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Original Article

Social representations of health councilors regarding the right to health and citizenship

Representações sociais de conselheiros de saúde acerca do direito à saúde e da cidadania

Representaciones sociales de concejales de salud sobre el derecho a la salud y a la ciudadanía

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ABSTRACT

Objective: To know the structure of the social representations of right to health and citizenship of health municipal councilors.

Method: This is a qualitative study, based on the central nucleus theory of social representations, carried out in eight municipalities of the Integrated Region for the Development of the Surroundings of the Federal District, Brazil. The intentional sample consisted of municipal health councilors. Between June and December 2012, free recall questionnaires were used, of which 68 were answered with the inducing term health, and 64 with the inducing term citizenship. Data were analyzed using EVOC software and Bardin's content analysis.

Results: The representational field of the right to health is associated with the idea of universal law guaranteed by the Constitution and the Unified Health System (SUS), and of citizenship linked to rights and duties.

Conclusions: The conceptions of right to health are understood as a condition for reaching citizenship, and citizenship as social protection.

Keywords: Right to health. Citizen participation. Health councils.

RESUMO

Objetivo: Conhecer a estrutura das representações sociais de direito à saúde e cidadania de conselheiros municipais de saúde.

Método: Estudo qualitativo, fundamentado nas Teorias das Representações Sociais e do Núcleo Central, realizado em oito municípios da Região Integrada de Desenvolvimento do Entorno do Distrito Federal, Brasil. A amostra intencional foi composta por conselheiros municipais de saúde. Entre junho e dezembro de 2012 aplicaram-se questionários de evocação livre, dos quais foram respondidos 68 com o termo indutor Direito à Saúde e 64 com o termo indutor Cidadania. Os dados foram analisados por meio do *software* EVOC e da análise de conteúdo de Bardin.

Resultados: O campo representacional de direito à saúde está associado à ideia de direito universal garantido pela Constituição e pelo SUS e de cidadania vinculado aos direitos e deveres.

Conclusões: As concepções de direito à saúde são entendidas enquanto condição para alcance da cidadania e cidadania como proteção social.

Palavras-chave: Direito à saúde. Participação cidadã. Conselhos de saúde.

RESUMEN

Objetivo: Conocer la estructura de las representaciones sociales de la salud y el derecho a la ciudadanía de la salud de concejales.

Método: Estudio cualitativo basado en la teoría de las representaciones sociales y el núcleo central, realizado en los municipios de la región que rodea el Desarrollo Integrado del Distrito Federal, Brasil. Una muestra intencional fue compuesta por consejeros municipales de salud. Entre junio y diciembre de 2012 aplicaron cuestionarios de recuerdo libre, de los cuales fueron contestados 68 con el inductor del término derecho a la salud y 64 con el término ciudadanía inductor. Los datos fueron analizados utilizando el software EVOC y el análisis de contenido de Bardin.

Resultados: El campo representacional derecho a la salud se asocia con la idea del derecho universal garantizado por la Constitución y el SUS y la ciudadanía vinculada a los derechos y deberes.

Conclusiones: El derecho de los conceptos de salud se entiende como condición para el logro de la ciudadanía y ciudadanía como protección social.

Palabras clave: Derecho a la salud. Participación ciudadana. Consejos de salud.

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INTRODUCTION

The right to health is part of social rights, being one of the most difficult to achieve, especially when considering civil and political rights, which require effective State actions through effective policies and programs[1]. In this perspective, besides the universal right to health, intersectoriality of health actions, the regulatory role of the State in relation to the health market, decentralization, regionalization and hierarchization of the system were included in the Unified Health System (SUS, as per its acronym in Portuguese).

Popular participation in health services was ensured through collegial bodies called conferences and health councils[3]. These forums premise is the democratization of public management, and improvement of efficiency and effectiveness of social policies. However, the panorama shows that there is a low incorporation of the proposals of the conferences and that the councils have limited autonomy in the definition of public health policies, besides having a bureaucratic function[3-4].

The participation of the population and its organized groups in the management of health services represents a major step forward in representative democracy, because the right to health should be defined as a priority by the local community[5]. The community, by expressing health needs, becomes able to define the extension of the concept of health and delimit the scope of freedom (individual right) and equality (collective right), which are the base of the right to health.

