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ORIGINAL ARTICLE

Ethical-political care and neoliberal logic: Lived experiences of health leaders and professionals in vulnerable territories

Cuidado ético-político e lógica neoliberal: vivências de lideranças e profissionais da saúde em território vulnerabilizado

Cuidado ético-político y lógica neoliberal: experiencias de líderes y profesionales de la salud en territorio vulnerabilizado

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ABSTRACT This article addresses the production of care in health as a tool for confronting neoliberal logic, especially in Family Health Strategy practices. The study, employing a qualitative approach and conducted in a municipality of the Baixada Santista region with community leaders and health professionals, analyzes the senses and meanings of care production within the Strategy, based on the experiences of community leaders and health professionals in the mangrove areas of Cubatão (SP), a context marked by the advance of exclusionary neoliberal policies. It points to the influence of outsourcing in the health sector, highlighting the populations' difficulties of access and the intensification of the productivist logic. In contrast, affectivity emerges as a pillar for critical reflections on care, giving rise to the notion of ethical-political care – a notion aligned with the principles of the Unified Health System, emphasizing the importance of the struggle for rights, the promotion of solidarity and a sense of community, and ultimately contributing to the fight against the commodification of health and social injustices.
KEYWORDS Health care. Family Health. Qualitative research. Care.

RESUMO *O artigo aborda a produção do cuidado em saúde como uma ferramenta de enfrentamento da lógica neoliberal, especialmente em práticas da Estratégia Saúde da Família. O estudo, de abordagem qualitativa, realizado em um município da Baixada Santista com lideranças comunitárias e profissionais de saúde, analisa os sentidos e os significados da produção do cuidado na Estratégia, a partir de experiências de lideranças comunitárias e profissionais de saúde na região dos mangues, em Cubatão (SP), contexto marcado pelo avanço das políticas neoliberais excludentes. Aponta a influência da terceirização no setor da saúde, destacando as dificuldades de acesso da população e o acirramento da lógica produtivista. Em contrapartida, a afetividade surge como um pilar para as reflexões críticas sobre o cuidado, suscitando a proposição da noção de cuidado ético-político – noção alinhada aos princípios do Sistema Único de Saúde, enfatizando a importância da luta pelos direitos, a promoção da solidariedade e o sentido de comunidade e, por fim, contribuindo para o enfrentamento da mercantilização da saúde e das injustiças sociais.*
PALAVRAS-CHAVE *Cuidado em saúde. Saúde da família. Pesquisa qualitativa. Cuidado.*

RESUMEN *El artículo aborda la producción del cuidado en salud como una herramienta de enfrentamiento a la lógica neoliberal, especialmente en las prácticas de la Estrategia Salud de la Familia. El estudio, de enfoque cualitativo, realizado en un municipio de la Baixada Santista con líderes comunitarios y profesionales de la salud, analiza los sentidos y los significados de la producción del cuidado en la Estrategia, a partir de las experiencias de líderes comunitarios y profesionales de la salud en las zonas de manglar de Cubatão (SP), un contexto marcado por el avance de las políticas neoliberales excluyentes. Señala la influencia de la tercerización en el sector salud, y destaca las dificultades de acceso de la población y la intensificación de la lógica productivista. En contrapartida, la afectividad surge como un pilar para las reflexiones críticas sobre el cuidado, lo que da lugar a la propuesta de la noción de cuidado ético-político – noción alineada con los principios del Sistema Único de Salud, que enfatiza la importancia de la lucha por los derechos, la promoción de la solidaridad y el sentido de comunidad y, por último, contribuye al enfrentamiento de la mercantilización de la salud y de las injusticias sociales.*
PALABRAS CLAVE *Cuidado de la salud. Salud de la familia. Investigación cualitativa. Cuidado.*

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Introduction

Discourses about economic and social development in the international arena intensified after World War II, engaging various countries in the pursuit of guiding principles for their economic policies, including health policies. Inequalities between countries grew, making it necessary to propose solutions to overcome the distribution and use of natural and financial resources[1].

