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Beyond reporting: the media serving to promote health and the management and care networks

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Abstract:

This essay discusses how the involvement of communication professionals in processes related to health, connected through networks and an interdisciplinary system of cooperation, can create opportunities for communication and strengthening processes in integrated health care. The experiences of the communications advisory group, which includes the United Network (Rede Unida) and other partner agencies dedicated to promoting initiatives to enhance the National Health System (Sistema Único de Saúde – SUS), demonstrate the importance of communicating and using public health as a way to promote the quality of life of the population. Shared management, permanent education and more active social participation according to the guidelines followed by the SUS are all essential.

Key Words: Health Communication; Public Health; Interdisciplinarity; SUS.

Introduction

The institutional logic of communication does not always broaden the understanding of the people who work in that field or of the relevant institutions, even in the health care sector. In general, communication advisory groups examine the image of an institution and its managers and develop strategies for improving the organisation's relationships with internal and external audiences. The flow of information most frequently follows informational power strategies, taking into account the location of speeches, the person who provides the information, the image portrayed and the social context of the communication within historical space and time. Such speech acts impose and legitimise information from the institutional perspective and, to some extent, from that of the health system as a whole (MORAES, 2008).

From a historical point a view, communication was always a prerogative of health institutions, which relied on it to support the implementation of their policies, to disseminate actions and to prescribe behaviour. The means and channels of expression were not made available to individuals, leaving them as mere 'receivers' of institutional communication. (ARAÚJO *et al.*, 2007, p. 62).

In public administration, communication as a system is jeopardised by a lack of long-term planning and suffers from changes in management and the influence of programmatic and policy trends. Communication also suffers from the consequences of political relationships, a lack of resource allocation and a lack of regulation, all of which distort existing structures. These factors prevent the development of more permanent and effective programmes for institutions and the actors involved. The result is the centralisation of voices, the fragmentation of initiatives and the use of shallow with a focus on authority figures. This phenomenon is referred to by Torquato (2010) as a focus on the communicative personality ("fulanização comunicativa"), which prioritises the person instead of the facts.

Journalists also maintain a stance that reinforces pre-conceived images of health. Because they rely on data transmitted through sources whose credibility is guaranteed, reporters and editors emphasise technical and statistical data (MACHADO, 2011, p. 35) and the technical, specialised interpretation of that data, as if this were the only matter at hand. This approach authenticates what is being said and endows it with greater weight.

The use of this tool does not always actually guarantee accuracy, which generates conflicts between journalists and health professionals. The health care sector uses the language and criteria associated with the contemporary tradition of scientific rigor and seeks to safeguard the accuracy of the terms and parameters used in each field. Communications professionals seek to "translate" specific information into an easier and simpler language to achieve widespread understanding, and they also summarise this information according to the available space and time allotted for such reports. This strategy does not always ensure sufficient accuracy, at least with regard to healthcare. Most importantly, the technical interpretations of the data and the modes of transforming them into information are rarely questioned.

The logic of health

The relationship between patients and health professionals has changed throughout history. Foucault (1979) said that the medicine of the 17th and 18th centuries was deeply individualistic and dependent on the doctor, as doctors embodied the knowledge contained in texts and transmitted them to the public as secret recipes.

The intervention of the doctor in the disease was organised around the notion of crisis. The doctor should observe the patient and the disease from its first signals and describe the moment in which the crisis appeared. (...) The idea of a long series of observations within the hospital, in which constants, generalities and particular elements could be recorded, etc., was excluded from medical practice. It is seen, thus, that nothing in the medical practice of the time allowed for the organisation of hospital knowledge, and nothing in the organisation of the hospital allowed for medical intervention. Hospitals and medicine, therefore, continued to be independent until the middle of the 18th century. (FOUCAULT, 1979, p. 59)

According to the discourse of the time, changes in the process sought to purify hospital environments of "harmful" effects that would facilitate the transmission of diseases within the population. Thus, the doctor gained prominence as a centraliser of health processes and as the best source of information about health. In accordance with Foucault's analysis, the following passage describes the transformation of knowledge, practices and professional behaviour within the hospital:

