DOI: 10.1590/1413-812320182310.21082018

Towards a reticular approach to health care

Sílvia Portugal [1]

Introduction

Discourses on health care are increasingly dominated by a managerial language, which emphasizes the organizational realms associated with the "health system". The impacts of neoliberal globalization are thus felt in different ways: in the retraction of public policies, in the expansion of the *homo economicus* ideal to all social and political spheres, in obscuring subjectivities, interactions and forms of resistance.

Thus, it becomes pertinent to find problematizing approaches that reveal the complex nature of stakeholders and flows that sustain health care. The paper by Breno Fontes underscores the relevance of the "network paradigm" to respond to this challenge. I would add the contribution of another approach - that of "care paradigm."

The "care paradigm" option implies recognizing that care is cross-cutting in the life and routine of all people, and not only the sick. Several challenges arise when we make this choice[1]: recognizing our vulnerability throughout the life cycle[2,3]; recognizing that the cared also take care[4]; paying attention to life details[5]; setting up a different language that transcends the traditional biomedicine and welfare models, which compartmentalize the needs and objectify the subjects.

The conjugation of this approach with a reticular perspective evidences several heuristic potentialities: it allows us to look simultaneously at the form and content of social relationships; it allows us to place the subject at center-stage, adopting integrality as a guiding principle[6]; it allows us to question concepts such as "governance", revealing the complex articulations between stakeholders, between public and private, and between State, market and civil society.

Three worlds or more?

The work by Esping-Andersen – *The Three Worlds of Welfare Capitalism* (1990)[7] – significantly marked the reflections on well-being production in the late twentieth century. Its central concept is that of "decommodification", that is, the system's ability to provide subjects with access to reasonable living conditions without having to sell their labor force in the market. The author classifies the industrialized countries in three models: the liberal/residual regime (which includes the United States, Canada and Australia), in which the degree of decommodification is scarce; the conservative-Catholic/corporatist regime (which includes Germany, Austria, Belgium, Italy, and France), which is characterized by a moderate level of decommodification; and the democratic/universalist social regime (which corresponds to the countries of Northern Europe, and Sweden in particular), in which the level of decommodification is high.

The criticisms of Esping-Andersen's trichotomy are numerous and diverse. We shall not proceed with its exhaustive examination here. However, one of the lines of discussion is relevant to this debate. The typology gives scant attention to the southern European countries, addressing them as "mixed". In opposition to this perspective, several authors have argued that certain characteristics of these countries allow us to identify a fourth type of regime - a "Southern Model" (which includes Portugal, Italy, Spain, and Greece). Ferrera[8] characterizes it through four fundamental features: 1) a highly fragmented and corporatist system, where generous protection for some sectors of the population coexists with total lack of it for others; 2) the establishment of a National Health System based on universalist principles; 3) low state penetration in social protection with a complex articulation between public and private actors and institutions; 4) the persistence of clientelism in access to social protection of the State.

Regarding the family, the Southern Model's exceptionality lies in the fact that maintaining traditional models seems to be more a matter of survival than of choice - in the lack of alternatives, the family is the resource that one can always rely on[9,10].

The work of Gough et al.[11] shows how European countries share many characteristics with the countries of the opposite hemisphere, extending the concept of the "South" used in Eurocentric analyses. The contribution of Barrientos[12] on Latin America analyzes the reforms carried out in several countries of the South American continent, identifying a transition from a "conservative-informal" regime to a "liberal-informal" regime. The author

[1] Centro de Estudos Sociais, Faculdade de Economia, Universidade de Coimbra. Coimbra Portugal. sp@fe.uc.pt

identifies articulations between State, market, and the family that are very similar to Southern European countries.

Networks and care

In general, in health, the prevailing trend in the definition of care builds around the opposition between formal and informal care[13]. A closer look relativizes this distinction. In daily life, the differentiation occurs through the type and intensity of care provided, which reveals different levels of involvement between formal and informal caregivers[1]. The studies are evident in this area: the more severe the dependency situation and the more demanding the needs, the higher the involvement of the family[13,14]. Specifically, in Southern countries, the more demanding the type of support, the fewer responses there are, and the higher the accountability of the informal sphere[15].

The work I have been conducting in the areas of illness and disability shows that when we look at people's life paths and analyze their social networks, the family emerges as the primary care provider: searching for information or diagnosis, designing therapeutic paths, providing daily, permanent and long-term care[1,16,17].

The formal provision of care often shows an intervention that reveals a weak capacity to integrate individual specificities, producing normalized and normalizing care that hardly meets the life circumstances of people with any diagnosis or illness. Family care tends to contradict this way of acting. The care provided by the family network stems from the needs of those who are cared for[15]. If biomedical care has difficulties in addressing specificities, singularity-based family care allows integrating difference and responding to it adequately[1].

