

Geography and health: the place as premise of the informational activity of Primary Care in the Brazilian Unified Health System

Geografia e saúde: o lugar como premissa da atividade informacional da Atenção Básica do Sistema Único de Saúde

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Abstract

The aim of this article is to warn the necessity of considering the place as an important variable of the information activity in the Brazilian Primary Care. Informational activity, as a standardized process, based on the State centralism and on a constrained view on health, undermines new opportunities to understand the places of the country in an emancipatory, autonomous way, in which voice is given to the upward forces that inhabit everyday life. Thus, we need to understand health's relationship with places, as well as their influence on all the processes of social life. A new informational activity must be able to capture local realities and their geographies, being, therefore, more likely to ensure health and life for everyone.

Keywords: Geography and Health; Health Information; Upward Information; Place and Autonomy.

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Resumo

O presente artigo visa chamar a atenção para a necessidade de se considerar o lugar como uma variável importante da atividade de informação em saúde na Atenção Básica do Brasil. Enquanto processo normatizado e fundamentado no centralismo do Estado e numa metodologia restrita de se enxergar a saúde, a atividade informacional, como é concebida hoje, acaba por minar novas possibilidades de compreender os lugares do país de uma maneira emancipatória, autônoma e que dê voz às forças ascendentes que habitam o cotidiano. Nesse sentido, alertamos para a necessidade de se compreender a saúde na sua relação com os lugares e da influência destes em todos os processos da vida social. Uma nova atividade informacional deve, entretanto, ser capaz de capturar as realidades locais e suas geografias, sendo assim mais susceptível de sucesso, no que diz respeito a garantir a saúde e a vida de todos.

Palavras-chave: Geografia e Saúde; Informação em Saúde; Informação Ascendente; Lugar e Autonomia.

Introduction

The aim of this article is to discuss the process of production, systematization, management, availability, and access to health information, what we will call “informational activities.” We led the discussion from a geographical point of view, considering the ideological content involved in these activities. Research grants that supported the discussion were held in the period of two years (2012-2013). We investigated aspects considered ideological frameworks of health information activity in Brazil, focusing on Primary Care, whose use of the Information System (SIAB) and the recent e-SUS indicate strong continuities of the hegemonic model of perceiving health. We started the research with the following points:

- The technical and methodological strategy of health information in Brazil has a set of value determinations that limits the broad understanding of health: the clinical paradigm (biomedical or flexnerian) (Foucault, 1998; Freidson, 2009; Illich, 1975);
- The restriction of the intellectual and methodological elaboration of the informational activity for the institutional means of the State, with special authority of federal instance through DATASUS and DAB, which reaches the places through rigidly standardized hierarchical happenings¹. Hence the mention of terms such as monarchist model (Branco, 2006), Panopticon (Balbim, 2003), or downward health information circle (Silva, 2010) for such activity;
- Information external to the biomedical model of thought appear only in a residual form, and yet within a software system that has as its premise the registration of patients, first in paper forms, and then electronically, the latter being one of the main causes of medical informatics;
- Although beneficial, the increasing informatization of more primary scales of the health

¹ “The hierarchical happening is one of the results of the tendency to rationalize the activities, it occurs under a command, an organization, which tend to be concentrated and force us to think about the production of a meaning, printed on the lives of men and on the life in space. [...] In this case we have the primacy of the standards, no longer with the relevance of the technique, but of politics” (Santos, 2012, p. 140-141).

care system in Brazil little changes the relationship between health professionals and the places where they work. This process maintains Primary Care as an “anteroom of the hospital” and the decentralization and expansion of informational activity as an operational mechanism;

- Such characteristics standardize health information activity in the country, keeping in the background the complex eccentricities of each place, and therefore the complex demands for health.

We glimpsed that this “operational” set creates a vacuum within the reinforcement process of primary health care, which was thought and designed having the Declaration of Alma-Ata as a mark:

[Primary care is] essential to the health care based on practical, scientifically sound and socially acceptable methods, and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (OMS, 1978).

Thus, we believe that conducting a further review in the current model of informational activities on primary care is necessary. The hierarchically organized form of this activity expropriates the populations from the possibility to understand health linked to a process of autonomy (Illich, 1975) “whose effectiveness depends on the **opportunities** offered by the places” (Santos, 2008, p. 337, emphasis added). This process of autonomy would be a constraining factor, perhaps impossible for the standard and rigid deter-

mination of what is normal and what is pathological (Canguilhem, 2009). In our view, such a review on the model established by the Brazilian Ministry of Health in its informational activity focused on primary care would go through two basic topics:

- To reinforce a theoretical counterproposal on health that is alternative to the currently hegemonic one, which would consider the broad idea of health and, more importantly, the autonomy of individuals and places;
- To find theoretical principles for the concepts of information contained in the idea that “it is the place that offers to the world’s movement the possibility of its more effective achievement” (Santos, 2008, p. 338) and that is the local order that “founds the scale of everyday life, and its parameters are copresence, neighborhood, intimacy, emotion, cooperation, and socialization based on contiguity” (Santos, 2008, p. 339).

We considered the fact that the political project of making an upward health information circle goes through the challenge of facing the future from a further critique that enables an alternative to the hierarchical and centralized power of the State. This concern regards geography by the premise that places, as spaces where the use of the territory is effected, must be defined from within, from the household and contiguous solidarity, i.e., from organic solidarity. (Cataia, 2010). The attempt to face future political and ideological challenges encompasses the need to take stock of the past and of the present (Mészáros, 2004). This is because we must learn from the past and avoid previous unsuccessful strategies. In addition, from the point of view advocated here, for every social movement, a new geographical order is settled, “either by creating new ways to meet new functions, either by the functional change of the existing forms” (Santos, 2012, p. 60). In other words, we cannot ignore the material elements, the territorial configuration, and the present, elements that can and should be used “as mediation links with the expected alternative order, qualitatively different” (Mészáros, 2004, p. 35).

