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“Health for All” in England and Brazil?

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Abstract

This article discusses the achievements and challenges that England and Brazil face in relation to their capacity to address inequalities in health through health promotion and public health policies. Using secondary data (policy texts and related documents), this article contextualizes, explains, and critically appraises health promotion and public health efforts for the reduction of inequalities in health in the 2 countries. A historic documentary analysis was undertaken, with hermeneutics as the methodological framework. The global economic crisis has prompted the so-called developed economies of Europe to reconsider their economic and social priorities. England represents a state facing this kind of challenge. Equally, Brazil is assuming new positions not only on the world stage but also in terms of the relationship it has with its citizens and the priorities it has for state welfare. The United Kingdom continues to finance a health care system allowing universal access in the form of the National Health Service, and state concern about the public health task of reducing inequalities has recently been underlined in policy. For Brazil, although there have been recent achievements related to population access to healthcare, challenges continue, especially with regard to the quality of care

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Our purpose in this article is to discuss the challenges and opportunities of efforts to achieve “Health for All” in the 2 very different social, political, and cultural contexts of England and Brazil. We argue that there are both similarities and differences in challenges and responses to Health for All in the countries and that engaging in comparative analysis can be useful in understanding what action is required to move the different contexts toward greater health for all of their respective populations.

The methodology employed was collection and analysis of a range of secondary data related to health policy and practice in Brazil and England. Official data and policy texts from both countries were used (i.e., material generated by governments and their agencies). In addition, observations and commentaries from global agencies such as the World Health Organization and the World Bank were utilized. We also sought to examine commentaries and analyses from academic and other independent commentators. We identified possible literature to analyze through searching a range of databases, including PubMed, Medline, and the International Bibliography of Social Science Online. We undertook an initial search using the terms “Brazil public health policy” and “England public health policy.” This led us to a wide range of documents that we selected down, by a process of abstract analysis, to those that appeared relevant to our interests in health promotion, health improvement, and inequalities reduction. In total, 110 documents related to the Brazilian context were used and 95 with an English focus. (Some of the latter required interpretation to the specific context of England, as they addressed the whole of the United Kingdom.) Only a portion of these documents are referred to in this article, for reasons of space and narrative development.

Having identified our secondary dataset, we undertook a historic documentary analysis, applying hermeneutics as the methodological framework.¹ Hermeneutics entails immersion in a text, not as a mechanical and technically closed procedure, but as an exercise to understand reality in the sense that events follow and condition each other. The practice of hermeneutics involves an attitude of understanding the lives contained in or affected by the texts considered, moving analysis beyond simply symbolical comprehension. It implies the possibility of interpretation to establish relationships, develop arguments, and draw conclusions.² Given this, it is particularly appropriate for use in comparative analysis, where we seek to understand not only lives within particular contexts, but also the nature of relationships between lives lived within different contexts and those contexts themselves.

We begin the account and discussion of our findings by providing a brief demographic overview of the separate countries, move on to consider the

separate health systems that have evolved or been developed in the 2 places, and then engage in analysis of achievements, possibilities, and challenges for health promotion and public health within and beyond these systems. We conclude by suggesting issues to consider in moving toward the ideal and imperative of Health for All against the background of a shifting geopolitical and economic world.

England is part of the United Kingdom, a collection of 4 countries within the British Isles located off Northern Continental Europe. Its territory is 130,395 km². It is a constitutional monarchy with a deeply embedded parliamentary democracy. Of the 4 countries that form the United Kingdom (England, Wales, Scotland, and Northern Ireland), the latter 3 have separate representative parliaments or assemblies. All countries are represented at the Westminster Parliament, with Wales, Scotland, and Northern Ireland possessing varying degrees of autonomy. Westminster has responsibility alone for foreign affairs and defense across the Kingdom. In 2012, the total UK population was nearly 63.7 million.³

In common with other developed countries, key health indicators for England continue to show improvements over the last 20 years. Life expectancy at birth in the United Kingdom is 81.9 years for women and 77.7 years for men, an increase of 4.9 years and 4.7 years, respectively, since 1990.⁴ Within these overall figures, however, are significant local, regional, and class-based variations.⁵ Levels of infant mortality in 2010 were 4.1/1,000 live births, half the figure of 1990.⁶

