

CHALLENGES OF COMPLEMENTARY AND ALTERNATIVE MEDICINE IN THE SUS AIMING TO HEALTH PROMOTION

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Abstract

The complementary and alternative medicines (CAM) besides promoting the reduction of costs, have also proven to be effective as well as they have invested in health promotion and health education, as a means of preventing the disease to take control and possibly result in serious consequences. **Objective:** to investigate the knowledge, opinions and social representations of managers and health professionals about those practices (CAM) in Public Health System (SUS) as well as to identify the difficulties and challenges that are present in their implementation, use and disclosure in the Health Services. **Methods:** the survey was carried out in a Basic Health Unit and Specialty Clinic in the northern area of São Paulo/SP, Brazil. We chose the qualitative approach with its instruments, documentary analysis and interviews based upon pre-established guidelines directed to managers and health professionals of these units. The total of 35 interviews took place between the months of July to August 2010. **Results:** the results support the thesis that managers are not prepared to implement the National Policy on Complementary and Integrative Practices (NPCIP) in SUS: only five out of the twenty six respondents were aware of the National Policy (NPCIP); the biomedical model sessions still prevails; material supply and acquisition of raw materials used in some of the CAM have become a major issue in the unit; the disclosure of the CAM has not been enough so as to be fully known by professionals and users alike. Furthermore, most of the professionals working in the Specialty Clinic where the CAM has been offered have undervalued those activities. The Complementary and Alternative Medicine have not played the role they should and/or could in the SUS for the Promotion of Health yet. **Conclusions:** it is pivotally necessary that the City of São Paulo/SP encourages and creates conditions for taking the CAM into all Health Units, so as to improve, disclose and support the inclusion of non-medical professionals, provided that they have proper training since practices such as Homeopathy, Acupuncture, Anthroposophy and Phytotherapy are already considered as medical specialties. Included in Public Health System (SUS), the Complementary and Alternative Medicine can certainly contribute a lot for the Promotion of Health.

Key words: complementary and alternative medicine; public health promotion

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INTRODUCTION

Modern medicine as it is performed at the National Health System in Brazil (SUS) is being questioned regarding its possibilities of attending to all the existing demands of services.

About two decades ago, before the Sanitarian Reform in Brazil, health was not considered a social right. In this field, private services were predominant and served people who could afford health care; besides them, workers of the formal market, being covered by national insurance, were entitled to public health services.

Sanitarian Reform Movement was the name given to a social mobilization that reunited many different social actors that were engaged in changing an exclusionary model. By that time Brazil was undergoing a moment of political opening, and the movement used this opportunity to strengthen democratic principles and to build a broader and more sustainable health care model. The claims that guided the movement were presented mainly by Municipal Health Secretaries, and catalyzed at the 8th National Health Conference, in 1986¹.

SUS was created in 1988. It appears in the Constitution to offer egalitarian care and promote health to all Brazilians. This unique social movement materialized through prevention, health promotion and care actions.

Constitutional amendment n. 29, which was approved in 2000, modified one of the articles of Brazilian Constitution (n. 198) and granted that public health services and actions were made part of a regional, hierarchical network, composing a unique system organized around 3 principles: I – decentralization, with single direction at each level of government; II – comprehensive care, prioritizing preventive activities at the same time as the offer of care; III – community participation².

In its more than 20 years of existence, SUS has broadened access to health care to many Brazilians who were previously excluded or dependent of philanthropic institutions. In 2009, 721,000 outpatient appointments and 11 million high and medium complexity procedures and admissions³.

In spite of that, the new Index of Human Values publicized by the United Nations Development Program (UNDP) in 2010 brought to light that in terms of health Brazil has had a lower performance than in work and education areas. This assessment considered waiting time for medial or hospital care, easiness of understanding the language of health professionals and the interest of the medical team perceived by the patient⁴.

The biomedical Cartesian paradigm is prevailing in modern medicine; however, it is less so in different medical systems, such as traditional complementary medicine.