Economic growth and technological innovations in some countries have not translated into improved living conditions and quality of life for others, especially the poorest. Since the postwar period, proposals emphasizing the role of the State in overcoming this crisis – associated with inequality and the very concept of development – have coexisted with those that relied on the power of the market to transform social reality[1].

Neoliberalism emerged in the 1970s and 1980s as an alternative to overcoming the crisis of global capitalism, creating a new crisis in relation to public and social policies[2]. This model imposes a new rationality, which intervenes in markets and also in the modes of production of subjectivity. It can be defined as "[...] the set of discourses, practices and devices that determine a new mode of governing men according to the universal principle of competition"[3(17)], advocating a minimal and austere State in fiscal controls, which focuses less and less on satisfying people's needs and promoting citizenship and autonomy through social protection and public policies.

In addition, it transmutes rights into consumption opportunities and, by basing itself on individualistic principles of competitiveness and merit, and not on solidarity[2], weakens bonds and ties between individuals. For Dardot and Laval[3], the State begins to manage public policies as if it were a company. Thus, citizens with rights become consumers of highly fragmented actions.

In this context, in the 1990s, Brazil implemented its Unified Health System (SUS), a public policy based on the principles of universality, comprehensiveness, and equity that seeks to reorganize health care models, with a view to promoting and guaranteeing basic social rights[4]. It emerges as a counterpoint to the state's abdication of responsibility and the transformation of the right to health into a commodity, reaffirming care as a social and collective right. The National Primary Care Policies stand out, fundamental for strengthening the principles and guidelines of the SUS, with the Family Health Strategy (ESF) as the main model[5–7].

Despite research and publications proving the positive effects of Primary Care actions on the overall health of the population, since its conception the ESF has faced challenges and tensions caused by the country's neoliberal development model[8]. It is important to highlight that the publication of the new National Primary Care Policy (2017) opens the possibility of dismantling the ESF model as the organizer of the Unified Health System (SUS), through the outsourcing of services and distortion in the composition of teams, favoring the exclusion of the Community Health Agent (ACS)[7,9].

In 2019, the Ministry of Health established the Previne Brasil Program, a new financing model that changes the way federal resources are transferred to municipalities, based on three principles: weighted capitation, payment for performance, and incentives for strategic actions. With this, it was expected to improve the quality of services and the population's access to Primary Health Care (PHC), considered the gateway to the SUS. However, for authors such as Massuda[10], instead of combating and reducing health inequalities, this new policy would contribute to reversing historical achievements by limiting universality, increasing distortions in financing, and inducing the focusing of PHC actions within the SUS. The program was discontinued in April 2024, with the adoption of a new methodology for federal co-financing of PHC.

From an analytical standpoint, in this work intersubjectivity was considered a theoretical-methodological strategy that enables the understanding of the influence of socio-historical phenomena on people's lives, since dialectically they are both products and producers of the reality in which they live[11,12]. Considering the dimension of subjective experience, Sawaia[13] considers affectivity a parameter for analyzing social exclusion, providing a benchmark for the effectiveness of public policies[14], specifically the practices of the ESF in improving lives. This perspective allows for a valorization of the subjective/affective dimension and contributes to the re-signification of struggles against various forms of oppression, power asymmetries, and the de-ideologization of everyday life[15-17].

Thus, the modes of care production in the practices of the ESF can express the quality of the affective and social bonds established at different levels, revealing what Boff[18] and Pintasilgo[19] – when considering 'care' as the core of social public policies – called the ethical-political dimension of care[20]. For these authors, when considering the existence of the other, solidarity and collective responsibility, the ethics of care goes beyond simple assistance through technique, being an ethical-political commitment. In the context of public health and the ESF, this perspective becomes fundamental because it values intersubjectivity, the construction of bonds and attention to the unique needs of people. In contrast to the neoliberal logic, which tends to fragment the subject and commodify access to health, this ethics aligns with the principles of the SUS, placing care as a fundamental right and instrument in the fight against the precariousness of life.