Final Notes

As emphasized by Breno Fontes, a reticular approach to health care delivery highlights the relevance of a broad range of actors (patients, families, health professionals, social workers, associations, state, market, community), knowledges (lay and scientific), practices (formal and informal) and relationships (social, material and symbolic).

The "Southern Model" has several heuristic advantages: it allows us to complexify the approaches, covering a reticular field where actors and multiple flows circulate; it brings to the fore a model today subject to strong constraints, due to the demographic, economic and political pressures; by revealing the importance of kinship ties, it requires being concerned with those without a family. The crisis has brought to the forefront of political and social debate the issue of shared responsibilities between public and private solidarity and, as such, the (re-) discovery of the relevance of family as a sphere of social protection. The virtualities of family care cannot be an excuse for the retraction of the state provision, nor for a retreat of the subjects from the space of citizenship to the domestic space.

These points of reflection remind us of the importance of (re) thinking modern state political rationality, the construction of the individual, macropolitics, and micropolitics, the government of others and self-government – aren't these good reasons for abandoning the concept of *governance* and revive the concept of *governmentality*[18,19]?

Ciência & Saúde Coletiva, 23(10):3137-3139, 2018

References

1. Portugal S, Alves J. Doenças raras e cuidado: um olhar a partir das redes sociais. *Cescontexto Debates* 2015; 9:34-40.
2. Kittay E. *Love's Labor: essays on woman, equality, and dependency*. New York: Routledge; 1999.
3. Tronto J. *Moral Boundaries: A Political Argument for an Ethics of Care*. New York: Routledge; 1993.
4. Lovell AM. Aller vers ceux qu'on ne voit pas. Maladie mentale et care dans des circonstances extraordinaires. In: Lovell AM, Pandolfo S, Das V, Laugier S, éditeurs. *Face aux desastres*. Paris: Ithaque; 2013. p. 27-81.
5. Laugier S. Le sujet du care: vulnerabilité et expression ordinaire. In: Molinier P, Laugier S, Paperman P, éditeurs. *Qu'est-ce que le care?* Paris: Payot; 2009. p. 159-200.
6. Pinheiro R. Integralidade como princípio do direito à saúde. In: Pereira I, organizador. *Dicionário da educação profissional em saúde*. 2ª ed. Rio de Janeiro: EPSJV; 2008. p. 255-263.
7. Esping-Andersen G. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press; 1990.
8. Ferrera M. The Southern Model of Welfare in Social Europe. *Journal of European Social Policy* 1996; 6(1):17-37.
9. Andreotti A, Garcia SM, Gomez A, Hespanha P, Kazepov Y, Mingione E. Does a Southern European Model Exist? *Journal of European Area Studies* 2001; 9(1):43-62.
10. Portugal S. *Família e Redes Sociais. Ligações fortes na produção de bem-estar*. Coimbra: Almedina; 2014.
11. Gough I, Barrientos A, Davis PA, Room G, Wood G, Bevan P. *Insecurity and Welfare Regimes in Asia, Africa and Latin America. Social Policy in Development Contexts*. Cambridge: Cambridge University Press; 2004.
12. Barrientos A. Latin America: towards a liberal-informal welfare regime. In: Gough I, Barrientos A, Davis PA, Room G, Wood G, Bevan P. *Insecurity and Welfare Regimes in Asia, Africa and Latin America. Social Policy in Development Contexts*. Cambridge: Cambridge University Press; 2004. p. 121-168.
13. Triantafillou J, Naiditch M, Repkova K, Stiehr K, Carretero S, Emilsson T, Di Santo P, Bednarik R, Brichtova L, Ceruzzi F, Cordero L, Mastroyiannakis T, Ferrando M, Mingot K, Ritter J, Vlanton D. *Informal care in the long-term care system: European Overview Paper*. Athens, Vienna: Interlinks; 2010.
14. Glendinning C. *Care Provision within Families and its Socio-Economic Impact on Care Providers*. York: University of York; 2009. (Working Paper EU 2342).
15. Alves J. *Cuidar e ser cuidado. Uma análise do cuidado quotidiano, permanente e de longa duração* [tese]. Coimbra: Faculdade de Economia; 2016.
16. Barbosa R, Portugal S. O associativismo faz bem à saúde? O caso das doenças raras. *Cien Saude Colet* 2018; 23(2):417-430.
17. Portugal S, Nogueira C, Hespanha P. As teias que a doença tece: a análise das redes sociais no cuidado da doença mental. *Dados* 1993; 57(4):935-968.
18. Foucault M. *Segurança, Território, População*. São Paulo: Martins Fontes; 2008.
19. Foucault M. *Nascimento da biopolítica*. Lisboa: Ed. 70; 2010.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License