Positive social indicators include literacy rates, which are extremely high at 99% and have remained constant since the 1990s; the average time spent in compulsory education is 11 years.⁷ The United Kingdom has the 10th highest proportion of university graduates among Organization for Economic Co-operation and Development countries, although commentators have noted difficulties in maintaining or improving this position.⁸

Brazil is a federal republic in South America, with more than 200 million inhabitants⁹ living in a territory of 8,514,215 km².¹⁰ Territory and population alone confirm the enormous geographical difference between the 2 countries in our comparative analysis. Since 1985, after the end of a two-decade military dictatorship, Brazil has been a constitutional democracy. Population density varies considerably in regions of the country. The Southeast and South form the major concentrations of population (86.92 and 48.58 inhabitants per square kilometer, respectively), whereas the North and Central-West Regions possess only 4.12 and 8.75, respectively.¹⁰

Brazil's emerging global, political, and economic power and status have had a remarkable impact on public health. Over the same roughly 20-year period reported for England, overall life expectancy in Brazil of 66.6 years in 1990 had increased to 72.8 years by 2008.¹¹ Infant mortality has dropped from 47/1,000 live births in 1990 to 14 in 2013.¹² During the same period, indices

particularly relevant to Brazil's status as an emerging power, in part characterized by the World Health Organization's Millennium Development Goals, include the percentage of children younger than age 5 classified as underweight being 2.2% (a 67% decrease from 1990). Equally, aspects of healthcare coverage have dramatically improved. For example, by 2010, births attended by skilled health personnel reached 97% and antenatal care coverage (between 1 and 4 visits) was at 98%.¹³

However, other characteristics show a country that, despite remarkable economic growth, still maintains a developing nation profile. For example, the illiteracy rate is 13.3% and the average length of schooling is 5.7 years (contrasted with the English figures cited above). The picture within this average length demonstrates inequalities based on ethnicity (6.6 years for Caucasians and 4.6 years for Black and "Mulatto" populations).¹⁰ Violence is a structural component of Brazilian society¹⁴ and a consequence of the fragility of social cohesion, strongly related to structural and social inequalities.¹⁵ Indeed, the major problem facing Brazilian society is its deeply unequal nature.¹⁴

This is partly illustrated by the enormous social, economic, and demographic inequalities that exist among its 5 major geographic regions. Demographically, e.g., of Brazil's 189.5 million inhabitants, almost 80 million live in the Southeast Region and only 27.5 million in the South Region. South and Southeast together represent the best social and economic indices of the country; e.g., life expectancy in these regions is the highest in Brazil.¹⁵ On the other hand, the North Region (15.2 million people) and the Northeast Region (53.5 million people) represent much less favorable social and economic structures. To take 1 index as an example: access to internal household water and sanitation supply covers 82.5% of the 57.5 million households across the country, but in the North Region specifically, just over half (53.5%) of the 15.2 million households have such access.¹⁵

Equally, the ratio of physicians to population in Brazil is poorly allocated. Although São Paulo and the Federal District have 3.37 and 3.57 doctors per 1,000 inhabitants, a density seen in European countries (this compares very favorably to the UK position described below), several states in the North and Northeast Regions have densities of less than 1 doctor per 1,000 inhabitants.¹⁵

Health Systems in England and Brazil: A Short Overview

Through secondary data such as policy texts and related documents, we aim to contextualize, explain, and appraise health promotion and public health efforts for the reduction of inequalities in health in the 2 countries. Accordingly, a historic documentary analysis was undertaken, employing hermeneutics as our methodological framework.^{2,16} At the outset, it is important to point out that although health systems generally and primary care structures in particular are

essential to recognizing and dealing with inequalities in health,¹⁷ we also recognize that health systems alone cannot deal with the social determinants of health that are the fundamental mediators of health status.^{18,19}