Such mediation links make us believe that we should not wait for a radical inversion of values and material conditions of the clinic ideology in Brazil, but to assume that the Brazilian Unified Health System (SUS) has real possibilities of creating mechanisms that result in “fundamental changes required to transform potential into reality through the hard work of a radical restructuring in the existing order” (Mészáros, 2004, p. 35). And then

Not being important how small are the improvements designed for the future, if it is expected their sustainability, [...] they only become feasible if they are inserted in a broader setting of significant strategy change [...] and if they are not cancelled, as it usually happens. (Mészáros, 2004, p. 36) (Our translation).

We believe that the existing structure of public health offers possibilities to become real mediation links between a restricted health conception to another that centralizes the places as epicenter of all the public health activity in the country. And if the information anticipates political action, this variable becomes, therefore, essential for the transformation process of the reality we envisioned.

The information of Primary Care is downward information

The strategy e-SUS, institutionalized in 2013 by the Brazilian Ministry of Health as an alternative to the SIAB, is a process derived from the National Plan of Information and Health Informatics, which is originated from clinic intentionality, and, by the medical informatics, it encourages the technological development in the areas of individual electronic record, electronic medical record, and telehealth. In this regard, health information is confused with medical information, and Informatics is applied in a skewed way. When deploying such logic in primary health care, this level of care plays, inside the macrostructure of SUS, the role of a local for screening and referral to the levels of secondary and tertiary care (specialized clinical care). That is because the territory, which is an important element

of the primary care management in public health, is understood in reduced form: it becomes a collection of bodies, which should be monitored in a computerized and more agile way, to improve the decisions of health professionals and managers, which would improve reference and contrarreference systems, responsible for regulating the movement of SUS users in the different stages of health care. This logic is noted since SIAB and is maintained on e-SUS. Data collected are predominantly clinical, although there are, in residual form, information of socioeconomic and demographic nature.

In addition, if SIAB was a tool associated with the activity of the Family Health staff and community health workers, e-SUS expands and reaches other staffs and professionals authorized to work in primary care by Ordinance No. 2488, of 21 October 2011: nurses, doctors, dental surgeon, oral health technician, oral health assistant, nursing assistant, community health worker, all those professionals who make up the various family health staffs, but also the professionals who make up the Family Health Support Centers (NASF): acupuncturist, social worker; professional/physical education teacher, pharmacist, physical therapist, speech therapist, gynecologist/obstetrician, homeopathic physician, nutritionist, pediatrician, psychologist, psychiatrist, occupational therapist, geriatrician, internist (clinical medicine), occupational physician, veterinarian, professional with degree in art and education (art educator) and public health professional, i.e., professional with degree in health care and graduated in public or collective health or in another course related to one of these areas.

Thus, assuming that primary health care is provided with a wide range of professionals who are within the logic of the medical division of work – except for the art educator, community health worker, and public health professional – it is natural that the set of informational tools available within SIAB and e-SUS are directed to such professions. Such technical information system would be a reflection of the demands that the employees have in their daily lives. Both SIAB and e-SUS, through their software CDS and PEC, have the function of being useful to a professional group already established in SUS.

It is no coincidence that PEC, besides being a data collection instrument, has become a tool for scheduling and organizing appointments, for example.

To that extent, the transition of SIAB to the e-SUS generates a set of benefits for these professionals, since the computerization of the system accelerates and rationalize their working time, making better use of the workday to exercise their main functions.

Another beneficial effect of e-SUS is that, in its scenery of maximum informatization, when the professionals themselves transmit the information directly to DATASUS, simultaneously to the moment when they are harvested, the return of data to the local management is faster, which possibly means that, in theory, the local managers, whether in municipal secretary, health districts, or in basic units, will have greater flexibility to work with information and make decisions.

It seems clear, therefore, that the technosphere², basis for the information activity in Primary Care, is associated with a specific psychosphere, whose characteristics are: restricted conception of health and illness; neutral position of science, as it creates a linear idea that more informatics is more information, and, therefore, more health; as DATASUS and the Department of Primary Care maintain their regulatory positions in design methodology and in data control, a rigid separation between the State and the places is created: the technical information system of Primary Care of SUS is internal to the functional structure of the health sector of the Brazilian State, being, therefore, their technicians' work. At the other end, the places are perceived as "data warehouses", intelligible to the informational system deployed by SUS.

The first characteristic listed is a clear consequence of the ideological competition that exists about the concept of health and, therefore, of poli-

tical actions internal to SUS. It is our responsibility to reinforce that regardless of the fact that e-SUS has expanded its informational range for a set of information of social, demographic, geographic, or economic source, it does not radically expands the practical alternatives for carrying out subversive health actions to the ideologically hegemonic model.

The second and third characteristics substantiate the informational activity organized under the form of downward information circles, which are related, according to Fonseca (2011), to the fulfillment of the territory with information technologies that allow the arrival of these informational circles in places, or, according to Alves (2010), are based on standards external to subspaces. In this regard, information is assumed as a purely technical activity, work field with challenges, to be worked out by experts, who must "find the most effective encoding (speed and cost) to convey a telegraphic message from a transmitter to a recipient" (Mattelart, 2005, p. 6). In this case, the places are the transmitters, and the recipients are the public managers. Technical and methodological means by which the information goes from one point to another (the informational system itself) is basically controlled and built by the specialized professional center that lies under ministerial scope: DATASUS and DAB.