In this context, the struggle to guarantee the right to health ended up being the figures of citizen subjects, that is, political activists who seek to guarantee better living conditions for the population[6]. This is, therefore, the exercise of citizenship, which takes place primarily as a practice of identification with public issues, that is, with issues of public interest. In other words, the exercise of citizenship is a daily practice[7].

Nonetheless, it should be noted that the search for guarantees of the rights to health, and the political activism of the organized civil society has been incorporated into the coordination of neoliberalism, with the modes of subjectivation of the political claims themselves[6]. As a result, there is the risk of losing this right, which was hardly achieved in the health reform process, the universal coverage of health services for all the population.

Based on this, it is important to understand how subjects behave and justify or position themselves in relation to their actions to defend the right to health and citizenship, since a citizen action is related to the guarantee of rights and to the exercise of democracy.

Accordingly, social representations of the right to health and citizenship of municipal health councilors can contribute to the design of restricted or comprehensive health care models, and also greatly influence municipal public health policies that are reverted into services rendered to the community.

Therefore, a question emerges: Which social representations of right to health and citizenship permeate daily practices within municipal health councils? For this reason, this study had as objective to know the structure of social representations of right to health and citizenship of health councilors of municipalities of the Integrated Region for the Development of the Surroundings of the Federal District (RIDE-DF).

METHOD

This study is part of a thesis[8] that analyzed the organization and dynamics of municipal health conferences and councils in order to reach users' satisfaction.

The methodological design chosen was the qualitative research, based on the Social Representations Theory[9], along with the complementary proposal of the Central Nucleus Theory[10]. This theory proposes that a social representation is organized around a central nucleus, which is formed by one or more elements that give meaning to the representation, and that, for this reason, are stable and define the homogeneity of a group. Around this central element, or these central elements, the peripheral elements, considered the moving and evolutionary aspect of a representation, would be organized, with the function to reify, regulate and defend the central nucleus[10].

Using the structural approach of social representations, it is possible to access and identify the terms and expressions that better define and organize the representations of the right to health and citizenship, assisting in the analysis of the common field, which corresponds to the beliefs shared by the municipal health councilors.

The present study was carried out in the municipal health councils of eight municipalities of the Integrated Region for the Development of the Surroundings of the Federal District (RIDE-DF), which is formed by municipalities of the states of Goiás and Minas Gerais located around the Federal District, and was created by virtue of Complementary Law No. 94 of February 19, 1998, regulated by Decree 7.469 of May 2011. Its creation aimed at the improvement and expansion of essential public services and promotion of economic activities in the region, and at overcoming the difficulties experienced by its population, such as the lack of health services[11].

It is important to note that these municipalities are considered as dormitory cities, and have a significant population contingent that, due to speculative home purchase in the territory of the Federal District, had to migrate to adjacent cities. In these municipalities, there is a strong dependence on the Federal District for public health services; in addition, there is low average income among the majority of the population, and a high rate of informality in the labor market, where more than 80% of the population does not have private health insurance[12].

Thus, the municipalities were selected if they were representative of the RIDE-DF regions; had a population of more than 50,000 inhabitants, and held municipal health conferences every two years. Hence, the sample consisted of Municipal Health Councils of the South Surrounding regions (Cidade Ocidental, Novo Gama, Santo Antônio do Descoberto and Valparaíso, all in the state of Goiás); of the North Surroundings (Formosa and Planaltina, municipalities of Goiás); Region of Pirineus (Pirenópolis, Goiás); and the region of Unaí (Buritis of the state of Minas Gerais).

The intentional sample consisted of health councilors from the municipalities described above, with at least six months of office, present at the ordinary and extraordinary meetings of the councils from June to December 2012, and who volunteered to participate, totaling 68 subjects who answered the questionnaire on the inducing term *right to health*, and 64 who responded as to the inducing term *citizenship*. Twenty-one meetings were followed for the application of the questionnaire. Councilors with less than six months in office, or who were absent from meetings or who refused to participate in the survey were excluded from the sample.