Since then, the form of the cloister, of the religious community, that had served to organise the hospital, was banned in favour of a space that should be organised medically. Moreover, if the diet, ventilation, the serving of drinks, etc., are healing factors, the doctor controlling the regimen of the patients, to a certain extent, assumes responsibility for the economics of the hospital, hitherto the privilege of religious orders. At the same time, the presence of the doctors was affirmed and multiplied within the hospital. The frequency of visits increased steadily during the 18th century. (FOUCAULT, 1979, p. 59)

Thus, scientific information as it was conceived in the modern era began to dominate health care processes in a hermetically sealed process that sought precision and control over all of the aspects of the biological functioning of the human body and its disease curing mechanisms. This discourse was not seen as subject to examination or questioning by the media; because it was the absolute truth, it could not be challenged.

Such an approach, however, can generate hegemonic discourses in health care by disregarding questions regarding the strictly biological framework. This disregard permeates the approach to the health-disease process and remains visible in the "concept of health as providing highly technical services, with users taken by their biological standards, as the health-disease process is constituted by natural history", as described by CECCIM *et al.* (2008/2009, p. 447-448). Here, the hospital occupies the top of the qualitative hierarchy of work in health care. According to the authors, this concept is a product of training and is based on corporate and private interests.

However, from this formal point of view, the relationship between health services and users involves many other aspects besides the physical encounter between the doctor and the patient:

Among other factors, there are health policies in every locale and individual conceptions of what it means to be sick. Sickness is an experience that is not limited to purely biological alterations but also serves as the substrate for a cultural construction, which is a concurrent process. Not to say that there is a sequence of "biology first and culture later", but there are cultural perceptions about this phenomenon that encompass biology and surpass it. That is, a particular bacterial pneumonia can be caused by the same infectious agent worldwide, with equivalent physiopathological alterations in various individuals. However, the form of treatment, the available health system and, above all, the perception that the affected individual has about the illness will vary enormously (OLIVEIRA, 2002, p. 64-65).

As noted by Kucinski (2000), journalists must be aware of other forms of health practices that are not directed by the biomedical hegemony and seek to examine these medical practices and the health-disease process from a critical, holistic perspective. Communication has the power to interrupt the pattern that has been created within health care in recent centuries.

Akerman *et al.* (2012, p.175) emphasise that there are sources of information about health, illness, life and death that are historically and socially constructed, such as oriental medicine,

popular knowledge about health and various other types of knowledge that different social segments accumulate during their existence. The health and illness process and the modes of organising care are not only simply linear; rather, they arise from conflicting world projects. The visibility of these projects is part of the conflict:

Public policies are decided in the struggle for hegemony, in which symbolic power is a central element. As noted by Bourdier (1989), the 'power to make someone see and believe' uses communication as an important vector. Essentially, when, due to certain variables, an individual or a group succeeds in making its point of view more widely accepted as the truth about an aspect of reality than others, they will increase their chances of directing public investment in the sector. They increase their influence over public policy. The communication devices employed in this conflict, of any order of size or visibility, are an active component of the process and may neutralise other components, such as economic capital (ARAÚJO *et al.*, 2007, p.23).

Comprehensive health care involves more than access to bio-scientific technologies. The guarantee of access is not equal for all sectors of the population due to other factors that increase the chances of timely intervention, including political and scientific approaches and different therapeutic practices. These factors can facilitate listening to, caring for and treating people and groups and can make it possible to overcome sector crises. Thus, these factors generate a social source of intellectual thought in this field (CECCIM *et al.*, 2008/2009, p.447).

Regarding the capacity to analyse these factors in a broader manner that is less subject to "scientific sense" (versus intellectual thought, which facilitates a more dense reading of daily life), public health has produced concepts that are considering. To guarantee better coverage of pertinent themes, the National Health System (Sistema Único de Saúde – SUS) developed the concept of 'quadrilateral training' as a way of uniting teaching, care, management and social control in health, beginning with education: "This concept is the result of a process of reflection and the development of innovations for a permanent national education policy, i.e., the management of comprehensive training for the daily tasks of the National Health System" (CECCIM *et al.*, 2008/2009, p. 449). The term "quadrilateral" is a central concept in the health education policy for the SUS and gives visibility to the process that through which care or management is constructed instead of presenting a fixed image. This concept contributes to the debate on how a new logic of health communication can be developed.