This is a fundamental condition for the maintenance of the downward structure of this information circle, to the extent that the way which it was built restricts the use of the information to a very select group of people. Although the Constitution of 1988 and, later, the Law No. 12,527/2011, anticipate the access to information produced by the State for the Brazilian people, this access is only partial, since it is hampered by the highly specialized scientific language of information and by its instrumental tools (the computer and the internet) not yet widespread in the country. In this sense, the Brazilian

2 Technosphere and Psychosphere form the "pillars with which the technical-scientific field introduces the rationality in the content of the territory" (Santos, 2009, p. 51). Important to remember that "psychosphere is strongly dominated by the speech of objects, of relationships that move it and the reasons that preside them" (Santos, 2009, p. 50), psychosphere also belongs to the geographical environment, providing objective rules of rationality or imaginary, but it is, often, the product of a society wider than the place. Kahil (1997) shows us that, in the modern world, the complementarity, competition, and antagonism that exist regarding diversity of signs, meanings, and meanings that the Technosphere produces, it is inevitable to understand the phenomena by observing the Psychosphere – complement of Technosphere, which represents the way of life. Psychosphere is the materialization of the values of a new social identity.

Ministry of Health produces a stock of information that is manipulated by a few (Santos, 2007), which increases the difficulties for the formation of a full citizenship for all.

The downward information is therefore invasive to places. Even if the agent responsible for this activity is the State, and more precisely a section of it that is directly linked to a traditional welfare care such as health, downward information becomes invasive by favoring a methodological and instrumental hardening and discharge the places - in all the singularity that this concept represents - of the completeness of the information production process.

It is important to remember that health information belongs to public policies which, as we know, originate from Anglo-Saxon countries and would be an alternative to traditional planning. These policies have a partial view of the problems, these actions bring flexibility, however fall short when it comes to global vision. In general, they result in partial and limited approaches, in fact, they are based on the territorial anti-planning. But this is subject for another study, which is in stage of completion.

Returning to our discussion, we could even assume that, unlike the downward information circles of private corporations, which are subject to more explicit expropriation interests, the informational activity of SUS would have "good intentions." But this downward structure seems to restrict its use, through a technical and intellectual framework, which strengthens political action only to those who have a "superior intellectual apparatus", which would invoke a "principle of consciousness that comes from 'outside', [...] [for] when the intellectuals find their 'spiritual homeland', so through them the masses will find it too" (Mészáros, 2002, p. 480).

When observing all the work stages of the health staffs of Primary Care, more precisely in terms of informational activity (Curioso, 2011), it was clear that, throughout the different steps, there is a moment governed by homologous and complementary happenings, under strong influence of everyday life, and another moment governed by hierarchical happenings, whose imposition of standards of DATASUS is the greatest influence. These happenings metamorphose as the movement of information

occurs: starting by the intellectual concept of information systems within the restricted framework of specialized technicians and analysts, since the information survey, done by the community health worker on each home, passing by the consolidation of individualized information, made by various professionals in Primary Care, and finally, for the transmission of data for the Brazilian Ministry of Health. These characteristics are visible both in the SIAB phase and in the current institution of e-SUS.

The thought developed here admits that the territory, the region, and the place are material, human, and historical totalities. Material-human entities and history are realities in constant transformation; in a constant process of totalization. Totalization is the movement by which a totality is constituted as synthetic unit. The energy of this movement is the society in its complexity. To analyze the place from this complexity is, to some extent, to counteract the sectoral vision, which is still an outstanding characteristic of public policies.

The place taken in an atomized way and considered out of totality is an abstraction. Objects (equipment, clinics, hospitals) and places only make sense if understood in a system of mutual belonging. This is the system in which the places find their *raison d'être*. This reason has its meaning in society's general movement and close private combinations, leading to territorial differentiations and conferring specificity and particularity to places through solidarity happening. It is in the scale of the place and in everyday life that we verify the simultaneous existence of the time in the world, of the nation, and of the place. We should talk, therefore, about solidarity, not that of moral nature, but rather the "compulsory realization of common tasks, even if the project is not common" (Santos, 2008, p. 166). In this sense, there are several ways in which these solidarities occur, which we call happenings (Santos, 2008). These are in the dimension of the events and, consequently, of the action systems. Solidarity happening occurs in three different forms: counterpart happening, complementary happening, and hierarchical happening. These basic forms of action correlate one place to another, giving to the totality

its dynamic aspect, and to the places the dimension of the world.

The hierarchical happening “is the result of orders and information from one place that occurs in another, such as work” (Santos, 2008, p. 166). This happening, as already noted, tends to the centralization, it is the result of rationalization as a single element to be considered, which eliminates any attempt of introducing uncertainty, singularity, circumstances, and contingencies on the reflection, eliminating thus the possibility of a situational analysis (Silveira, 1999; Matus, 2005). Within the hierarchical happening, the one of orders and inside information, the horizontal lines are removed, life happens in the realm and primacy of standards and politics, in the realm of vertical relations.

The hierarchical happening responds to structural dimensions that make up the territory, which are driven by the State, by international bodies, and by the global market. The pragmatic and technocratic thinking, produced distantly from the places, require sociotechnical organizations through which the guidelines and commands produced worldwide reach the places. The role of technical and informational density, which we will define later in our text, is essential to understand the extent to which a place is coupled to this structure aforementioned. In this regard, we acknowledge that the instrumental action, the main direction of the action that feeds the administrative paradigm (Ribeiro, 2013), demands a density of both informational and technical objects - the main material condition that transforms the hierarchical happening - from the places.