The data collection instrument was a semi-structured and self-administered questionnaire, divided into three parts. The first part was intended for evocation, where the free evocation technique was used so that the councilors could cite six words or expressions that occurred to them immediately in relation to the inducing terms *right to health* and *citizenship*. The second part used the technique of hierarchy of items so that the councilors enumerated, in order of importance, three words or expressions considered more important. The third part of the questionnaire was intended to justify in writing the three words or expressions considered of greater relevance for each inducing term. This free evocation questionnaire makes it possible to know mental elements quickly and objectively, by apprehending the elements of the central and peripheral nucleus of a representation, avoiding masking of elements through consciousness, as it happens in the interview [13].

In order to identify the structure of the social representations, the answers collected in the first part of the questionnaire were submitted to the evocation analysis, through the software EVOC (Ensemble of Programmes Permettant l'Analyze des Évocations), version 2000, for the analysis of free evocations. This allows to identify not only the content of the representations, but their internal organization based on a double criterion: frequency (freq.) versus average evocation order (AEO). The closer the average is to one, the greater the importance of the indicated words. According to the assumption of the structural perspective of social representations, the association of these two criteria distributed in four quadrants reveals the probable central and peripheral elements of a social representation[10]. Words with a high frequency, and to which the subjects attribute an importance in the definition of the object, and express a central and organizing sense of social representation; therefore, they are more important in the cognitive arrangement. The words in the peripheral system have less frequency and distant evocation, and are important for providing support to the central nucleus, as well as being more fluctuating to changes. The intermediate elements, located in the contrast zone, are expressed with low frequency, but with the next evocation by the subjects, or high frequency and distant evocation, and signal the existence of relevant differences in the representation when they deviate from the central elements, indicating the existence of a representational subgroup[13]. The analyses with the software of the words/expressions evoked from the inducing terms, *right to health* and *citizenship*, were carried out separately.

The organization of the data from the second part of the questionnaire was submitted to the centrality test. In this step, the words or expressions evoked after the enumeration in order of importance in the EVOC software were analyzed, and their internal organization took place in frequency versus average order of importance (AOI) in order to proceed with the comparison with the free evocation order.

The content of the third part of the questionnaire was submitted to content analysis[14] for each of the inducing terms. This seeks to discover the nuclei of meaning that make up communication through the procedure of thematic-categorical analysis consisting of three phases[14]. The first one is pre-analysis that consists of choosing the documents to be analyzed; in the resumption of the hypotheses and the initial objectives of the research, reformulating them using the material collected; and in the elaboration of indicators that guide the final interpretation. The second phase concerns material exploration, which consists of the coding operation. The last phase

refers to the treatment of the results obtained and interpretation for proposition of inferences.

The present study was submitted to the Ethics Committee of the Foundation for Teaching and Research of the Federal District, and approved under number 001/2012. All research subjects had voluntary participation and signed a free and informed consent form.

RESULTS AND DISCUSSION

The analysis performed with the EVOC software allowed the identification of the probable central elements, that is, those that give meaning and organize the representation, as well as the probable elements of the periphery of the social representation of *right to health* (Table 1).

The data obtained from the analysis of free associations of the inducing term *right to health* (Table 1) revealed two important elements in the central nucleus: Constitution and SUS. These elements characterize the legal instruments for the materialization of this right, as well as the idea of accessibility and everyone's right. In the second quadrant, there are the terms that are probably part of the peripheral system closest to the central nucleus, where the right to health and the right to receive medicines appeared as the

Table 1 – Quadrants with the structure of social representation of the municipal health councilors of the eight municipalities of the RIDE-DF on the term *Right to Health* – 2012

Central Nucleus			**Peripheral System – First Periphery**		
1st Quadrant Frequency >= 8 Average Order of Evocation <3			2nd Quadrant Frequency >= 8 Average Order of Evocation >=3		
Evoked Term	**Freq.**	**AEO**	**Evoked Term**	**Freq.**	**AEO**
accessibility	8	2.625	medication	11	3.182
constitution	11	2.000	responsibility	9	3.556
everyone's rights	16	2.000			
SUS	10	2.300			
Peripheral System – Contrast Zone			**Peripheral System – Second Periphery**		
3rd Quadrant Frequency < 8 Average Evocation Order <3			4th Quadrant Frequency <8 Average Evocation Order >=3		
Evoked Term	**Freq.**	**AEO**	**Evoked Term**	**Freq.**	**AEO**
care	6	2.333	basic care	3	3.333
citizenship	7	2.571	communication	3	5.000
citizen	5	2.200	knowledge	7	3.714
commitment	6	2.833	education	3	4.667
health council	4	2.500	humanization	5	4.200
state obligation	7	2.714	elderly	4	4.250
rights	3	2.333	financial resources	3	4.333
exams	3	2.000	respect	4	4.250
fundamental	3	1.333	treatment	3	3.000
hospital	6	2.333	universality	7	4.429
equality	6	2.500			
taxes	4	2.500			
comprehensiveness	3	2.333			
legislation	7	2.429			
physician	5	2.800			
denied	4	1.000			