The reach of public health

The goal of developing a larger spectrum of activity by different professionals, all intended to promote health, is one of the themes of public health. Public health is defined as the core of knowledge and social practices whose objective is to fulfil the set of social health needs that "support the practices of distinct categories and social actors in relation to issues of health/disease and the care organisation" (DONNANGELO, 1983 cited AKERMAN *et al.*, 2012, p.171). Intellectual production in health policy that is intended to promote health is one of the strategies that is currently utilised to displace biomedical logic from its hegemonic position in modernity.

Nunes (2006) compared the public health field to a mosaic – "a set of separate parts that come together when the understanding of problems or the proposition of practices is situated

beyond the limits of each 'disciplinary field' and requires interdisciplinary arrangements" – i.e., a field of knowledge rooted in the practices of daily life.

Due to the range of activities involved, public health programmes are reflected in the social health practices of people and social groups, including users, health systems and health service programmes – hence the importance of contributions from various disciplines to the health field (AKERMAN *et al.*, 2012, p.173).

In the health field, these contributions include integrated, multi-professional and interdisciplinary development and the capacity to establish broad channels of communication between professionals and users to guarantee greater participation. Ceccim (2005) argues that the organisational framework for work processes must follow a different logic than that used in businesses in general and is inherent in various contemporary work processes that are related to health. To avoid deemphasising the unique complexity of this work, professionals and users should be understood as *organised collectives*:

The notion of a collective accounts for the willingness of a group of interconnected people to complete a task with a productive purpose. The notion of an organised collective implies the convergence of this group of people, a wheel-like composition, as in the previously mentioned mandala. When we refer to a collective organisation, we are not referring to workers individually or to society or workers but to the groups articulated for a specific purpose. An organised collective, therefore, is not necessarily configured as a unit. It is not a body but a device. It is not proposed as an esprit de corps, as the spirit of a body or as patronage but as the production of an encounter, the exchange of provocations, of alterity. The collectively organised device is not an identity share among its members but its productive goal (CECCIM, 2005, p. 170).

That is, the hierarchical and naturalised logic that often underlies communication strategies helps to strengthen the existing image more than it does to empower new arrangements. Merhy (2007) speaks of the effective commitment that health workers should make to the needs of users, which requires the exhaustive use of health technologies in a new mode of managing health care. "This shows how these pass from the production of new work collectives that are politically and ethically committed to the radical defence of individual and collective life" (CHAGAS *et al.*, 2009, p. 192).

The communicator should consider the importance of different working professionals and of different modes of organising this work, as well as whether they strengthen the SUS or other technologically oriented care arrangements. The communicator should seek to integrate the health processes such that this field needs to recognise the communicator as a professional who can become a part of the interdisciplinary group, especially in health management, to provide skilled support in addressing the communication needs in the field. More than corporate demand, we stress the understanding that the core of professional communication capacities helps to broaden the capacity to produce communications better suited to strengthening the SUS.

As noted by Araújo *et al.* (2007), in the health field, communication is intended to improve all dimensions of the public health system and the effective participation of people in these improvement efforts. "The objective must be, at least, to establish public debate about the subjects of interest and to guarantee sufficient information to the people to broaden citizen participation in health policy" (ARAÚJO *et al.*, 2007, p. 61).

In the health field, communication is not dissociated from the notion of rights. It is directed to the 'citizens', intended to improve all dimensions of the public health system and the effective participation of people in the generation of this possibility. Consequently, [communication] cannot be limited to persuasion as a strategy or function only with the aim of divulging information: the objective must be, at least, to establish public debate about other subjects of interest and guarantee sufficient information to the people to expand citizen participation in health policy (ARAÚJO *et al.*, 2007 p.61).