Universal health care coverage in the United Kingdom extends back to 1948 and the origin of the National Health Service (NHS), which was part of the post-World War II “welfare settlement.”²⁰ Prior to this, access to health services had been patchy, based on ability to pay and a multiplicity of insurance-based schemes. Equally, despite the tradition of Victorian public health reform, interest in public health as we might now understand it had been mixed, and partly dependent on geography and the presence of interested individuals in a given area. Local authorities largely dealt with public health, bodies that remained administratively separate from the NHS following its 1948 creation. This arrangement continued until 1974 when responsibility for public health was transferred to the NHS.²¹

The 1948 NHS Act and its various successors have all sought to enshrine the principle that health care should be available to all at the point of delivery and funded mainly through taxation. The Secretary of State for Health in the Westminster government has had, since the inception of the NHS, a duty to provide comprehensive health care to the UK population,²² a duty that, since processes of political devolution in the late 1990s, has also been carried forward by health ministers in Northern Ireland, Wales, and Scotland. Despite supposed efforts by the current Coalition government to abandon this duty, it remains part of the Health and Social Care Act 2012.²³ However, the duty has always been seen by some analysts as being so vague as to be almost meaningless in the real world of need and entitlement.²²

The beliefs of the political founders of the NHS in 1948 – that over time it would reduce the burden of ill health on the state to such an extent that the costs of running it would, at the very least, be constantly lowering²⁰ – were fairly soon afterward seen to be optimistic. Exactly why skilled politicians were so wrong in this judgment is a difficult question to answer,²⁴ although at least some of it has to do with the constantly increasing post-war technological capacity of health care and the cost of delivering this to a population whose “health expectations” have similarly been rising. The ratio of physicians per 1,000 of population, e.g., has been steadily growing over recent years and in 2011 was 2.8/1,000²⁵ (compare Brazilian figures above). In 2002, public expenditure on health care in the United Kingdom as a whole was 5.9% of gross domestic product and in 2010 it was 8.0%.⁵ Yet despite such demonstrable increases, “health expectations” have seemed in recent years to be almost constantly disappointed.

What is important for this discussion is that as a consequence of ever-increasing costs, the NHS has been subject for much of its history to a succession of organizational reforms, all exercised by its political controllers as attempts to render the service more efficient and nationally affordable.²⁶ Governments of all political persuasions since the 1970s have tried to exercise efficiency and

economy on the service, at least partly through the introduction of neoliberal reforms such as privatization.²⁶ Moreover, it needs to be made clear that although the NHS provides for all and is funded mainly through taxation, there is a market for private medical insurance. Since the 1990s, approximately 11.5% of the overall UK population has been “double covered” by private medical insurance and National Insurance, a figure that has remained broadly static since that time.²⁷ However, there are limitations to private medical insurance; e.g., all emergency treatment in England is provided by the NHS.

Along with government efforts to exercise efficiency and economy on the NHS, notions have developed that those using public services are consumers and, consequently, services must be personalized to meet their demands.²⁸ The Coalition government, formed in 2010, has moved this kind of agenda further still, attempting through legislation to open up almost every part of the NHS to competition from private providers and to make general practitioners (GPs) (local doctors who have traditionally been concerned only with the individual patients attending their practices) responsible for the commissioning of local health services, as opposed to NHS managers.²³ At the same time, public health services removed from local authorities in 1974 were returned to them in 2013, in the belief that these democratically elected bodies have a much stronger sense of what the health needs in a given area actually are and how they can be met.²³

At this point, the importance and complexity of primary care structures in the English health care system must be emphasized. GPs are the pivots in a system of primary care that delivers the vast majority of day-to-day healthcare in England. Not only do GPs deliver care, but they are also the route through which patients must pass to access hospital care. Since the foundation of the NHS in 1948, GPs have in fact been independent practitioners within the state system. General practices are, in effect, small businesses, yet at the same time they are usually highly regarded as public services par excellence by the local communities they serve.²⁶ The combination of a small business-like focus and the classic individual-centered medical training that all GPs will have undergone has meant, paradoxically, that primary care has frequently had little interest in public health or even broader local conceptions of healthcare need beyond its surgery doors. There is, then, some oddness in the recent legislation we have reported above that places GPs at the heart of local healthcare commissioning.²³

Despite all the organizational changes endured by the NHS and other structures associated with health improvement, such as local authorities, commentators continue to assert that health policy in Britain has failed to properly respond to the fundamental challenge of inequalities in health.²⁹

