sensitivity whose principle of justice identify in absolute privation the focus on which society must be mobilized…

Nevertheless, from the second half of the twentieth century on, this political-theoretical trend – centered around economic determinations of production and reproduction of life – was target of intense critique and reformulations when, then, new political actors joined the dispute on the terms around what was understood as rights. Although it had assumed specific dimensions in each particular context, that reconfiguration resulted in a progressive diversification of demanding actors and, above all, vindications and notions of right, now also mobilized in identity terms such as gender, sexual orientation, race/ethnicity, nationality, age group, among many other branches, more and more ramified along time. The very debate about right to health inserts itself in such context of outbreak of *new* social movements, not necessarily centered on class contradictions[9].

Nancy Fraser labelled this diversification as a tension between two distinct perspectives: on one hand, the struggle for distribution of rights and necessary resources to one's realization. On the other hand – in an almost irreconcilable way, the struggle for recognition of historically depreciated differences. While the first perspective focuses mainly on the struggle against economic and political injustices and inequalities, pleading for the dissolution of social differences, the second one takes the socially presumed differences, not to propose their suppression, but, conversely, to affirm them and make them positive in their supposedly specific differences[10,11].

Another divergence adds to the one observed by Fraser, with the same tension potential, namely, the polarity between *universalization* and *focus* of public policies[7]. The first tendency – used by both the Sanitary Reform movement and the defense of the right to the city movement – is guided by seek for expansion of social rights to the whole society, without restrictions. Health scope may exemplify this tendency with the adoption, in article 196 of the 1988 Federal Constitution, of Universality as a fundamental principle of the Unified Health System, which states: "Health is a right to all and duty of the State" and "universal and equal access to actions and services for its promotion, protection and recovery"[12]. This movement "had the function of breaking the split line that existed along health history in Brazil, in which there was a restricted right to individual medic care, exerted by workers who had a formal job and contributed directly to social security[13].

The second tendency, named in literature as *focus,* is understood as "the action of concentrating available financial resources in a defined population"[14,15]. Among the forces involved in its formulation, there is a notable and hard-to-frame subject, although it has always been present in disputes around social policies, but not always labelled: market, as well as government and multilateral agents who act in its name, as the World Bank and International Monetary Fund. It is true, when Brazilian sanitary policies are analyzed, that since the 1930's, the debate around health is already linked to perspectives of regulation between capital and workforce and strategies for building a national State[7]. However, the matter highlighted here is that initially, at least, even in proposals that brought poverty issues forth, the hegemonic debate on Rights presented itself as an alternative (and counterpoint) to the political forces that centralized the contradiction between capital and workforce, foreseeing its overcome[16]. Nonetheless, the contradiction Capital vs. Workforce tended to be replaced by a polarization between State and Civil Society.

Market-problematizing argument has not always been highlighted in debates about rights, because initially, at least, politic perspectives (liberal at first) that guided it had privileged the tension between State and Civil Society, either dismissing the economic sphere scissions and contradictions or betting on the dispute for the making of a State that met social needs. Nevertheless, the last decades of the twntieth century were marked by a double inversion of the scenario. On one hand, capitalism structural crisis[17] resulted, in the political dimension, in intransigent *advocacy* – led by a group of multilateral forces and agencies that act in their own interests – of the dissolution of an already weak *Welfare State.* For such group, social imbalances of any order were regarded unchangeable realities that prevented universalization of rights. Therefore, what remains is action in the system critical factors:

The notion of focus translates the understanding that, facing contingency and limited availability of funds to supply infinite demands for social services and benefits, establishing, for instance, the classic cost-benefit ratio, State must prioritize and direct its action towards the scope of social policies for the most underprivileged layers of population[15].

From this point on, when focus proposals are more closely observed, their possible inter-

nal dissents orbit around definitions regarding what criteria should be used to define underprivileged groups and, therefore, which subjects to prioritize in the scarcer and scarcer government actions. Such movement had been largely linked to an ideological guidance – neoliberal – that targeted dismantlement of Welfare State, structured in previous decades in central capitalist countries and some peripheral ones.

On the other pole, left-wing crisis[18] overwhelmingly influenced by Stalin's crimes and, the further fall of Berlin Wall, but, most importantly, by these forces' inability to respond to the structural changes they proposed to face – resulted in a politic-theoretical turnabout that started identifying search for universalization of rights as a synonym – or, at least, a substitute – of the seek for social emancipation[16]. Consequently, in the turn of the millennium there is a polarity at stake in political debate, which goes from defense of focus to universalization of social policies. The first one, defended by market itself – envisioning a replacement of logics from civil right to commodity – and the second, widely present among Sanitary Reform formulators, defended as symbol of emancipation or, at least, social justice.