The counterpart and complement happenings are in the dimension of the situation. The former concerns the functional contiguities, it is the resultant created by modernization through specialized information, but that “is marked by a routine shared through rules that are locally made or reformulated” (Santos, 2008, p. 167), here the information tends to be horizontal. The complement happening refers to the exchange of nearby places, for example, among towns of a metropolitan region. Both indicate the directions of the action oriented in regional or local scale, and although there is the constitution of instrumental action as guidance plan for the for-

mulation of public policies and action of companies, which are inserted in a geographical situation to fight over direction along with the actions coming from “under”, with a strong role of everyday life and the world of the individual in its body scale, creating new forms of action and use of the territory through their short-term needs. The communicational density is the condition of existence of counterpart and complementary happenings, as it indicates the production of social life of others to the technical rationality of the present times.

The non-observance of this whole process brings, as a consequence, the fact that the details of daily life and of the place, which are almost entirely seized by the community health worker, are not seized properly by the current informational activity, and are gradually being lost. The rich details of space start making room for the statistical generalization and for the restriction to biomedical science. As details get lost, breadth and reach are found. This model of information flow, which resembles the panoptic architecture discussed by Balbim (2003), has as its final recipient the Brazilian Ministry of Health, which, although it is not in its power the ability to capture everyday life and the primacy of the forms of the place, it ensures the possession of statistic data from all users of the basic system, of SUS, throughout the national territory.

Santos (2008) perceives the place as the space of solidarity happening or as the spatial dimension of everyday life. This dimension of daily life would be basically given by the existence of a counterpart happening, which works according to the internal logic of a place, and a complementary one, based on the relation of mutualism and reciprocity among different but contiguous places. In common is the fact that they both relate in a territory which, according to Santos (2008, p. 167) “is marked by a routine shared through rules that are locally made or reformulated. In this case, the information used tends to be generalized horizontally.”

We do not want to annul the benefits that the informational activity of Primary Care brought, to the extent that it has become more decentralized and modernized through the transition from SIAB to SUS. The improvement of informational activity

in the models listed throughout this article is beneficial as it promises to improve the work routine of several professionals, as well as to organize the reference and contrarreference systems, bringing potentially a great economy to the public health budget. In addition, the flexibility of the e-SUS strategy on softwares used allows municipalities to create their own informational solutions, so that the methodologies and informational activity of Primary Care are made in a more decentralized way and with a little creative room for manoeuvre so local technicians and managers can, somehow, represent the singularities of where they live within this informational routine. We must stress that these positive characteristics of informatization and information policies of Primary Care of SUS have as a substrate the importance that the Family Health Strategy gained in SUS, precisely because of the explicit concern with the construction of a health policy that, if not necessarily part of the places (bottom-up), considers them as particularities that must be observed. The territorial policy of the Primary Care of SUS remains as a *sine qua non* so the proposal of this article to construct information and communication policies more diverse can fully occur.

However, such softwares cannot escape the instrumental determinations for e-SUS, defined by DATASUS and DAB on a national scale. Statistics and quantification would still be the only possible parameters, and such a creative maneuver could only occur within them. We believe that the operational decentralization of informational activity maintains the preexisting logic of SIAB, of being “tax primer from the Brazilian Ministry of Health to municipal managers [which] is characterized as a regulatory instrument that provides a reverse bottom-up planning” (Aranha, 2010, p. 96). It is no coincidence that Dantas and Aranha (2009) understand that decentralization, as a synonym for municipalization, is a misconception³.

Hence the need to rethink the informational activity of Primary Care by adopting assumptions

that escape the regulatory force of the hegemonic rationality on health, both from the epistemological (centered on the clinic) and administrative (centered on the formulation of centralized policies) point of view. We need a new understanding about health, information, and place, finding theoretical, political, and technical elements involving these three concepts. From now on, we will outline the theoretical elements that helps the understanding about health, place, and information, and that aims to engender an upward proposal of the information circle of Primary Care. We will catch a glimpse of health in its broad concept just based on this precept, with its association with the idea of autonomy, and that the place in all its richness may be, finally, the diffuser locus of new emancipatory rationalities.

Health, autonomy, and self-determination of places

Disease consists of “a reduction of the margin of tolerance for the infidelities of the environment” (Canguilhem, 2009, p. 78). And, according to this author, man feels in good health only when he feels more than normal, that is, “adapted to the environment and its demands, but normative, capable of following new norms of life” (Canguilhem, 2009, p. 79). The proposal of this author allows a further discussion about health and its implications for the political action.

The source of his concern in conceptualizing health is in his dissatisfaction with the clinical design, whose models of what is physiological and pathological are universal, standardizing all manifestation of changes in the body within the theoretical scheme assumed by this branch of knowledge. These theoretical standardized schemes are not enough, since the line between the state of health and illness of the body varies and the person who suffers is the only one able to set his own limits and possibilities (Canguilhem, 2009).

The relationship between health and disease is not limited, nor should it have as a starting point the biological life, but rather the social life:

³ This discussion goes through the issues of regionalization, federation, borders, and the understanding of what really is a municipality in Brazil.

Ultimately, we can live with many malformations or disorders, but there is nothing we can do in our lives, so limited, or rather, we can always do something, and it is in this sense that any state of organism, if it is an adaptation to circumstances imposed, ends up being basically normal, as long as it is compatible with life. (Canguilhem, 2009, p. 79) (Our translation).

We must look beyond the body, considering that men assess it “only as a means of all possible means of action” (Canguilhem, 2009, p. 79). Health is ultimately “a feeling of security in life, feeling that, by itself, does not impose any limit” (Canguilhem, 2009, p. 79). With this conception about health, new adaptation would be given to the most central disciplines of the flexnerian paradigm, such as the physiology. This would become a “science of stabilized rhythms of life,” and such an object would be more associated with social habits than with the individuals’ nature: the mutability of the models and theories of biological knowledge about human body would be a fundamental premise, considering that for a set of habits, the criteria to determine the limits of the body change (Canguilhem, 2009).