Altering focus to the Brazilian context, it is possible to say that until the 1920s, there was no comprehensive, organized public system of healthcare. Between the 1920s and 1960s, the federal government provided limited medical

assistance and social insurance for those working in a small number of occupations. During the dictatorship period (1964–1985), the Brazilian State favored conservative economic development. The Social Security System was characterized by political and economic centralization at the federal level and by a lack of any kind of participation or democratic accountability. Health care was largely privatized. During the 1970s, categories of workers were integrated in the National Institute of Social Welfare. This comprised the third-largest government budget in the country and was used to buy private health services to assist workers and their families.³⁰

During the 1980s, Brazil faced a strong economic recession and the growth of social inequalities, demonstrated in part by difficulties in gaining access to healthcare and by poor health, as evidenced by indicators of morbidity and mortality.³⁰ One product of the re-emergence of democracy in Brazil in 1982 was an intense interest in health reform and a desire to move away from a dictatorship, which was characterized by private interest, and instead toward establishment of a collective concern for health and healthcare. The Unified Health System (SUS) emerged as a result of this re-democratization of society and encouraged movements for sanitary reform and collective health.³⁰

The creation of the SUS in 1988 remains one of the main achievements of the re-democratization of Brazilian society because of its inclusive public policies, focusing on health as a right. Its creation and development represent public health policy initiating the state's responsibility in relation to the health of all citizens. It brings with it a broad inclusive understanding of the concept of health, embracing structural determinants such as education and employment.¹⁸ The SUS itself is based on the principles of universal access, comprehensive coverage, equity, decentralization, and social participation.

Both the complexity of the policy and the fact that it offers a direct challenge to private interests means that implementation of the SUS is still facing difficulties with regard to making concrete the concept of equity in access to, and comprehensiveness of, healthcare. It demands a model of care focusing not only on the treatment of diseases, but also on health promotion and tackling the determinants of the health-disease process.³¹ As a healthcare system, the SUS is free at the point of use and is taxpayer-funded in the same way as the NHS. Indeed, it is partly modeled on European experiences with healthcare delivery.³⁰ Equally, however, as with England (and to a greater extent), private medical insurance forms part of the Brazilian healthcare economy. In 2009, >20% of the Brazilian population had the “double coverage” of SUS and private insurance. Needless to say, such coverage is concentrated in those from higher socioeconomic classes.¹⁵ Public expenditure on healthcare in Brazil was 5.0% of gross domestic product in 2002 and 8.7% in 2011.³²

Even considering the important advances described in relation to public provision, it can be argued that Brazil still spends too little on health. Yearly health spending stands at \$700 per capita (vs \$3,322 in the United Kingdom²⁶) and

some of the health indicators that we have described show the consequences of such low levels of expenditure.³² The Brazilian system involves the participation of the private sector, but it is important to point out that the most expensive interventions are possible only because of public resources. The SUS, then, is undoubtedly an advance for Brazil, mainly because of its inclusivity and driving principles. But decades of neglect within the Brazilian health system make the task of addressing health inequalities and moving toward “health for all” difficult and arduous.

We have already noted that principles of universal access and comprehensive coverage are common to both the NHS and the SUS. These principles can be related to an overall European tradition in healthcare provision, which has been modeled in a South American context.³⁰ The decentralizing element within Brazilian health policy is also important to note and to some extent is matched by recent developments in UK policy, with more power for commissioning decisions being given to local doctors,²³ although this has been strongly criticized for its possible negative impact on clinical decision making and potential for leading to variations in access to treatment and care.³³ Social participation has played a central role in the formation of the Brazilian SUS, perhaps even more so than it did at the point of the founding of the NHS and in that system’s subsequent history. As one Brazilian commentator describes: “It would be difficult to understand the process of change leading to public health improvements without crediting the social movements and forces that catalyzed it. The virtuous cycle of power, entrusted by the people to a political process responsive to the health and wellbeing of all, is the true engine of the massive health improvement observed. . . .”^{34(p1985)}