The curious fact in observing Brazilian case is that the advent of Unified Health System in the late 1980's – in its assertion of health as a universal right – came contrary to a worldwide trend of State dismantlement by pointing exactly to the State duty of providing rights. The outcome was the structuration of a reform focused on universalization, but at the same time sensitive to the existence of specific characteristics in population. The principle of equity is well expressed in the Unified Health System text[19].

In order to handle such particularity, Amélia Cohn distinguishes policy focus – as proposed by the World Bank in its frank engagement against the State as provider of rights – from the existence of specific Programs – that recognize disparities in health – focused on the universalization of access[7]. Even so, despite the great social pact that enabled the emergence of the Unified Health System at the end of the 1980's and beginning of 1990's, the following years were marked by successive attacks to this perspective, mainly to what regards system financing and organization[13].

The factor I intend to problematize at this point is: to what extent is the identity group agency around defense of right to the city or health related to the previously mentioned polarities? Here, I refer to either the polarity between recognition and distribution, as well as between universalization and focus.. Furthermore, to what extent can we think such tendencies as polar and this reflection contribute to the "old" and so contemporary search for universalization of civil rights? To what extent does the polarity between recognition and distribution translate itself in the tension between universalization and focus of health policies? As it is impossible to elaborate wider judgements on the state of health sector as whole, I am focusing attention in a field of investigation and intervention named "Black population health".

Concepts of politics: the field of black population health at issue

"Black women's health is not a knowledge area or a relevant field in Health Sciences". So begins a scientific article recently published by one of the most important intellectuals and activists who support the Unified Health System, and it continues:

"Knowledge production in this area is inexpressive and the theme does not take part on the syllabi of different graduate and post-graduate courses in health, with very rare exceptions. It is a vague subject often ignored by most of the researchers, students and health professionals in Brazil"[20].

Since its "emergence" within health sector, the field named "black population health" confronts at least three challenges that are important to the scope of this article. The first one relates to the very quotes used in the word *emergence.* Although the specialized literature on health has not familiarized completely with such debate, we ought to remember that our country was largely influenced by various cultures brought by African peoples. The compilation "African-Brazilian Religions, Health Policies and the Answer to HIV/Aids Epidemy", organized by Celso Ricardo Monteiro, et. Al. is quite instructive in showing that the major collective kidnap in history resulted not only in compulsory importation of workforce, but also in reception – not always acknowledged – of an infinite repertoire of knowledges, practices and work techniques regarding, above all, health.

The second challenge, with a more political and programmatic character, relates to difficulties in instituting the field of black population health, either in academic or political terms. Even though it is not possible, in this space, to take up the rich history of this theme consolidation in

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the Unified Health System public agenda, it is worth mentioning that the black movement has been present in important moments of struggle for the Sanitary Reform[21,22] and that the first governmental experiences focused on black population health date from the 1980's, when some municipalities incorporated certain demands from the black movement – mostly the black women movement.

Nevertheless, it is only after national mobilization around the Third International Conference against Racism, Homophobia and Related Intolerances, held in Durban, South Africa, in 2001, and the resultant creation, in 2003, of the Special Department for the Promotion of Racial Equality, that the Ministry of Health created a Black Population Health Technical Committee, targeted on promoting racial equity in health. It is true that this mobilization was only possible due to a history of articulations, studies and *advocacy* that date back to previous decades and governments, but, in this context, articulations quickly advanced to the institutional acknowledgement of a group of racial disparities in health and, consequently, to the agreement on a programmatic response to the identified scenario.

Consequently, there is an evident set of dialogues among the Ministry of Health executive managers, as well as other collegiate bodies as the National Council of Municipal Health Departments (Conselho Nacional de Secretarias Municipais de Saúde – CONASEMS), National Council of Secretaries of Health (Conselho Nacional de Secretários de Saúde – CONASS) and other social movements linked to health, that culminated in the approval, in 2006, at National Council of Health (Conselho Nacional de Saúde – CNS) of the National Policy of Integral Health of Black Population (Política Nacional de Saúde Integral da População Negra– PNSIPN). This Policy, amended in a Three-way in 2008, and published by Ordinance 992 in 2009, presents as its mark the acknowledgement of racism, ethnic-racial inequalities and institutional racism as social determinants of health conditions, in order to promote health equity, as well as the recognition, by the Ministry of Health, that black population life conditions impact the health, disease and death process.