Source: Research data, 2012.
Freq.: Frequency.
AEO: Average Evocation Order

responsibility of the managers. In the third quadrant or contrast zone emerged a representational subgroup formed by the idea of citizenship, where the citizen has the right to care, and it is the duty of the State to provide it, as well as the right to social participation, objectified in the health council. The issue of tax collection reinforces the idea of citizenship and right to health. In the more distant peripheral system, right to health referred to the elements of basic care, communication, knowledge, education, the elderly, financial resources, respect, treatment and universality.

Table 2 presents the results of the centrality test of the term *right to health* for comparison of the elements of the central nucleus in average evocation order and in average order of importance.

When performing the centrality test, it was verified that the central elements of *right to health* (Table 2) remained in order of evocation, as well as in order of importance, reinforcing the evidence that these elements make up the central nucleus.

It was found that the social representations of *right to health* of health councilors are anchored in the ideas of the Sanitary Reform that were approved by the VIII National Conference of Health in 1986, to strengthen the public health sector, to expand coverage to all citizens, aiming at establishing a unified health system[2]. Another element evidenced was the Constitution, which is characterized as a legal instrument for materializing the universal right to health.

Using the content analysis of the justifications of the three words or expressions of greater relevance for the inducing term *right to health* two thematic categories emerged.

The category named **Right to Health** revealed that the right to health is universal; however, a speech pointed out that SUS is for the underprivileged. The councilors also revealed that the governors should ensure compliance with health laws regarding health, and convert taxes collected into the health system, since there is a need for investment in the SUS. In addition, they showed the *right to health* as a conquest, the result of the collective struggle and that to guarantee it, the society should know the laws that support the SUS to demand their compliance by the public power, even through judicialization. Another idea that emerged on the subject was the supervision of the fulfillment of the right to health by health councils, public ministries, and courts of accounts. The collective discourse also highlighted that accessibility to appointments, diagnostic exams, treatments, humanized and quality care reify this right.

The universal health system has allowed the accessibility mentioned by the councilors of this study to appointments, diagnostic exams, treatments, and humanized and quality care. The right to health includes access to the resources needed to achieve health, the ability to withstand conditions that endanger health, health information and transparency, informed consent, and even the right to make a decision[15].

UNESCO, in 2005, through the Universal Declaration on Bioethics and Human Rights reaffirmed health as a fundamental human right and that the population's access to health care is essential to quality health, and should therefore be the central objective of governments[16].

In the category called **Full Health**, other factors that influence health conditions, such as basic sanitation, housing, employment, education, food, water quality, access to sports and leisure were pointed out. On the other hand, some councilors cited private health plans for access to differential treatment and better health, albeit at high costs.

Table 2 – Centrality test of the term *Right to Health*, RIDE-DF – 2012

	Evocation			Importance		
	Evoked Term	**Freq.**	**AEO**	**Evoked Term**	**Freq.**	**AOI.**
NC	accessibility	8	2.625	accessibility	8	2.625
	constitution	11	2.000	constitution	11	2.091
	everyone's right	16	2.000	everyone's right	16	1.875
	SUS	10	2.300	medication	11	2.727
				SUS	10	2.400
SP	medication	11	3.182	responsibility	9	3.889
	responsibility	9	3.556			

Source: Research data, 2012.
Freq.= Frequency
AEO= Average Evocation Order
AOI= Average Order of Importance