Thus, this article aims to analyze the senses and meanings of care production in the ESF, based on the experiences of community leaders and health professionals in the mangrove region of Cubatão (SP), a context marked by the advancement of exclusionary neoliberal policies.

Material and methods

This study is qualitative and based on participatory research. Understanding the parameters that guide the construction of intersubjectivities, highlighting the quality of relationships, cultural contexts, psychosocial aspects, and the degree of commitment to people's living conditions, proves to be a necessary basis not only for understanding the lived territory, but also for promoting transformations in reality and greater effectiveness of public health policies[21,22].

The notion of sense and meaning that guides the reflections originates in socio-historical psychology. Sense refers to the unique way in which subjects interpret their experiences in the world, while meaning concerns the symbolic dimension, culturally shared among people[23].

The issues raised emerged from the diverse and intense work of researchers linked to the Laboratory for Studies on Social Inequality (LEADS). This involves more than a decade of teaching, outreach, and research activities, in line with the Political-Pedagogical Project of the Federal University of São Paulo – Baixada Santista Campus (UNIFESP/BS), in the search for meanings and significance regarding health and care in territories of social vulnerability[24].

Qualitative information[11] from three projects whose research field was circumscribed in a community in the mangrove swamp of Cubatão (SP) was analyzed. Two of them – Social inequality and subjectivity: life trajectories and struggles for better living and health conditions in vulnerable territory of Baixada Santista and Ethics of care and construction of rights: psychosocial support in family health practices in situations of social exclusion – were carried out between June 2017 and October 2018. The third, Care in social inequality: interdisciplinary approaches in addressing the aggravations of COVID-19 in vulnerable territory, was carried out between March 2024 and July 2025 and focused on the pandemic and post-pandemic period.

By using information from different research projects, collected at intervals, the aim is to enrich the understanding of the phenomenon of health care production in confronting the neoliberal logic in the ESF. This work considered that information from different unique historical moments, when articulated, reveals the challenges imposed by neoliberalism, and that the integration of different sources of information provides a more robust and multifaceted view of the reality investigated.

The changes in context, highlighting the COVID-19 health crisis and the implementation of new health policies, were considered in the interpretation of the narratives. In this way, it was possible to understand how these events shaped experiences, perceptions, feelings, and coping strategies of leaders, health professionals, and the local population, ultimately indicating different dynamics of care, and suggesting the construction of the notion of ethical-political care.

Mangrove region of Cubatão (SP)

Cubatão (SP) is one of the nine cities in the Baixada Santista Metropolitan Region (RMBS). According to 2022 data from the Brazilian Institute of Geography and Statistics (IBGE)25, the estimated population of the municipality was 112,476 inhabitants. The main economic activity is petrochemicals, whose industries were established in the 1950s, along with the construction of major highways, such as the Anchieta, which enabled the emergence of neighborhoods on the slopes of the Serra do Mar, known as Cotas. In addition, the city was built on mangroves, revealing the complexity of its urbanization in relation to the preservation of the environment and living conditions[26].

Cubatão (SP) has a high Gross Domestic Product (GDP), resulting from industrial activities. However, wealth is not distributed equitably among citizens. Despite its great water potential, about 7.4% of the population does not have access to water[27] and only 59.3% have access to sanitation; the Municipal Human Development Index (MHDI) is 0.737 and the São Paulo Social Vulnerability Index (SVI) indicates that 32.68% of people live in territories of very high vulnerability[28,29]. This contradiction makes the municipality one of the most unequal in the Baixada Santista region.

The neighborhood known as Mangue de Cubatão is located between the Casqueiro River and the Anchieta Highway. It has a Family Health Unit (USF) with a mixed model, comprising three family health teams, each consisting of a gynecologist-obstetrician, a psychologist, a physiotherapist, and a dentist. With the exception of the ACS and the unit manager, all primary care professionals are contracted by a Social Organization (OS).