However, what seemed to be the "ordinary" flux of any Policy created in the scope of the Unified Health System turned out to be a great frustration to the multiple subjects involved in its formulation. Usage of the term ordinary in this sect. Does not ignore the fact that a simple policy formalization means, not necessarily, its accomplishment as implementation process or its success in terms of expected results. On the contrary, the very consolidation of the Unified Health System as a governmental policy focused on guarantee of health as a right implies a still disputed social pact. From the very beginning, PNSIPN – drafted primarily as a transversal policy, i. e. on the incorporation of anti-institutional-racist struggle and adoption of process and result indexes, disaggregated by race in other Policies and Programs from the Ministry of Health[23] – faced an institutional resistance to its establishment. Such resistance arose by unawareness on the part of health managers and professionals in the three levels of the Unified Health System, as well as by the non-incorporation of actions, indexes and goals predicted by its Operative Plan – by other policies and programs of the Ministry of Health[24].

Estela Maria Cunha[25] regards that resistance explainable by the concept of institutional racism, constituted as the difficulty or impossibility of public institutions – especially the ones aimed at the promotion of social rights – to respond effectively to racial imbalances. According to Jurema Werneck, the concept of institutional racism is similar to the concept of program vulnerability, since it "moves from the individual dimension and establishes the structural dimension, corresponding to organizational forms, policies, practices and norms that result in treatments and uneven results. It is also called systemic racism and guarantees the selective exclusion of racially subordinated groups, acting as an important lever for the differentiated exclusion of different subjects in these groups"[20]. This problem, sustains the author, is fed by both the belief in absence of racism in Brazilian society and the unawareness of its negative influences on people's health.

At this point, we approach the third challenge faced by the referred policy: positions explicitly contrary to the existence of the field of black population Health and the "risks" that it would supposedly represent[8,26-30]. Theoretical arguments contrary to the field of black population health can sum up the following topics:

1. disagreement on the validity and scientific and/or politic usage of the concept of race
2. criticizing of what would be the colonial importation of American concept of biracial (black/white) to the Brazilian context
3. disagreement about the influences of racism in health and advocacy of centrality of economic questions as determinants of health conditions

4. Labeling of health field as policy of focus, supposedly in consonance with political and economic forces that undermine the search for universalization of the right to health.

There is neither room nor need for discussing here each of the topics above, once they have already been problematized and confronted by an important subsequent literature[20,25,31-34]. What matters highlighting is how the polemic around the field of black population health refers to the tensions depicted in the first section of this article. On one hand, the tension between recognition and distribution, translated in the dispute by elements to be considered central as social determinants of health and, on the other hand, tension between universalization policies and focus policies, expressed in the argument on the need or not of an affirmative action in the scope of the Unified Health System.

Such tensions, I believe, are partly explainable by the flagrant unawareness and/or dismissal of racism as a social determinant of health[20,35].The still hegemonic belief in the myth of racial democracy in its unsurpassable underestimation of racial conflicts in Brazilian society – added by the historic absence of black or even white people supportive of the antiracist struggle in power spheres of Health Sector, either in production and validation of scientific knowledge on health or in management and operation of the Unified Health System – results in the already denounced frame of Institutional Racism.

However, as follows, there is another element to analyze in its relation with and strengthening of institutional racism. Namely, a frequent simplifying on dealing with categories that relate human equality, difference, singularity, particularity and universality, mainly when applied to the institutional politic field.

Unscrambling the way

Amélia Cohn and Yasmin Lilla Bujdoso[36], in a study that investigates the dilemmas related to institutional spaces of health policies social control, as the National Health Council, question to what extent such instances have constituted spaces of general multiple-interest articulation or, conversely, are reduced to the dispute of private interests from the multiple segments there represented. Thus, they raise awareness to the fragmentation risk implicit to the emergence and dispute of interests of multiple subjects in the political scenario. As they argument, it is worth to observe in each concrete reality:

To what extent these new practices would not mean weakening of the political system, once the emergence and generalization of social movements and participation on management councils produce social identities in the restricted scope of specific social demands and not of the collectivity[36].

In rousseauian terms, these "generalized particularisms" which the authors approach, would mean the replacement of the "general willingness" – in line with the articulation of private interests towards general welfare and preservation of the common – by the "willingness in general", as the impossibility of such articulation[37]. Nevertheless, neither the first two authors above, nor even Rousseau, present the problem in terms of antagonism between particularity and universality, but as concrete challenges to articulation possibilities between the poles, in a scenario lined by the search for democratization of access and universalization of the right to health.

It is not the same case for the trends against the existence of black population health field, which, besides erroneously labeling it as an effort to "racialize health policies", in consonance with global (neoliberal) demands for focus, and refusing to recognize racism as a social determinant of health[20], attribute to the field – and not to what the field proposes overcoming – the weight of moving away from the tradition represented by Sanitary Reform in its effort towards universalization of rights. In other words, the category Universal is taken – in this framing – not as a synthesis of diverse particularities that compose it, but as its antithetical pole, so that the assertion of one implies negation of the other.