It was verified that the councilors, when referring to the *right to health*, went beyond the field of health, since they pointed to other factors that influence health conditions, such as basic sanitation, housing, employment, education, food, water quality, access to sport and leisure, as demonstrated in the theme category **Full Health**. Accordingly, health systems and their governments, in order to guarantee the right to health, should work on the social and environmental determinants of health, derived from the form of organization of production in society, and the inequalities that exist in it, emphasizing that the action on these factors should be the responsibility of all State sectors(2), considering the complexity of this right, as it achieves several spheres, including health, law, financial, educational, technological, housing, sanitation and management policies(17). Thus, the *right to health* has been closely related to other human rights such as human dignity, life, non-discrimination, equity, prohibition against torture, privacy, access to information, and freedom for organizing associations, meetings, and movements(18).

Nonetheless, in the **Full Health** thematic category, the complementary health network was considered of better quality when compared to public services, showing strong indications of a progressive penetration of private interest in the public health system. This contrasts with the perspective of the Sanitary Reform, which defended the creation of a public and universal health system, where private initiative would be established in a complementary manner, with the perspective of its gradual reduction in the context of the SUS(6).

Table 3 – Quadrants with a structure of social representation of municipal councilors of eight municipalities of the RIDE-DF on the term *Citizenship* – 2012

Central Nucleus			**Peripheral System – First Periphery**		
1st Quadrant Frequency >= 13 Average Evocation Order <3			2nd Quadrant Frequency >= 13 Average Evocation Order >=3		
Evoked Term	**Freq.**	**AEO**	**Evoked Term**	**Freq.**	**AEO**
obligations	20	2.600			
rights	27	1.556			
respect	19	2.526			
Peripheral System – Contrast Zone			**Peripheral System – Second Periphery**		
3rd Quadrant Frequency < 13 Average Evocation Order <3			4th Quadrant Frequency <13 Average Evocation Order >=3		
Evoked Term	**Freq.**	**AEO**	**Evoked Term**	**Freq.**	**AEO**
action	3	1,667	citizen	5	3.200
constitution	3	2,000	collectivity	3	4.000
right to health	3	1.000	commitment	3	3.333
equality	4	2.500	knowledge	6	4.167
social participation	10	2.400	dignity	5	3.800
health	6	2.833	education	6	3.833
empathy	7	2.714	job	5	3.600
union	3	2.000	ethics	3	3.667
vote	6	2.500	humanization	3	6.000
			mobilization	4	4.500
			housing	3	4.667
			responsibility	6	3.500
			sanitation	4	4.750
			society	8	4.250

Source: Research data, 2012.
Freq.: Frequency
AEO: Average Evocation Order

In this direction, health councils are extremely relevant, especially to vocalize the defense of health as a public good. Community-based participation is also be important to ensure access to a wide range of health promotion, prevention, curative and rehabilitation health services[19].

The analysis with the software EVOC revealed the representational structure of the term *citizenship* (Table 3) from the arrangement of the elements in the upper left quadrant or central nucleus, upper right quadrant or first periphery, lower right quadrant or second periphery and lower left quadrant called contrast zone.

Regarding the free evocation of the inducing term *citizenship* (Table 3), the analysis showed, in the central nucleus, the elements of exercise of rights, fulfillment of obligations, and respect. The second quadrant that corresponds to the peripheral system that is closest to the central nucleus appeared empty. In the third quadrant or contrast zone a representational subgroup appeared, formed by the idea of citizenship associated with action, based on the constitution, which guarantees the right to health, equality, social participation and voting, and that there is a need for solidarity and union among people. In the most distant peripheral system, citizenship referred to the conditions for a person to be recognized as a citizen.

Table 4 presents the result of the centrality test of the term *citizenship* for comparison of the elements of the central nucleus in average evocation order and in average order of importance.

When performing the centrality test, it was seen that the central elements of the term *citizenship* (Table 4) remained in order of evocation and in order of importance, indicating that these elements probably form the central nucleus because they resist to the test.

