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PUBLIC HEALTH POLICIES IN BRAZIL IN THE CONTEXT OF THE COVID-19 PANDEMIC: RESPONSE THROUGH PROCESSES OF INDIVIDUALIZATION

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The COVID-19 pandemic has put countries worldwide in the challenging position of responding to the urgency in public health by means of national public policies. In Brazil, this response has reinforced and radicalized the dynamics of social individualization. Social individualization is expressed by a triple individualization process: dissolution of modern traditional forms; loss of the traditional security in the spheres of the labor market, the educational system, family structures, and social rules; and a "new type of social cohesion," of control and (re)integration[1]. Social individualization is structured by institutions and destroys the established foundations of the collective social coexistence of what the German sociologist Ulrich Beck calls first modernity. Therefore, individualization (re)shapes the social structure, transforming the individual into the unit of social reproduction.

Studies of social individualization thus focus on the institutional structures that sustain the state and the market. On this basis, and drawing from two exemplary cases, we look at the execution and implementation of public health policies to control the pandemic and how they have produced and reinforced institutionalized individualization, in opposition to the collectivist principles that are the foundation of SUS, the Brazilian unified health system, which recognizes health as a universal right.

Facing the pandemic through the expansion of hospital beds

The centrality of the occupancy rate of clinical and ICU beds by patients with COVID-19, widely adopted by states and municipalities to design COVID-19 responses, expresses and reaffirms the logic of institutional individualization. In several Brazilian states, bed occupancy rates were the parameters adopted to control the acute pandemic phase, to determine the levels of economic activity, and to establish quarantine regulations. For example, in the state of São Paulo, often the epicenter of the pandemic in Brazil, this was the main criterion adopted in the economic recovery plan[2]. This choice, anchored in biomedical and clinical epidemiology knowledge, reflects a concern with the most severe forms of the disease while neglecting the degree of virus transmission in the population, which would invite an approach of social epidemiology or even classical public health.

The Council of Municipal Health Secretaries and the National Council of Health Secretaries – two important entities in the design and implementation of health policies in the country – repared a guiding document[3] based on two sets of indicators: "health provision capacity" indicators, including the occupancy and forecast of exhaustion of hospital beds, and epidemiological indicators, including the number of deaths, the number of symptomatic cases,

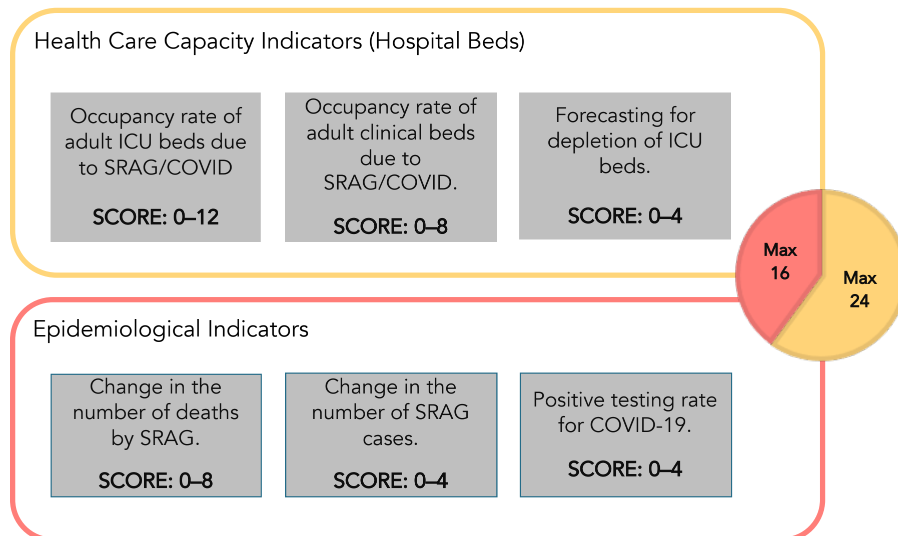

Figure 1. Graphical systematization of the guidelines for the response to the pandemic. Authors' elaboration based on CONASS and CONASEMS[3, p. 8].

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and the positivity rate for COVID-19. However, different weights were assigned to these two sets, with emphasis being placed on the former, especially the rate of occupation and availability of ICU beds. The "positivity rate" of COVID-19 tests, from the epidemiological component, had lower weight than the variation in the number of deaths, and there was no indicator of the rate of community transmission (Figure 1).

Controlling the pandemic: vaccination and medical autonomy

The federal government's refusal to recognize the severity of the pandemic, as well as its criticism of vaccines, led subnational governments to formulate and implement their own immunization strategies through the services of the Unified Health System (SUS) they control. In the city of São Paulo, for example, the website "De Olho na Fila"[4] was created. It allowed access to information on vaccination sites, the waiting list status, and the availability by vaccine type at each site. Later, due to a shortage in the supply of the AstraZeneca vaccine, the system incorporated a new functionality to enable visualization of sites that allowed for the interchangeability of vaccines – individuals could take Pfizer as a replacement for AstraZeneca[5]. Progress in collective immunization, in this context, was obtained by a dependence on the individual's search for the vaccine and health centers, in a market logic of supply-demand that is at odds with the SUS sanitary tradition, focused on collective and public health through universal care and epidemiological surveillance.

Rather than focusing on national immunization, the Ministry of Health invested in the so-called "Early Treatment campaign," which involved the use of Hydroxychloroquine and Ivermectin to supposedly treat and prevent infection by the coronavirus. This treatment was supported by the Federal Council of Medicine[6] under the argument of medical autonomy – the decision on treatments would be up to the doctor and patient, therefore exempting the CFM from its role as a regulatory body. In this scenario, two of the main regulatory bodies of health policy in the country, the MS and the CFM, institutionally decided to approach treatment at the individual level. The decision made by the CFM, interpreted as an immunity granted to doctors against the possible accusation of an ethical violation, does not, however, exclude them from possible criminal or civil liability. Also, by establishing that the choice of treatment is exclusive to the doctor, the CFM produced the individualization of the problem, blaming doctors and patients for a phenomenon of collective dimensions. Thus, the calculations of clinical and legal risks are individually assumed, without the mediation of specific institutions that are tasked with the regulation of the medical profession. This notion of "medical autonomy" that is disembedded from professional ethics helps further individualization and weaken the collective dimension of public health, with dire consequences for Brazil's ability to respond to the pandemic.

Conclusion

Public policies to control the pandemic produced and reinforced institutionalized individualization, in opposition to the collectivist principles that are at the foundation of SUS, the Brazilian health system, which recognizes health as a universal right. The focus on the availability of hospital beds resulted in inconsistent epidemiological and health surveillance, detracting COVID-19 responses from population-level strategies such as contagion control and mass testing. In addition, it (re)produced inequality in health care, following structural inequalities in Brazilian society. The individualized search for vaccines and the freedom to prescribe medication under the protection of medical autonomy reinforced individualization in public health through a market logic of supply and demand, rather than of collective social protection. The examples herein discussed allow us to better understand how social individualization was processed within a socio-sanitary phenomenon and by means of the public policies that were adopted.

Notes

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