It is insufficient for the communicator to only transmit information or organise events or campaigns in the health care arena without engaging with the needs in this area that act on traditional communication processes. An example is the subjects cited by Akerman *et al.* (2012, p. 172) that address social needs, including the environment, working conditions and cultural habits, that affect a person's way of life and the structure and delivery of health services. These are not objects of direct intervention for the communication professional as the manager or as the service provider, but they are routinely on the agenda in the media or are part of the dissemination and advisory capacity of those involved in institutional communication. Communication has an educational potential that must consider work dynamics:

The work of health teams and organisations must contribute to broadening the autonomy and the capacity for intervention of the users of health programmes and services in their own lives, supporting the people so that they can broaden their capacity to think in social and cultural contexts. This work cannot be taken only as an efficient search for diagnostic evidence, care, treatment, prognoses, etiologies and prophylaxes for diseases and disorders. It must also seek to develop conditions of care for the health needs of people and populations, to develop sector management and to generate social control in health. The conceptual and practical construction of teamwork stems from efforts to change vertically hierarchical technical work to work that involves social interaction among the workers, with the potential for autonomy and creativity in collective efforts (CECCIM, 2005, p. 168-169).

More active communication

In health, communication is not limited to disseminating values, enhancing a brand or reporting particular facts. It constitutes the "right of all citizens to know the phenomena of living, becoming sick, caring for oneself and dying. This knowledge is indispensable to greater autonomy to produce/direct your own health" (AKERMAN *et al.*, 2012, p. 175).

Considering that the majority of health practices include a strong communication component, these professionals, whether they are involved in basic or specialised care or in prevention or the promotion of health, are directly involved in this field and develop communication strategies, even if this does not occur in a planned and 'authorised' manner. Thus, this multifaceted communication with many subjects and environments cannot be seen as exclusively composed of communicators, although their commitment and specialised knowledge are necessary. This allows us to understand communication as a space for the social construction of meaning, which involves the production, circulation and appropriation of symbolic goods (ARAÚJO *et al.*, 2007, p.73).

Another concern is the effort to decentralise communication to broaden the participation of the actors involved. To accomplish this goal, it is necessary to adjust embedded management practices that consolidate and concentrate power and legitimise certain voices at the expense

of others. "Concentrating communication means concentrating power. Centripetal forces organise around the struggle for the democratisation of communication. Within the practical communication environment of health, however, the debate is scarce and thin" (ARAÚJO *et al.*, 2007, p. 77).

In the same manner as social networks develop, official communication apparatuses must create conditions in which other voices are heard and valued as legitimate discourse. Such efforts emphasise concepts such as equity (giving greater opportunities or support to those who are at a disadvantage to help eliminate differences) and universality (access for all). When they are targeted toward various discursive communities, such efforts may be adequate at the appropriate level. As indicated by Araújo *et al.* (2007, p.82), "the redistribution of these capacities does not mean equal power but rather creates conditions in which social polyphony can be heard and considered", and this process may appropriate and take control of means of production, circulation channels, the content in circulation, information and processes.

Communication has an important role to fulfil here and in mediated processes, as it is able to facilitate or hinder participation. It will hinder the process if the only practice conceived for the production and circulation of materials serves to disseminate the voice of health professionals and to teach the population health promoting habits and behaviours, without considering their knowledge or offering them dialogue, presenting health problems as consequences of individual behaviour, concealing their social, economic and political determinants (...) It will facilitate the process if the principal strategy is to develop spaces, processes and practices that increase the inclusion of peripheral voices, whether they are from discursive communities, health workers or the population, allowing them to spread their interests and points of view. In a complementary manner, if knowledge about their rights and other information that facilitates their relationship to health services and institutions is offered to this population, it will encourage them to take ownership and facilitate new initiatives. (ARAÚJO *et al.*, 2007, p. 84-85).

The responsibilities of communicators in the health care industry – whether in the media or in advising – involve more than mediating the transfer of information within the population. The communicator is also a critical agent of and participant in public health policy, as is expected of all citizens. A greater role is expected of this group due to the social nature of the action of the communicators.

Operating in a network

Health communication assists in the prevention of diseases and the promotion of health by stimulating changes in the behaviour of individuals, facilitating the transfer of information and utilising the cultural resources of society. The use of strategies to capture the attention of individuals within a group based on their knowledge of reality, their daily lives, and their needs, behaviour, social interactions and expectations is a method of promoting health that is more integrated with the needs and capabilities of specific groups.