The definition of disease in Canguilhem is very similar to the concept of social iatrogenesis proposed by Illich (1975, p. 31), who assumes that this “is a painful disharmony between the individual situated within his group and the social and physical environment, which tends to organize itself without him and against him. This results in a loss of autonomy of action and over the control of the environment”. Iatrogenesis is a concept commonly used to designate the unwanted side effects that the medical action causes in the body of the individuals. This author assumes that such a phenomenon does not occur only in the biological dimension of the human body, but achieves even more damaging scales when is perpetuated by the social environment.

For him, “the institutional control of the population by the medical system gradually withdraws from the citizen the domain of the salubrity in work and leisure, food and rest, politics and environment” (Illich, 1975, p. 32). The author still assumes that

the greatest evil caused by the expansion of the medical division of work is because it produces dependence, which

tends to impoverish social and physical environments in his healthy and dressing aspects, though not doctors, decreasing the organic and psychological possibilities of struggle and adaptation that common people have. (Illich, 1975, p. 37-38) (Our translation).

The definition of Canguilhem mentioned earlier, as well as Illich’s notes about social iatrogenesis, includes an important question. What does make the environment unfaithful and how to make it more faithful to mankind? These are fundamental questions. The questioning about health points to a direction in which the biological dimension of the body is just one of the consequences of such faithfulness. To face this issue, two ideas must be considered: the concept of **Salubrity** discussed by M. Foucault (1984) in his text “The Birth of Social Medicine,” in which the tonic is attached to the state of things, constitutive elements of the environment, and of the material base of social life; and the concept of **Spatial Dimension of Everyday Life** of M. Santos (2008, p. 321), here the materialities assume, at the same time, a condition for action, a control structure, a limit to the action, and an invite to action. In addition, this dimension would be the materialistic connection among men, forcing the locality to emerge and be opposed to global and the vertical extensions. In this dimension, the temporalities are superimposed dialectically, in which the cooperation is installed and the contiguity is creator of the communion, in it “politics is territorialized, with confront between organization and spontaneity” (Santos, 2008, p. 322), in this dimension the homologous and complementary happenings overlaps the hierarchical happenings, in it the creativity and spontaneity are installed and the environment becomes more “faithful”.

Even though Illich credits man’s loss of autonomy in the place in which he lives to social iatrogenesis, we cannot presuppose the existence of an autonomy of places in pure form. Otherwise,

we would be turning our backs to the dialectical tradition of understanding reality as an ongoing renewal of the relationship among the singular (the places), the private (regions or nation state), and universal (the world) (Santos, 2008). To confuse the autonomous with the isolated individuality, a analytical penumbra of reality is created, which omits, from the point of view of the individual, the global processes that composes and often determines it. (Mészáros, 2009). Today the places are increasingly “condition and support of global relations, which without them (places), would not happen” (Santos, 2012, p. 156). Thus, the places cannot be contained in themselves. “Today, certainly more important than the conscience of the place is the conscience of the world, obtained through the place” (Santos, 2012, p. 161).

Hierarchical happenings, besides making up the place, are responsible for the government of local order, through a “distant regulation, whose objectives are sectorial, private, exclusive of only one intention. Such excentric, challenging, and destructing rules, superimpose the standards locally established” (Santos, 2012, p. 162). Rather they are private intentionalities or those provided by the State, when they are external to the local order, they possess the same characteristics and cause disorder.

Autonomy here, therefore, is not the search for isolation, but for the rescue of locally established standards, of organic solidarity, governed by homologous and complementary happenings (Santos, 2008), which will only be modified when the world contained in each of those spaces is observed.

To know the world to get to know ourselves belongs to a movement of conscience, which could only be “generated from within the base of the mass society [...], by the masses, in response to the tasks and challenges they have to face in their attempts to solve material, political, and cultural problems of their everyday life” (Mészáros, 2002, p. 482). It is in this sense that, in the project to construct the autonomy of the places, the active participation of the common man is crucial.

Thus, a theoretical horizon on health based on a project in which each place seeks its own social

organization is constructed. To bring the decision-making power into every portion of the Brazilian space means, in other words, to make the environment more “faithful” to men. Obviously, making places totally “faithful” to each individual is not possible, since every human being is just one of several agents that make up the social fabric of the territory. As the place is the spatial dimension of everyday life, it reveals itself as locus “where antagonist social forces are detached, as well as struggles, and regulation of conflicts” (Tedesco, 2003, p. 147).

We believe that the starting point for social manifestation of this alternative way of thinking about health occurs through informational activity, since we are in a period of history when this variable is one of the major forces that make up the operating system of the territory - on the side of workers, resources, and capital (Brunet and Dollfus, apud Castillo, 1999). In addition, considering that “each hegemonic action is accomplished today based on precise information - which allows the ideal choice in time and space and promotes territorial arrangements best suited to particular purposes” (Castillo, 1999, p. 37), we cannot dispense this activity if we want to strengthen or even hegemonize the emancipatory action that will redefine the health of the places.

The places and the upward forces

With globalization, the places, and particularly the big cities, gain a new existential dimension. Today the city “brings together people from different backgrounds, from different levels of instruction, of wealth, of understanding” and, accordingly, it keeps “a great richness of perspectives” (Santos, 2007, p. 60). Thus, it holds within itself a diversity of concerns that lie basically the existing biunivocal relationship between the world and the places, in a way that the former seeks to influence the places, but they “also have their weight in relation to the universe” (Santos, 2008, p. 25).