Luz, 1996⁵, affirms that simplified, non-invasive types of treatment, as well as consumption of drugs coming from natural products and an active

proposal of health promotion are part of these therapeutic systems and practices of treatment and care since mid-seventies. In this period, homeopathy was successful in creating spaces for a natural perspective; besides, the counterculture movement and an anti-technology position of people regarding their health defended treatments coming from nature. This did not mean only a rejection of specialized and technological, anti-natural, invasive and iatrogenic medicine: it reaffirmed the presence of a curative force belonging to the natural environment.

Complementary and alternative medicines not only reduce costs in treatment; they have been shown to be effective and able to promote health and to educate people about their health, in a way that helps to avoid diseases' onset and to lessen their consequences.

Therefore, seen as a new health culture, health promotion tends to result in a more comprehensive, holistic dialogue different from the biologic's model resulting from specialization and knowledge fragmentation. What is more, it is capable of stimulating the rupture of modern science, based on microorganisms and in the environment as a determinant of diseases⁵.

SUS has been shown as favorable to the use of more effective, affordable therapeutic resources in many treatment instances, in particular regarding the, Complementary and Integrative Practices of care are popularly known as Alternative. The set of practices and knowledge have been named by the World Health Organization (WHO) Complementary and Alternative Medicines (CAM)/ Traditional Medicines (MT).

These practices aim at stimulating the use of natural methods of prevention and recovery, with emphasis on the development of a therapeutic bond, integration of human being with nature, broadened understanding of health-disease process and promotion of care⁶ in supporting allopathic treatments. Around 80% of south hemisphere countries have used some sort of Traditional and Complementary Medicine as part of basic health care⁷.

Given the need of integrating modern medicine to non-conventional practices of health care, Brazilian Health Ministry has approved in 2006 the National Policy on Complementary and Integrative Practices (NPCIP). This was an answer to the need of understanding, supporting, incorporate and implement experiences that were already being done in the public health network of many municipalities and estates. At the same time, it responded to the needs of part of the population, expressed regularly in the recommendations formulated at the National Health Conferences since 1988.

The intention when the NPCIP was published was to grant access in the scope of SUS to these type of services, in particular Chinese traditional practices/acupuncture, homeopathy, phytotherapy,

anthroposophic medicine and termalismo-crenotherapy⁸.

The guidelines for the implementation of the NPCIP include relevant aspects to this research, therefore are presented here. The first one refers to structuring and strengthening CAM care at SUS, through its insertion in all levels of health care, in particular in primary care; it encourages a multidisciplinary approach, the implementation of financial support mechanisms, the definition of technical and operational rules and the linkage with National Policy for Indian People Health Care, as well as other policies of Health Ministry.

The second guideline refers to the development of professional training in CAM for SUS technicians, in accordance with principles and guidelines established for continuing education; the third one defines CAM information dissemination actions aimed at SUS health professionals, managers and users, based on participative methodologies and popular and traditional knowledge⁹.

Even though there is a Public Policy that determines the use of CAM, it was possible to perceive that challenges and limitations have prevented a really effective implementation. In February 2011, CAM National Coordination in the Ministry of Health published a whitepaper on CAM management at SUS during the period 2006-2010. This document considered extremely relevant for implementing the National Policy: (i) professional training and hiring of appropriate numbers of professionals; (ii) monitoring and assessment of services in their adequacy to national policies general guidelines, the institutionalization of basic care evaluation, the specificities of different services and levels of the health system; (iii) input supply (homeopathic/phytotherapeutic remedies, acupuncture needles); (iv) structuring of the services in the public system; (v) development or adjustment of specific legislation for SUS health services; (vi) the investment in research and development in order to integrate knowledge and practices of different fields that can contribute to more human, holistic and transdisciplinary projects.

The white paper admits that CAM are in crescent use, and at the same time recognizes some difficulties in their adoption, mainly due to their differences with modern medicine.

METHODS

This research adopted a qualitative approach, which deals with the universe of meanings, motifs, aspirations, beliefs, values and attitudes which correspond to a deeper space of relationships, processes and phenomena that cannot be reduced to variables operationalization⁹.

Qualitative approach allows the use of instrumental techniques and resources adequate to the understanding of cultural values and social representations of a given group, and the

investigation of how the relationships amongst actors which act in a particular theme¹⁰.