The social representations of *citizenship* of the councilors are anchored in theoretical and philosophical frameworks that were the basis for the citizen's constitution, by presenting in the central nucleus the right elements, obligations, and respect. In the Brazilian constitution, citizenship is guaranteed in three areas: civil, social and political rights. Hence, the civil rights of individual freedom preservation, such as contract, property, expression, conscience; political rights of representation and participation; and social rights, which are aimed at avoiding the worst effects of capitalism, with the right to health, education, food, labor, housing, leisure, safety, social security, maternity and child protection, and assistance to the disadvantaged were related to the citizen's condition[18]. In short, the term *citizenship* has contemplated the rights, obligations, as well as respect to the laws that the citizen has in relation to the country where he/she was born or chose to live in.

Two thematic categories emerged from the content analysis of the justifications of the three words or expressions of greater relevance for the inducing term *citizen*.

The category called **Social Activism** revealed that the rights, respect for the laws and neighbors, and the fulfillment of obligations were considered the basic principles of citizenship. In addition, the set of rights allowed social activism and participation in public life. In this sense, an individual is considered a citizen when he/she is aware of his/her rights and obligations. Among their obligations, they mentioned voting, here put as the greatest expression of citizenship.

These findings revealed that *citizenship* encompasses a set of rights that allow the active participation of individuals in public affairs. Participation would take place, concretely, from the choice of governors, through the electoral process, with representative democracy guaranteed in the constitution, as demonstrated in the thematic category **Social Activism**.

However, this has proved to be insufficient to address the problems presented by most of the population. Thus, participatory democracy mechanisms are adopted as a political, social and cultural strategy capable of guaranteeing the expansion of the public sphere, and greater participa-

Table 4 – Centrality test of the term *Citizenship*, RIDE-DF – 2012

	Evocation			Importance		
	Evoked Term	Freq.	AEO	Evoked Term	Freq.	AOI.
NC	obligations	20	2.600	obligations	20	2.550
	rights	27	1.556	rights	26	1.692
	respect	19	2.526	respect	19	2.789
SP						

Source: Research data, 2012.
Freq.= Frequency
AEO= Average Evocation Order
AOI= Average Order of Importance

tion of citizens in the public discussion of the community[4]. Participation is anticipated in the Brazilian constitution through the institutional channels of social participation, among them, councils and conferences.

The historical conjuncture of the citizenship constitution took place during the formation of the national States, and the establishment of capitalism, due to the decline of feudalism and bourgeois rise. Therefore, citizenship developed as a principle of justice and with the normative function of organizing the political system and legitimizing political authority through citizens who hold rights and obligations[20].

In addition, social movements have played a key role in the consolidation of citizenship, because through struggles they overcame the development of social protection systems, aiming at reducing the deleterious effects of the capitalist system, based on the economic inequality of the social classes[20]. Accordingly, social protection has developed legally, in the form of rights guaranteeing the status of citizenship, and institutionalized in the systems of provision of health, education and care goods and services, seeking to increase the population well-being[20].

Another category that emerged, called **Full Citizenship,** revealed that for citizenship to be complete it is necessary that the city be clean and organized, as a means of avoiding the spread of diseases, denoting a concern with the sanitary condition.

In this category it was understood that the councilors anchored their representations of *citizenship* in the reformist ideology that postulated the improvement of sanitary conditions as a pathway for access to the extension of the right to citizenship, more precisely to the democratization of society.[2]

CONCLUSIONS

The content of the social representations of the subjects of the study signaled that the right to health is understood as a condition for reaching citizenship, and this as a form of social protection. These representations were shared by the group and possibly guided attitudes and behaviors within the councils, with a significant potential to influence the proposals and the decision making of the municipal health policies.

The structure of the social representations of citizenship was limited to the fulfillment of obligations, and the exercise of rights; however, the elements in the peripheral systems brought the conditions to have citizenship and the mechanisms of social protection, signaling a tendency to amplify its meaning. It must be recognized that the process of changing social representations is a slow movement, because first the peripheral elements of social representations are transformed, and then the central elements are modified.

Based on the SUS scenario, it was verified that the foundations of the health reform were built, but they require efforts to keep health as a public good, requiring a profound political change, which extends to an awareness of the right to health and citizenship. Therefore, to become a reality one must consider that modifying actions implies changing the representations that guide them.

Limitations of this study include the need for expanding the investigation on the influence of social representations of right to health and citizenship of municipal councilors on health policies, municipal health plans, and on the provision of community health services. In academic terms, the study may contribute to discussions and prompt new investigations about social representations in the field of health.

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