We see the advance of technological modernization, which contributes for global variables to have “a general idea about all or most of the territory and

to affect all the inhabitants” (Santos, 2008, p. 95), explained basically by the dissemination of information and new forms of consumption. Information establishes in places “the world of fluidity, velocity, the frequency of displacements, and the banality of the movement and allusions to places and things far away” (Santos, 2008, p. 314-315). Big cities, the main recipients of this technological modernization, also receive this way of seeing the world. But the coexistence in the city reveals a contingency of proximity, because in all its technical, scientific, informational, and communicational density it reveals an everyday anarchy and, consequently, intensifies the interpersonal relationships.

We can affirm that even though the contemporary world is marked by instrumental overlapping of the global reason on the many local reasons (Silva, 2002), the latter does not wane. Local orders have political, cultural, social, and economic agendas that, rather than persist until their perishing, react, absorbing global variables and metamorphose themselves, taking advantage of opportunities of our times to exist. These local forces are generated by the inevitability of copresence, neighborhood, and by the exchange that we call upward forces, which also shape the space according to their own productive, cultural, and social wishes, more or less oblivious to world events that are internalized in the places.

The place consists of a technical density, i.e., of the material composition of technical objects from different origins in contiguity, which results in informational density, as the information, when activated by human action, is unequivocal, “it is an information obedient to the rules of the actor, and introduces, in the space, a vertical intervention, which usually ignores the surroundings, put at the service of those who command” (Santos, 2012, p. 160). Its social energy is the production of **knowledge** through technical instrumentality, and we agree with the idea that the existence of certain objects “increases the degree of rationality of the environment from which they belong, and ultimately limits the scope of the actions of actors who use them, according to a set of predetermined procedures” (Contel, 2006, p. 276). This is the main

revealing characteristic of a downward force, creator of its own informational circle and, therefore, is external to the place. It is the health information currently implemented. But the upward forces found in everyday life also reveal another component of the places, the communicational density, which is a result of the state of copresence of the places. Communicational density brings people together, in immediate contact, generator of face-to-face situations. The communication is generated in the place, and therefore, is a result of the social environment (Santos, 2012). Thus, it is an essential component for upward information circles.

The energy that metabolizes the communicational density of the places is **intelligence**, “inseparable from the affective life, i.e., of feelings and emotions, needs and desires, fears, hopes, or expectations from the subject” (Görz, 2005, p. 85). While the knowledge (informational density) implies a subject-object relationship between the individual and what is known, intelligence (communicational density), however, implies a subject-object-subject relationship. It is, therefore, inseparable from the concept of knowledge, since it is the knowledge of the world through intuitive and cognitive experience, in its sensitive reality. Through it “communicative relations are built, not subjected to a command” (Görz, 2005, p. 12).

We cannot imagine that a relationship between communicational and informational density does not exist. We believe that between knowledge and learning there is no dissociation, but rather hybridity, which will reveal several forms of information circles, upward as knowledge is only a complementary tool to local learning, or downward when the local learning is forgotten by the instrumental rationality to place for intentions. It is in this sense of inseparability between the upward and downward information that Fonseca (2011) points the interaction and conflict between the agents of these circuits, revealing new content. As the widely disseminated technical objects, such as the computer, strengthen the informational density, such “flexible techniques, of easy deployment in the territory (and therefore so broadcasted), reach the opaque spaces where they can gain new uses driven

by everyday scarcity.” (Fonseca, 2011, p. 90). The hybridity between the circuits of information also reveals the indissoluble junction between political action and the new instrumental possibilities of the current period.

We believe that the informational density can contain, as a possibility, a practical alternative to the strengthening of local orders, and therefore the search for autonomy. This possibility becomes real as it becomes an appendix of the communicational density. This occurs because informational agents are imbued with a self-managed perspective, which would make them see,

In the current technological revolution, not the extension of the old trends, but, conversely, a real organizational revolution, implies access to all information and, consequently, the self-government of men (Lojkin, 1995, p. 149) (*Our translation*).

Because it is a downward circuit, the information on health in the Primary Care excludes the communicational density (and therefore knowledge and intelligence) of its process. In addition, the health information policy does not allow access to all possible information to be seized, but only those who follow the theoretical-methodological hegemonic pattern, standardized by the Brazilian Ministry of Health.

The possibility to transform health informational activity into the Primary Care of SUS passes necessarily through the rearticulation of the existing human resources. This is because, as we said earlier, the informational density provided by technical objects of places can only be activated by human action. To transform the concept of health, we went through an upward transformation of the health sector itself, and the professionals who work in this part of the primary system, become fundamental elements. They, to a greater or lesser extent, are at the epicenter of an interface between the communicational density of places and primary health care. Thus, it is essential to introduce new professions, external to the medical division of the work, in the daily practices of Primary Care.

To link the informational activity to the autonomy of the places means to make them recognize

themselves and their circumstantial relationships with the world and with other places. It means to make them owners of strategies for information production and political agendas.

In this scenario the community workers play an important role and should be encouraged to produce free-form information, both with the aid of information technology (in a more extensive way than that required for the current informational systems) and with the use of alternative methods such as interviews, journal, and achievements of focus groups. In this sense, Cartografia da Ação (Ribeiro et al., 2002) could be an excellent tool.

The informational activity of each basic health unit should have flexibility to think about its daily life, which means to think about the place, to bring out the situation idea, versus that of diagnosis, because while this is a monologue, the situation analysis assumes the other one and the circumstances. We may not choose the world we live in, but we have the right to choose how we live in it.

In time, we would like to recognize all the efforts made by the health sector that culminated in the structuring bases of SUS, established, mainly, from the diagnosis made by the Health Care Reform movement over the decades of 1970 and 1980.