Qualitative approach is a field of knowledge that develops mainly through interpretative practices, for which quality is eminently holistic and inductive; it takes as referential the understanding, the construction of sense and intentionality¹¹.

As research tools, we chose document investigation¹² – that explored sources that were not treated analytically – and an interview using a predetermined script. The interview allows researchers to capture social information, to treat choices that are clearly individual and to include informers that could not be reached by other means of investigation¹⁴.

Data were collected in two public, municipal health services of São Paulo: a Basic Health Care Unit (UBS), which did not offer CAM to its community, and an outpatients specialties' service (AE) that included CAM to its users. In total, 35 interviews were made: 11 at the UBS, 24 on the AE. Subjects were the managers of each unit (three, as one was on holidays) and health professionals that worked there with distinctive attributions: medical doctors, psychologists, dentists, nurses, social workers, occupational therapists, physiotherapists, public health agents, helpers, administrative agents and technical helpers.

RESULTS

Managers

Interviewed managers at the UBS mentioned to have knowledge of NPCIP, considering of extreme importance to aggregate them to conventional treatments and their formalization in the public health services; however, they judged difficult their use. At the AE, the manager said she'd never heard about NPCIP, but knew something about CAM: homeopathy, acupuncture, Bach's floral remedies, orthomolecular medicine and Chinese body practices. In her opinion, there is nowadays greater openness to the insertion of alternative therapies as an option to the user that is not completely satisfied with a conventional medical appointment, and it responds to the requirements of São Paulo's municipal Health Secretary.

At the UBS, the fact that CAM were not being offered was assigned by the interviewees to a decision of the Technical Health Supervisor. This supervisor is responsible for "allocating [resources for CAM] between the units, in accordance with facilities and the required number of staff – there is a shortage of professionals, even for conventional care".

Interviewees also appointed the need of a cultural change of the health professionals and patients; of enforcing the Family Health Program's (PSF) model to all dimensions of health care, in a way that it could offer a option distinct of the biomedical model.

As one of them said: "one perceives a rejection from the doctors towards CAM, to what is scientific and to what is not". "Many of them consider meditation, for instance, as a mystical practice, which it isn't, in my opinion" (...) "this type of treatment asks for a cultural change that is slow, but there is more openness: [it is necessary] to understand that facilities and timing of these therapies also must be different".

Regarding their own use of complementary treatments when caring for themselves or family, UBS managers confirmed their use of homeopathy. One of them mentioned the use of acupuncture and more natural food habits, and the other practices circle dances and meditation on a regular basis, as she believes in their benefits and finds them "part of" a healthier life.

For AE's manager, the biological approach of medical training does not put them into favor the use of CAM, even though they refer an occasional empirical interest, like the one she mentioned: "we, medical doctors, are very reluctant. I mean... What's the need? I don't know... I've never needed [to use CAM], but surely when there's a little pain here...or there... somebody says it helps... when we do it... we learn on a daily basis...".

Health Professionals

None of the nine health professionals interviewed at the UBS had heard of NPCIP, and eight of them said they hadn't heard of CAM as well. On the other hand, all of the AE interviewees new at least two of the practices offered at that health service, and said they would suggest them to a patient, client, friend or family member. Of the total of 23 interviewees, only three mentioned to know the NPCIP; of these, nobody knew in depth its objectives or guidelines.

During the interview, when the researcher referred to the CAM as Alternative Therapies, 60% of the respondents referred to use or to have used in the past (or family members did) homeopathy, acupuncture, circle or senior dances, clay therapy, medicinal plants or Chinese body practices such as Lian Gong and Tui Ná. Besides having expressed sympathy for these practices, they have mentioned to have had some positive experience, or to know someone who had benefited from their use.

Excepting one of the interviewees, everybody declared to believe in the beneficial effects of CAM to their health or other people's, and thought it possible to include them to modern medicine, in spite of judging it difficult:

"I have used and observe the changes in people who use it, they seem more active, and expanding a world vision that formal model of treatment couldn't. [This] is a limiting model. When one is closed in a treatment protocol, other possibilities are limited. In Traditional Chinese Medicine one can perceive a different type of

behavior, another appearance, another countenance". And still "People don't take part only because there is no option. If we had [CAM] here, at the UBS, people would use it. Doctors have reserves, and we do need a medical referral because it is a public service, but clinicians [nowadays] do not refer, in my opinion they should do it more".