The challenge of establishing a closer link between health processes and communication strategies has guided the integrated consulting activities of the Brazilian Association of the United Network (Associação Brasileira da Rede Unida), the Collaborative Government Health Network (Rede Governo Colaborativo em Saúde), and the Observatory of Information Technology and Communication in Health Systems and Services (Observatório de Tecnologias

de Informação e Comunicação em Sistemas e Serviço em Saúde – OTICS). The purpose of these entities is to act collaboratively to improve the processes associated with management, education and care in the field of public health. Thus, the communication campaigns undertaken by this advisory service are also founded on a different logic. Such communication is intended not only to create a channel for institutional disclosure but also to promote concepts that are important to the public health field while seeking to utilise the strategies developed by health workers to improve the quality of the processes that affect the health of the population. Toward this end, this partnership has sought to develop communication initiatives that strengthen institutional partnerships with government agencies, universities and the entities representing workers, researchers, students and users.

In the activities of the advisory group of the United Network/Collaborative Government Health Network/OTICS, integrated action is intended to lend visibility to the projects and initiatives developed by these entities. The objective of such action has also been to emphasise these strategic partnerships intended to improve the SUS, reinforcing the essential concepts of public health in a collaborative manner to educate residents constantly about the promotion of health care.

Among these initiatives is the support for the VER-SUS, Experience and Training on the Reality of the Health System (Vivência e Estágio na Realidade do Sistema Único de Saúde), which helps university students to become familiar with the everyday public health services. The advisory service has coordinated the dissemination of these initiatives, seeking to enhance the experiences of and to allow a greater role for students.

Another highlight is the Collaborative Health Networks Journal (Revista Redes Colaborativas em Saúde), which is used to publicise the different segments of the Collaborative Government Health Network (Rede Governo Colaborativo em Saúde). The publication seeks to promote the best practices for the SUS, partner programmes and the scientific discoveries of the researchers in the network. The journal is published biannually in print and on the internet.

Another resource that uses communication practices to benefit public health is the United Nations video channel on the internet. This space brings together information from investigators, managers, workers, professors and students working on health care. The archive is helping to preserve and disseminate thoughts and proposals from different sources on the subject of health, with a focus on the collective and on the requirements for quality public health.

These communication strategies are intended to facilitate the participation of different actors and processes and to broaden the space for communicating with different groups. More than promoting the institution, the challenge is to establish communication programmes that help to stimulate cultural change and consolidate the Single Health System, better empowering health programmes for users and workers and improving the quality of care, management, training and social participation.

Final considerations

The efforts to promote network initiatives to improve the Single Health System developed in the United Network and its partner entities reinforce the need for interdisciplinary work in the health field. Different professionals need to be involved in promoting quality of life, humanised

care, shared management and more active social participation. Communications professionals should not be restricted to the dissemination and organisation of institutional programmes restricted to entities for whom they perform services.

The involvement of communications professionals from planning to execution assists in the construction of more effective communication strategies. These efforts drive interdisciplinary work, stimulating network strength and supporting the SUS. For health professionals, this work can also be beneficial, allowing them to rely on more specialised support in planning, developing and executing communication strategies for different audiences. It is also important to communicate with managers so that they remain consistent with the approach being taken and so that they can embrace and incentivise integrated work in health and communication.

In health communication, working in a network to promote permanent education requires greater involvement with the subject matter in order to integrate management, assistance, participation and education. From planning through execution, the actions of communications professionals assist in the construction of more effective communication strategies. In addition, these efforts can make it possible to develop different networks using communication tools. For news coverage, this approach can guarantee a more consistent and broad vision with respect to the SUS and the promotion of health, enhancing initiatives that improve the quality of life of the population and reduce tension with the model that preaches the health-disease progression as the only form of health.

The more active participation of health communicators can aid in the improvement of communication processes in this field, fostering interdisciplinary work that strengthens networks that support the SUS and all of the actors involved. For health professionals, this approach can be beneficial because it allows them to count on more specialised support in planning, developing and executing communication strategies with different audiences.

Incentives for training and qualification courses in health communication, with an emphasis on the SUS, are vital to encouraging more professionals to act based on a more comprehensive logic. It is important to review these issues with managers so that they also remain in tune with this stance and accept and incentivise integrated work in the fields of health and communication.

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