A recent example is *More Doctors*, a program that aims to fill more than 15,000 vacancies for doctors, with a significant contribution of foreign professionals, mainly in the most vulnerable regions of the country (predominantly the Amazon and Northeast). Brazil has 5,565 municipalities, 700 of which do not have a single doctor.³⁵ This decision was in part a response to the tens of thousands of protestors who took to the streets across the country in June 2013 demanding better public services, particularly in health and education. Alexandre Padilha, the Brazilian Minister of Health, declared, “The government is confident in the legal certainty of what is being done. Whoever wants to criticize and make suggestions is welcome, but their actions will not threaten the health of our population where doctors are needed.”³⁶

Inequalities and vast geographical distances challenge Brazil’s healthcare system. According to the World Bank, the country overall has 1.8 doctors for every 1,000 people – significantly below the 3.2 ratio in neighboring Argentina and well below those of Mexico, the United States, and the United Kingdom²⁵ (however, see above for an indication of regional Brazilian inequalities in this overall figure).

Nevertheless, both systems – in Brazil and England – still demand a deep discussion about their purpose and nature, which can be better understood by considering the actual or potential contribution of health promotion. To put health promotion into practice implies a need for professionals looking toward strengthening the health potential of individuals and groups, with ambition in this regard not restricted to treatment of disease and related problems alone. Indeed, there is a requirement to develop projects that recognize quality of life as the health goal to be achieved. Health promotion as a field of knowledge and practice defines quality of life at least in part through gaining a better understanding of, and working toward meeting, human needs.¹⁸

Public Health and Health Promotion: Achievements and Challenges in England and Brazil

For England, the shift in the second half of the 20th century was from a public health concern with infectious diseases as major causes of mortality and morbidity (e.g., tuberculosis and the infectious diseases of childhood) to the so-called diseases of lifestyle. There is little doubt that this shift was paradigmatic, although it is seldom noted as such in the history of public health and health promotion.³⁷ Perhaps this is partly because the shift was incremental, masked by other significant changes in the health and social arenas (e.g., the growth of technology and alterations in power relationships) and mediated by grudging and gradual acceptance of the importance of lifestyle “risk factors” in disease development. Some authors, e.g., point to the extremely slow acceptance of the fact that smoking is deeply damaging to health.³⁸ By the final decades of the 20th century, however, the “lifestyle” agenda in the United Kingdom had gained a significant enough hold to occupy a place in government policy direction, at least rhetorically.³⁹

It is true that there have been some measurable and important successes since the emergence of this agenda. Smoking (with its causative associations with heart disease and cancer) provides 1 example, with the reduction of smoking levels in England from 55% of men in 1970 to 22% in 2007 (the figure for female smoking has historically always been lower).⁴⁰ Diet provides another example of such an approach, with efforts at individual lifestyle change comingling with regulatory efforts such as more stringent nutritional labeling and, importantly in this case, “razzamatazz” publicity made more possible by increased public interest in cooking and food.⁴¹ However, although the embedding of the “lifestyle” agenda may have been incremental, by the final years of the 20th century and the beginning of the 21st, it was so well-accepted that it became policy-makers’ standard and much preferred way of representing the persistent problems of health and illness that faced the United Kingdom, along with what needed to be done about them. It was all about “lifestyle,” and “lifestyle” was

all about individual responsibility. This preference has spanned both major political parties and the health promotion or public health policies they have produced.^{39,42-44} Although there is currently much government talk of incorporating work aimed at addressing health inequalities into policy and practice, a strong strand of individual responsibility remains, and the importance of structural determinants (which, we have argued, are fundamental to tackle if there is to be progress in addressing inequalities in health) is neglected.

Of course, the degree of success that has occurred in addressing diseases of lifestyle (more properly, some of their probable causative factors) should not be dismissed, but this has not resulted in the diminution of health inequalities or the achievement of Health for All.²⁹ Even in areas as amenable to narrow public health and health promotion policy attention as smoking and diet, there is strong evidence of inequalities in health, or at least susceptibility to disease. We know that if people are poorer, they tend to smoke and that their diet will be poor compared to those who are better off.⁵ At a broader level, if it is accepted that inequalities in income affect a wide range of life chances, including the chance of good health,⁴⁵ then the problem of Health for All becomes even more deeply structural. We cannot address inequalities only through behavior change or even alterations to the environment. It must also be through redistributive means.