At the AE, most of the interviewees had favorable opinion regarding the use of CAM, evaluating them as good or great, very important, adequate and valid, or exerting a leading role in treatment model or even as a futures option.

It can be said that another group of professionals considered these practices as complementary to traditional treatments, sometimes helping in particular with pain and vital functions control, sometimes helping or improving quality of life of patients and of themselves. We highlight in their testimony:

"They occupy a central role in a Health service because in reality they give to the patients the notion that health is their own property... that they do not depend of the other, or of the medicine, but of self-care on a daily basis, and [...] these alternative practices refer to self perception and offer gains that are not only motors, but also psychic, of memory, of attention... there is a lot of benefits... one is working directly with prevention, care and maintenance of health".

The least visible practice, in their opinion, was homeopathy. This can indicate the lack of expressivity of homeopathy in this AE. During data collection, between July and September, homeopathy appointments had been suspended due to one of the two doctors was on holidays and the other on leave. Acupuncture was the practice with more representativeness, and it is the one receiving the biggest SUS investments. According to a report from the Health Ministry (Basic Care Report n 53), in 2008 there have been made 396,012 acupuncture appointments, with a total cost of US\$ 2,095,301, and more than 240,000 procedures of Traditional Chinese Medicine / Acupuncture versus 295,348 appointments of homeopathy, with a cost of US\$ 22,726,709¹ to federal government.

All interviewees at the AE believed that it is possible to aggregate CAM to traditional care at SUS. Most of them considered complementary to allopathic treatment in many clinical conditions, including chronic diseases or in anxiety or pain cases.

About the role of CAM to health promotion, most respondents said that they considered them important to improve people's health, besides preventing pathologies and making it more difficult to get sick, being seen therefore as a way of complementing conventional health care.

In their opinion, "people need health care, but they also need to find out that health is more than only medication".

1 Quotation of the dollar US\$1.89 in jul-aug/2009 – date of the publication.

Professionals' perception about the benefits and difficulties regarding CAM offer at the AE, revealed that there were qualified professionals to perform CAM: 3 medical doctors /acupuncturists, 2 physiotherapists, one occupational therapist and one psychologist.

The main benefits of CAM mentioned at the interviews were reducing stress, tranquilizer, analgesic and anti-inflammatory action. Regarding acupuncture, the increase in physical and emotional well-being was mentioned. As for the Chinese Body Practices, there was mention to improvements in quality of life with breathing techniques, better control of blood pressure, diabetes and an improvement of joints flexibility.

Lack of physical facilities was mentioned as one of the difficulties for the offer of CAM at the unit, as well as lack of support from the management and appreciation [of the techniques]. For acupuncture treatments, it was mentioned the lack of treatment rooms, stretchers, heating devices, needles and other disposable material, of more sophisticated equipment (laser) and of suction cups.

DISCUSSION

When health is not centered in biology¹⁵, there is more possibilities of thinking possible interventions to the different problems. Increasingly researchers are focusing on the study of CAM. In the global context, one can see the crisis of modern medicine paradigms. This medicine, supported by a biological approach, has strengthened a medical system that excluded traditional knowledge, and privileged an individual rather than a collective medical practice; a system that underestimates health promotion, is technician and worked towards specialization and fragmentation, instead of seeing the human being as an integral being. It is based in a hospital-centered logic, focused on procedures, surgeries, that overvalues medicines – which contributes to strengthen pharmaceutical industries and medical technology companies. *"A lot has been said and written about medicine's crisis, since the 1970's, assigning its origins to economical-financing or political causes, or even to corporative/ethic causes¹⁶".*

Pelicioni, 2005⁴, concludes that "biomedical model adopted during the last years did not bring to public health as many advances as it was thought it would". A new way of approaching public health would be to consider it under the view of health promotion broader and more inclusive, in order to incorporate different styles and health conditions, quality of life, training for autonomy and a more important participation of patients in the health/disease process.