Likewise, back to the polarity observed by Nancy Fraser, the disputes and negotiations for the promotion of rights are presented as *tension* instead of *articulation* between recognition and distribution. Here, it turns out there is a worry in taking part of the pole considered a legitimate representative of sanitary movement.

Sanitary Reform movement, based on the tripod universality, integrality and gratuity, as written into the Federal Constitution, conceives health as a universal civil right. Even with all the existent mishaps in health field in the country, there is a consensus on the health reform being one of the most successful political projects of incorporation of popular sectors, such sects having expressive presence of black people[8].

This binary grasp of social reality is not exclusive of perspectives that advocate distribution or universalization of access. It is also present in their opposites, represented by various identity

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movements, including the black health movement. Not only these movements, lined with policies of recognition, but also the multiple segments mobilized around equal distribution of economic resources, are susceptible of prioritizing one part of the social reality instead of its wholeness, or worse, considering their own part as the whole, rivalling other segments on the priority of policies. As Cohn and Bujdoso[36] observe:

These processes and dynamics end up blurring the limits between public and private spheres of social life, such as the blurry and scrambled limits between what is a public institution and a private institution in the health services market and in the very structure of State public equipment: on one hand, tax exemptions and ways to subsidize private service providers that have access to them because they "provide relevant services for SUS [Unified Health System]*"; on the other hand, philanthropic entities that start offering typically market-related services, or even state public health services that start hiring private entities "of public and social relevance" to direct management of health equipment*.

However, if considering diversity precluded universalization, it would be necessary to question the set of subjects and policies already mobilized around equity in health and not only the ones focused on the promotion of racial equity, under the risk of assuming that the described unrest is not about the equity perspective – neither with the risk of neoliberal focus – but with the attempt of reaching racial equity. The Unified Health System itself, in its notion of "amplified health concept", presents the principle of equity – and integrality – on the side of the principle of universality, and not as a counterpoint[38].

Conclusion

This paper itinerary enables the suggestion that, if multiple-interest groups agency is analyzed from a binary episteme, the only choice left would be the assertion of a totalizing particularity, blind to the common interests that surround it, or the denial of such particularities in benefit of a common goal – such as the universalization of access – that is not always capable, by itself, to range the diversity implied in the whole. In other words, if we would like to think the field of black population health in terms of their critics, we would have to ignore the diagnoses already made in benefit of an abstract universality, silent while facing racial disparities in health.

Even Rousseau pointed to this issue while arguing for the general willingness – in the sense of universality – as an articulation – not opposition – of needs and private interests[37]. If it does not solve the fragmentation risk pointed by Cohn and Bujdoso[36] and Cohn[39], at least it does not advocate the invisibility of the existent diversity in the social field. In the same way, Nancy Fraser[10,11] and Boaventura Santos[16] argument for the need to overcome a "false antithesis" between recognition and distribution towards a wider concept of justice that articulates the emancipatory elements from both tendencies. In this context, the Portuguese sociologist states, "we have the right of being equal when our difference makes us inferior, and have the right of being different when our equality makes us featureless".

Lastly, labeling the field of black population health as a focused policy, supposedly consonant to neoliberal prerogatives and confronting universalization, would only make sense if we dismissed, firstly, implicit prerogatives of the field itself. National Policy of Black Population Integral Health – PNSIPN, in its transversal perspective, depends, unilaterally on the progressive strengthening of the Unified Health System to be viable. As Kuiz Eduardo Batista[34] explains:

National Policy of Black Population Integral Health (PNSIPN)[40] when articulated inside SUS [Unified Health System], does not mean focusing on terms defined after 1990. PNSIPN [National Policy of Black People Integral Health] specificity seeks to complement, enhance and enable the universal policy in the scope of public health, using its management tools and observing specificities of the black population health-disease process in Brazil.

Secondly, the historical specificity of the Unified Health System emergence is more an articulation of specific programs oriented by the universality of rights directive than the idea of a market-defended focus, at the same time contrary to which prorogated neoliberalism[7]. What the field of black population health presents and vindicates – in consonance with this wider notion of social justice that articulates recognition and distribution – is the possibility of facing racial inequalities in consonance with the search for universalization of the right to health.

The same thought works towards the right to the city. The so desired freedom for building and rebuilding the city and ourselves as a precious good[5] – indispensable fact to people's quality of life – also undergoes the integral recognition of their composing subjects in their most diverse

differences and particularities, but, above all, the recognition of processes by which those differences convert themselves in imbalance, because, as Hungarian philosopher George Lukacs argumented:

Totality as one, as synthetic unit of the diverse, as a moment of totalization, is also multiple, because it has, as one of your faces, different level of understanding the real. Totality congregates the singular, the particular and the universal[41].

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