Our examination of public health and health promotion policy in England suggests that its focus has been strongly on individual change, more weakly on environmental alteration, and not at all on income redistribution. This problem with policy function (it is only in a very limited way doing the right things to improve health) is amplified by a difficulty of organizational structure. For the last decades, public health responsibility has mainly lain, at least until recently, within the NHS. In theory, this should be the driver for Health for All. Yet if, as we have argued, structural inequality (income levels and distribution) has the most profound effect on this possibility, then the NHS is powerless to make a difference. It is, after all, a *healthcare service* and not a mechanism for redistribution. It is, of course, too early to tell whether the shift in public health responsibility from the NHS to local authorities will improve the capacity of publicly funded organizations to address inequalities in health.

Turning again now to the Brazilian context, the present scenario indicates broad overall improvement in health and improvement in indicators related to the social determinants of health, such as housing, basic sanitation, and public transport.³² The Pact for Life, a branch of the Pact for Health, is one strategy for achieving the fundamental principles of SUS. It aims to define in an integrative way the priorities for improving the health conditions of the population. Thus it is necessary to consider the places where people live and the conditions under which they live. The Pact for Life is structured according to the principles of primary care and partnerships between municipalities and others in order to

address health needs in a particular region. Overall, it moves responsibility for health from the federal government to states and municipalities.⁴⁶

Primary care should be universal and comprehensive and involve the promotion, protection, and restoration of health. Continuity of healthcare can be achieved through strong levels of primary care. According to Macinko and colleagues,¹⁷ primary care provides the best level of intervention to solve prevalent problems of a population through action in relation to prevention, cure, and rehabilitation. It does so because it is close to communities and because it is likely to promote inter-sectorial cooperation. There is evidence from many industrialized countries that strong primary care systems are better able to achieve reductions in population mortality and to increase the capacity to monitor chronic health problems.¹⁷ To improve the SUS, since 1994 its activities have in part been structured through the Family Health Strategy (ESF) to expand coverage and to strengthen its comprehensiveness.⁴⁶ The ESF provides comprehensive primary care services in 95% of all municipalities, covering >55% of the population.⁴⁷ It is driven by the decentralization process and supported by innovative programs. Some good examples here are provided by the Directly Observed Treatment Short-Course strategy to increase the participation of homeless people in interventions to prevent and treat tuberculosis⁴⁸ and the project Our Children: Windows of Opportunity, which aims to improve health promotion practices and to strengthen the capacity of individual families with regard to successful child development.⁴⁹ Evidence demonstrates that the ESF has improved links between professionals and communities, as well as the health status of communities.⁵⁰ Of course, in pointing to particular health-focused programs, the importance and impact of other social programs on health improvement should not be ignored. Federal programs such as the Family Scholarship (Bolsa – Família), the Feeding Scholarship (Bolsa – Alimentação), the Gasoline Assistance Scheme (Auxílio – Gás), and the Food Card (Cartão – Alimentação) also contributed to the transfer of income to the most vulnerable populations. Given the relationship between income inequality and health, such programs will have had effects on key health indicators.⁵¹

Commentators have remarked on the substantial time gap of >20 years between the creation of the SUS and the eventual development of the ESF, which can reasonably be regarded as the public health strategy guiding the former.¹¹ Explanations for the gap have centered around the magnitude of the organizational task of developing and delivering a strategy designed to provide comprehensive care to an enormous population, together with the stubborn, professional ideological barriers between the curative and preventive that required breaking down.¹¹ Moreover, the shift to primary care and broader conceptions of public health that both the SUS and the ESF represent faces social resistance in the form of a consumerist view of healthcare that sees health as a commodity and a privilege to be paid for by individuals able to do so, rather

than as a collective good to be provided to all.³⁴ This is evident in the relatively high levels of “double coverage” that exist in Brazil and its obvious relationship to socioeconomic status. Although this kind of neoliberal climate equally exists in England, the deep embedding of the NHS in society, combined with the wide experience of, especially, primary care, provides a kind of social consensus around the importance of public healthcare provision. Although they try to do so, neoliberals find it difficult to fundamentally alter English healthcare structures.²⁶