Taken by the purposes of *Saúde e Sociedade* journal, whose focus and scope has as one of its objectives to stimulate the debate and controversy under different approaches, our purpose in this text is to counteract the territorial techniques (in the specific case we approach only informational activity) that have been established by SUS. In our understanding these techniques suffer from at least four misconceptions of origin: territory is commonly confused with area, this confusion is clear in newspaper clippings of “territorial” proposals for implementation of the actions of SUS: municipality, health district, micro area, coverage area, domicile-territory. The term territory process is being used, as if it were possible to unlink territory from process, or a living region as if there were a dead region; **Place**, a multiple sociocultural dimension in terms of the directions of the action, is confused with **local**, realm of a distant control by the instrumentalized action of economics and politics;

in general, these methodologies do not question the character of Public Policy that SUS closes. Public Policies were born as alternatives to traditional planning and are based on a partial and zoned view, antiterritorial even, leading to the belief that the health problem can only be resolved in the health sector. In this regard, the care for the place where every citizen lives should also be considered, not just where the individual seeks for hospital service; the decentralization centered on the municipality and the contempt for regionalization. In proposing the decentralization of municipal basis, following the example of diagnosis on the sector and the services, we should make a geopolitical diagnosis of the municipal matter. It would be necessary to ask ourselves: what is the municipality in Brazil? Due to the absence of such a diagnosis, today we have a SUS policy that is a federal policy for municipal "execution". Health is a regional phenomenon by nature, however the disarticulation between decentralization and regionalization is a mark of SUS, seen from outside (decentralization and regionalization) seem two completely different processes. Even as part of the structural principles of the actions of the State and the guidelines of SUS, regionalization is a matter yet to be faced. Even if it has been set by the Constitution of 1988 and reinforced by Operational Standard for Health Care (NOAS), in 2000, and by the Health Pact, in 2006, the implementation of the regionalization strategy is fragile, to say the least, it is one of the critical problems of SUS, according to Matus (2005).

As already noted, we approached in this reflection only one aspect of the informational activity, to expose the importance of territorial analysis. We believe that this contributes to the understanding of the relationships between health and place. Further discussion on the relationship between geography and territorialization techniques of SUS would be a subject for other studies.⁴

References

- ALVES, C. N. Os circuitos de informações no território: a produção musical em Recife. In: ENCONTRO NACIONAL DE GEÓGRAFOS, 16., 2010, Porto Alegre. *Anais...*, 2010.
- ARANHA, P. R. M. *Do mundo como norma ao lugar como forma: o uso do território pela estratégia da saúde da família*. 2010. Dissertação (Mestrado em Geografia) - Universidade Federal do Rio Grande do Norte, Natal, 2010.
- BALBIM, R. *Práticas espaciais e informatização do espaço da circulação: mobilidade cotidiana em São Paulo*. 2003. Tese (Doutorado em Geografia Humana) - Faculdade de Filosofia, Letras e Ciências Humanas da Universidade de São Paulo, São Paulo, 2003.
- BRANCO, M. A. F. *Informação e saúde: uma ciência e suas políticas em uma nova era*. Rio de Janeiro: Fiocruz, 2006.
- CANGUILHEM, G. *O normal e o patológico*. Rio de Janeiro: Forense Universitária, 2009.
- CASTILLO, R. A. *Sistemas orbitais e uso do território: integração eletrônica e conhecimento digital do território brasileiro*. 1999. Tese (Doutorado em Geografia Humana) - Faculdade de Filosofia, Letras e Ciências Humanas da Universidade de São Paulo, São Paulo, 1999.
- CATAIA, M. Uso do território e federação: novos agentes e novos lugares. Diálogos possíveis e participação política. *Revista Scripta Nova*, Barcelona, v. 14, n. 331 (16), 2010.
- CONTEL, F. B. *Território e finanças: técnicas, normas e topologias bancárias no Brasil*. 2006. Tese (Doutorado em Geografia Humana) - Faculdade de Filosofia, Letras e Ciências Humanas da Universidade de São Paulo, São Paulo, 2006.

⁴ In this regard, a series of research carried out within the research group Territorium (UFRN) seeks to further the analysis of public health policies from the understanding of place and of the process of regionalization: Dantas and Aranha (2009), Dantas, Aranha, and Feitosa (2012), Aranha (2010), Marques (2012), Feitosa (2013a, 2013b), Curioso (2011, 2013, 2014).