Managers' opinions raise important questions for discussion. First of all, the lack of knowledge about NPCIP in a health unit that was chosen exactly

for offering CAM can hinder the success of these practices in a place which already meets some of the demand. Secondly, it is funny that in the process of implementation of CAM there doesn't seem to be a dialogue and joint action between municipal, estate and federal management.

The manager that knew the National Policy was the head of a unit that did not offer CAM. On the other hand, the unit where they had been implanted did not have a lot of knowledge about it. Nevertheless, the testimonies clearly reveal their perception about the limitations of the biomedical model, and identified some characteristics of care that could be easily contemplated by the CAM and other medical rationalities.

It seems that there hasn't been disposition to reinforce CAM at the AE, since the manager affirmed that she does not take part of the institutional meetings that happen periodically, organized by the coordination responsible for implementing CAM in the SUS. In spite of the invitation and of easy access to the meetings, this manager preferred to send another professional from her unit, usually one of the acupuncturist medical doctors. This decision may also contribute to the invisibility of CAM at the SUS, making the implantation of new projects in this line more vulnerable. During this interview it became evident that this manager is not exerting her attributions in favor of the CAM.

It is not clear if the lack of knowledge about the CAM and even about NPCIP manifested by the interviewees at the UBS is due to an inefficient dissemination of information at the public network of health services, to a disbelief of health professionals in the medical rationalities due to their own training, to discrimination or prejudice, or if it is due to management's favoritism towards the biomedical model.

At the UBS that didn't offer CAM, interviewed managers not only knew the NPCIP but also used and indicated homeopathy, acupuncture, healthier nutrition, the practice of circle dances and meditation on a daily basis to family and friends.

In spite of these testimonies, their posture as managers was passive, which demonstrates a lack of preparation for implanting new health care and management models.

The application of the NPCIP hasn't been understood as an easy action to be taken, and the main motives were lack of adequate training for non conventional practices.

Most of interviewees believed in the therapeutic effects of CAM for improving health conditions and thought it possible to use them aggregated to modern medicine. None of the health professionals interviewed knew about NPCIP.

Some people considered health promotion as complementary to conventional health care, although did not relate it to a wider and positive way of thinking about health.

On the other hand, the AE manager – the unit that offered CAM – declared that she didn't know the NPCIP and that she barely knew CAM in general, differently from the professionals of her team: they declared that, besides knowing them, they were favorable and considered complementary to conventional treatments and to the improvement of people's quality of life.

As at the UBS, most of AE professionals uses or has used CAM in the care of their own or family's health. Even those who did not use CAM recognized their benefits and would recommend them.

Everybody believed that it would be possible to aggregate CAM to conventional care, but in order to do that an important point was the training of professionals. The availability of supplies is a major problem at the health unit.

Publicizing CAM to locals has been restricted, which prevents people of knowing and using them.

CAM as a tool for health promotion hasn't occupied the role that they could or should inside SUS. The fact that the Health Commitments Agenda does not contemplate NPCIP makes its implantation more difficult.

Besides having a low performance in health according to the UNPD, one believes that it can be related to the fact that health is not being prioritized by the government. The research made by the authors regarding the CAM at the SUS has had as one of the main results the identification of a lack of training of

the managers responsible for the health units, in particular the AE; they should manage the service using a joint model different than the biomedical, in order to attend to the demands of the population and offer a more efficient service, with more quality given by the offer of non-conventional therapies.

Thus, in spite of the action and interest of the National Coordination of Complementary and Integrative Practices, linked to the Ministry of Health, one can still perceive a resistance to this proposal, maybe as a consequence of the hegemony of the biomedical model also over the non-medical health professionals that work at the SUS.

In order to favor to the implementation of the CAM at the SUS, the following recommendations are made to São Paulo's Municipal Health Secretary: it should stimulate and offer conditions to the offering of CAM in all of its units; support the insertion of non-medical professionals when they have been adequately trained, in CAM able to promote the health of Brazilian population. The Health Coordination of North Region/São Paulo, through its Traditional Medicines Coordination, should improve the publicity about them, and to implant and monitor CAM in health services, and to offer supplies. The managers in the three levels – municipal, estate and federal – should stimulate the creation of new programs. CAM integrated to SUS will certainly be able to stimulate and contribute to health promotion of Brazilian Population.

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