Equally, however, an overall evaluation of the principles and interventions that support both the SUS and the ESF suggests that they are attempting to overcome the mantra of lifestyle that often seems to dominate English policy thinking. The SUS is concerned with critical values such as equity and justice that lead to healthy public policies and a population perspective on health.³² It acknowledges the crucial importance of community and participatory-based interventions and operates with a broad conception of the nature of health as a value. As Uauy argues: “Brazil demonstrates the virtuous cycle of democratic advances supporting gains in health to further popular support for democracy. This process occurs only if the democratic process is allowed to function on the basis of majority rule respecting the basic rights of all. . . .”^{34(p1984)}

Brazil is experiencing a trickle-down pattern to reduce inequalities. The ESF is designed to increase coverage first among disadvantaged groups in deprived municipalities.⁵² This can be regarded as a progressive universalism: “At its center lies a determination to ensure that people who are poor, gain at least as much as those who are better off at every step of the way toward universal coverage. . . .”^{53(p2160)}

In synthesis, health reform in Brazil is one manifestation of the struggle for the restoration of democracy. The participation of the community, although slow and difficult, should be regarded as an important achievement. The decentralization of services has impacted positively. Local communities are the basis for health interventions, seeking to develop monitoring actions that transcend the rigidity of traditional epidemiological surveillance. However, SUS still struggles for completely universal and equitable coverage. The interaction between the public and private sectors creates contradictions and competition. As we have described, federal funding of health care has remained largely static in recent years, resulting in constraints on financing, infrastructure, and human resources.³²

England and Brazil: Responses to Health Challenges from Health Promotion and Public Health Policy

As we have said, the UK Coalition government has not ignored the now highly sophisticated evidence related to inequalities in health presented by Marmot and others. Indeed, in both its 2010 White Papers (on the structure of health services

and on the nature and direction of public health work) and the legislation eventually emerging from these, it emphasized its interest in the debate. For example, recent policy declarations make it clear that: “The Government is radically shifting power to local communities, enabling them to improve health throughout people’s lives, reduce inequalities, and focus on the needs of the local population. . . .”^{54(p3)}

However, an examination of the action proposed in relation to this objective of inequalities reduction does not suggest income redistribution, fiscal alteration, or other measures that we have argued are crucial in reducing health inequalities, given the social determinants of those inequalities. Instead, there is talk of: “Empowering local government and communities. . . Making it pay to work. . . A Public Health Responsibility Deal with five networks on food, alcohol, physical activity, health at work, and behavior change.”^{54(p4)}

It is, however, unclear exactly what local government will actually be empowered to do. It seems that responsibility for work lies in addressing the individual and lifestyle factors that are central components in dominant policy conceptions of public health. The Responsibility Deal echoes the tone of previous public health policies, which we have critiqued in relation to their limited capacity to engage in genuine health improvement. The structural problem that we identified above – the NHS being oddly without proper public health capacity with regard to what is likely to make a significant difference to health improvement – is also acknowledged by the Coalition government, which as we have already described has, since 2013, shifted public health functions to local authorities. Directors of Public Health, responsible for the health of local populations and until recently part of NHS structures, have transferred to local authorities. These authorities are now responsible for Health and Well-Being Boards, which supposedly draw together a range of local partners with an interest in public health, such as the NHS and consortia of GPs. Public health budgets are supposed to have ring-fenced protection at the local level. Nationally, a new body known as Public Health England is responsible for commissioning and funding public health work, rendering budgets in this area separate from the NHS.⁴⁴ It is reasonable to believe that local authorities, with their interests in areas such as education, transport, planning, and housing (all likely to have an impact on health), are a sensible place from which to oversee and coordinate public health work.