- CURIOSO, R. *O lugar em uma ficha: estudos geográficos do sistema de informação da atenção básica em Natal*. 2011. Monografia (Graduação em Geografia) - Universidade Federal do Rio Grande do Norte, Natal, 2011.
- CURIOSO, R. O prisma geográfico para a ação política na saúde pública brasileira. In: ENCUESTRO DE GEÓGRAFOS DE AMÉRICA LATINA, 14., 2013, Lima. *Anais...* Lima: Observatório Geográfico de América Latina, 2013. Disponível em: <<http://observatoriogeograficoamericalatina.org.mx/egal14/Geografiasocioeconomica/Geografiamedica/04.pdf>>. Acesso em: 14 jul. 2016.
- CURIOSO, R. *Lugar, saúde e informação: os círculos de informação da atenção básica do SUS no contexto na disputa pelo conceito de saúde*. 2014. Dissertação (Mestrado em Geografia) - Universidade Federal do Rio Grande do Norte, Natal, 2014.
- DANTAS, A.; ARANHA, P. R. Saúde na perspectiva da geografia nova. *Revista Mercator*, Fortaleza, v. 8, n. 16, p. 125-132, 2009.
- DANTAS, A.; ARANHA, P. R.; FEITOSA, L. C. Da territorialização à regionalização do Sistema Único de Saúde (SUS). In: CONGRESSO INTERNACIONAL DA GEOGRAFIA DA SAÚDE, 4., 2012, Presidente Prudente. *Anais...* Presidente Prudente: Congresso Internacional de Geografia da Saúde, 2012, v. 1, p. 337-351.
- FEITOSA, L. C. *A regionalização da saúde no Rio Grande do Norte: elementos para a compreensão da dinâmica dos lugares*. 2013. Dissertação (Mestrado em Geografia) - Universidade Federal do Rio Grande do Norte, Natal, 2013a.
- FEITOSA, L. C. A efetividade do Plano Diretor de Regionalização do SUS no Rio Grande do Norte. *Revista da ANPEGE*, v. 9, n. 11, p. 21-26, 2013b.
- FONSECA, H. R. *Produção e difusão de informações na cidade de Campinas-SP: um estudo da região do Jardim Campo Belo*. 2011. Monografia (Graduação em Geografia) - Instituto de Geociências da Universidade de Campinas, Campinas, 2011.
- FOUCAULT, M. *O nascimento da clínica*. Rio de Janeiro: Forense Universitária, 1998.
- FOUCAULT, M. O nascimento da medicina social. In: _____. *Microfísica do poder*. 4. ed. São Paulo: Graal, 1984. p. 79-98.
- FREIDSON, E. *Profissão médica: um estudo de sociologia do conhecimento aplicado*. São Paulo: UNESP, 2009.
- GÖRZ, A. *O imaterial: conhecimento, valor e capital*. São Paulo: Annablume, 2005.
- ILLICH, I. *A expropriação da saúde: nêmesis da Medicina*. Rio de Janeiro: Nova Fronteira, 1975.
- KAHIL, S. P. Psicoesfera: a modernidade perversa. *Revista do Departamento de Geografia*, São Paulo, n. 11, p. 217-220, 1997.
- LOJKINE, J. *A revolução informacional*. São Paulo: Cortez, 1995.
- MARQUES, A. C. S. *Território e saúde: uma análise sobre o município de Guarabira/PB*. 2012. Dissertação (Mestrado em Geografia) - Universidade Federal do Rio Grande do Norte, Natal, 2012.
- MATTELART, A. Sociedade do conhecimento e controle da informação e da comunicação. In: ENCONTRO LATINO DE ECONOMIA POLÍTICA DA INFORMAÇÃO, COMUNICAÇÃO E CULTURA, 5., 2005, Salvador. Disponível em: <<http://www.gepicc.ufba.br/enlepcc/ArmandMattelartPortugues.pdf>>. Acesso em: 14 jul. 2016.
- MATUS, C. *Teoria do jogo social*. São Paulo: FUNDAP, 2005.
- MÉSZÁROS, I. *Para além do Capital: rumo a uma teoria da transição*. São Paulo: Boitempo, 2002.
- MÉSZÁROS, I. *O poder da ideologia*. São Paulo: Boitempo, 2004.
- MÉSZÁROS, I. *Estrutura social e formas de consciência: a determinação social do método*. São Paulo: Boitempo, 2009.
- OMS - ORGANIZAÇÃO MUNDIAL DA SAÚDE; UNICEF - FUNDO DAS NAÇÕES UNIDAS PARA A INFÂNCIA. Declaração de Alma-Ata.

- In: CONFERÊNCIA INTERNACIONAL SOBRE CUIDADOS PRIMÁRIOS DE SAÚDE, 1978, Alma-Ata (USSR). Disponível em: <<http://www.opas.org.br/declaracao-de-alma-ata/>>. Acesso em: 6 ago. 2016.
- RIBEIRO, A. C. T. Relações Sociedade-Estado: elementos do paradigma administrativo. In: _____. *Por uma sociologia do presente: ação, técnica e espaço*. Rio de Janeiro: Letra Capital, 2013. p. 95-116. (Volume 3).
- RIBEIRO, A. C. T. et al. Por uma cartografia da ação: pequeno ensaio de método. *Cadernos IPPUR*, Rio de Janeiro, v. 16, n. 1 p. 33-52, 2002.
- SANTOS, M. *O espaço do cidadão*. São Paulo: EDUSP, 2007.
- SANTOS, M. *A natureza do espaço: técnica e tempo, razão e emoção*. São Paulo: EDUSP, 2008.
- SANTOS, M. *A urbanização brasileira*. São Paulo: EDUSP, 2009.
- SANTOS, M. *Da totalidade ao lugar*. São Paulo: EDUSP, 2012.
- SILVA, A. M. B. *São Paulo, produção de informações e reorganização do território brasileiro*. 2002. Tese (Doutorado em Geografia Humana) - Faculdade de Filosofia, Letras e Ciências Humanas da Universidade de São Paulo, São Paulo, 2002.
- SILVA, A. M. B. Círculos de informações e novas dinâmicas do território brasileiro. In: ENCONTRO NACIONAL DE GEÓGRAFOS, 16., 2010, Porto Alegre. *Anais...* Porto Alegre: AGB, 2010. Disponível em: <<http://www.agb.org.br/evento/download.php?idTrabalho=4433>>. Acesso em: 14 jul. 2016.
- SILVEIRA, M. L. Uma situação geográfica: do método à metodologia. *Revista Território*, Rio de Janeiro, ano IV, n. 6, p. 21-28, 1999.
- TEDESCO, J. C. *Paradigmas do cotidiano: introdução à constituição de um campo de análise social*. Santa Cruz do Sul: EDUNISC, 2003.

Authors' contribution

Curioso was responsible for the design and review of the article.
Dantas contributed to the debate and guided the study.

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