However, there are difficulties with this policy direction. In the first place, policy in other areas (such as education and planning) is removing responsibility from local authorities, seeking to place it instead with a diffuse range of individuals and groups that somehow represent what the Coalition government has referred to expansively but vaguely as “The Big Society.”⁵⁵ If local authorities have less and less control of areas likely to influence health, and instead have to negotiate with and cajole a range of other people, what guarantee is there that they will be any more successful in building Health for All than a public health

function marginalized in the NHS? Second, although the government is clear that it does not see the removal of public health as leading to the abrogation of responsibility in this area by the NHS,⁴⁴ there seems to be the real possibility that public health will be seen as something that local authorities “do,” and a body with enormous capacity for promoting public health will turn inward still more toward treatment and care.

We move again to Brazil, a huge, populous, and heterogeneous country that has shown recent demographic changes in terms of age structure, rapid urbanization, the burden of infectious diseases, and the growing amount of chronic diseases. Above all of this, sharp economic and social inequity and inequality remain. There continue to be difficulties in relationships between the federal government, states, and local districts.³⁴ However, Brazil’s undoubted economic advancement appears to be having an important impact on healthcare systems and on the health of the Brazilian population. With a health system based on principles that include collective responsibility and equity, the state has an imperative to tackle the social determinants of health. This is an imperative for all democratic states, so hopefully, evidence from Brazil should provide encouragement for all democracies in this task, both the developed and the so-called emerging economies.⁵⁶

In important ways, healthcare systems in Brazil and England seem to be facing in different directions. Although attempts are being made in England to marketize, commercialize, and privatize public services, including health services, the SUS in Brazil is being improved by the expansion of primary care based on the ESF. The debate in Brazil is focused at the local level in order to strengthen population coverage. Equally, though, it is necessary to emphasize that there are difficulties with the level of budgetary allocation for health and with processes of social mobilization and community involvement. Generally, the position of the SUS requires further strengthening against the voices of privatization and individualization in health care. At a broader level, beyond healthcare, there is a need to develop and sustain services such as education, which have a profound influence on the capacity for health, and to integrate them effectively into public health policies.

Conclusion

Health for All in both England and Brazil remains an ideal, perhaps a horizon. Work at both policy and practice level to engage with health-related inequalities continues to be an imperative. Our comparative discussion leads us toward conclusions about what might need to be done to continue with both the ideal and the imperative: 1) the ways in which the relationship between health, collectivity, and democracy has been conceived in Brazil holds important lessons for those working in England; 2) there is a need in both contexts to protect the principle of universal access, because barriers to health systems can have

fundamentally negative impacts not only on treatment and care, but also on public health and health promotion; 3) the local level (community) should be a privileged space for the construction of individual identities and the development of individual rights, which are fundamental to the development of health and health-related capacity; 4) primary care continues to require strengthening, and the development of appropriate technologies to manage the complexity of primary care-related interventions needs to be further encouraged; 5) guidance for the evaluation of policy, management, training, and permanent education for a workforce, which daily faces the complex reality of social inequality, is essential; and 6) there is a need to recognize that social inequality is a collective problem, which calls for actions of collective solidarity. The answers to health improvement do not lie with the market, but rather in public policies supported by strong social mobilization.

We are aware of a number of limitations surrounding our study. First, Brazil is a large country with a highly heterogeneous society and deep regional differences. The Brazilian Amazon, e.g., represents particular difficulties connected to public health such as access, low population density, and poor medical coverage. In a time- and resource-limited study such as this, it is impossible to devote sufficient attention to each region of the country. We have only been able to point in the broadest ways to regional differences and diversity. Second, in both England and Brazil, health services are undergoing rapid change and development at both policy and practice levels. Our study accepts the certainty that what we have written about in both places is not static; nevertheless, we argue that the broad themes emerging from our work will be relevant in both places for significant time to come. Third, in different ways, Brazil and England face major social challenges beyond health services. For example, in Brazil in 2014, a fervent ideological debate that included health took place in the context of the country's presidential elections and staging of the football World Cup. In the same year in England, health was part of the debate about continuing austerity measures as the country faced severe weather patterns that some attributed to climate change.

Despite these limitations, consideration of the issues that emerged from our description and analysis of public health and health promotion policy and practice in England and Brazil will, we hope, support healthcare workers and researchers in their task of moving toward the ideal of Health for All and the imperative of tackling inequalities in health. As the world attempts to rebalance itself in the first part of the 21st century, different countries with different contexts and histories have much to learn from each other.

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