Construction of qualitative information

The information was gathered using mixed techniques, including: research of official data and document analysis; participant observation, with recording in field diaries; and the formation of Research Management Groups (GGP), from which the respondents' indications were obtained through semi-structured interviews and thematic workshops. The research of official data and document analysis served to update the sociodemographic and epidemiological profile.

The GGP became an important instrument for the collective construction of different stages of research and the joint production of knowledge, ensuring that the research objectives were appropriate to the reality and needs of the community. Its members included teachers, researchers, health service professionals, and community leaders. Community participants were selected through nominations from health professionals and community leaders, with those who received the most nominations being chosen. The GGP's dynamics aimed to promote dialogue, foster participation, and ensure that the research

was conducted ethically. Each meeting was guided by a script and documented by field diaries and audio recordings, which were later transcribed and stored in a database.

The research was conducted in accordance with the ethical principles established by Resolution No. 466, of December 12, 2012[30], which provides guidelines and regulatory standards involving human beings, and by Resolution No. 510, of April 7, 2016[31], which establishes standards applicable to research in the human and social sciences, both from the National Health Council. Participants were assured of the voluntary nature of their participation, the clarification of the research objectives, the confidentiality of their information, and the right to withdraw at any time without any prejudice. All interviews and workshops were recorded and transcribed in full, with the consent of those involved, in accordance with the Free and Informed Consent Forms approved by the Research Ethics Committee of the Federal University of São Paulo (Certificate of Presentation for Ethical Review – CAAE No. 66235417.3.0000.5505, Opinion No. 2,047,444; CAAE No. 68720217.8.0000.5505, Opinion No. 2,198,202; and CAAE No. 76944323.8.0000.5505; Opinion No. 7,122,283).

Analysis of qualitative information

The information was analyzed using Depth Hermeneutics (DH)[32], which proposes the analysis of cultural phenomena, contextualized socio-historically, and a methodology that prioritizes such phenomena and their symbolic forms, within structured contexts. DH is composed of three stages: socio-historical analysis, which seeks to understand the contexts of production, circulation, and appropriation of symbolic forms; formal or discursive analysis, which reflects on the internal organization of symbolic forms, seeking patterns and internal relations within the discourse of subjects in concrete situations of existence; and interpretation/reinterpretation, which articulates the two previous phases, inferring from a new perspective situations and themes elaborated by the subjects, in the light of Social Psychology[32,33].

Results

In contrast to the contemporary crisis governed by neoliberal logic, care is understood here as a life attitude that translates into an ethical-political commitment to the existence of the other, self-care, and responsibility for the sustainability of the planet. This perspective is built upon the meanings of care defended by Boff[18], Pintasilgo[19] and Jonas[34], and marks the trajectory of community leaders who have a history of fighting for improvements in living conditions, referring to the sense of community[35] as an ethical element that guides achievements.

Aspects that are part of a historical process of tension and underfunding of the SUS can be observed in initiatives such as Constitutional Amendment No. 95/201636, which established a ceiling for public spending for two decades and produced significant impacts on health financing. Although later replaced by the new fiscal framework established by Complementary Law No. 200/2023, the logic of containment and dispute over public resources destined for social policies has not been completely overcome. Studies by the Institute for Applied Economic Research (IPEA) on the effects of EC 95/2016 indicated significant losses of resources destined for the federal health spending floor in the first years of the measure's validity, highlighting the impacts of the contingency on the SUS's financing capacity.

In this context, the Previne Brasil program, established in 2019 under the argument of improving the financing and management of PHC, has been criticized for incorporating mechanisms associated with neoliberal rationality in the organization of care[10,37,39]. By introducing weighted capitation criteria and payment for performance, the program tended

to induce the valorization of quantitative goals and indicators, to the detriment of approaches oriented towards comprehensiveness and the needs of users[38,40]. This logic, by reducing the link to registration, tended to strain the construction of longitudinal links between professionals and the community, affecting ethical-political dimensions of care and solidarity associated with the principles of the SUS, especially in contexts already marked by budgetary constraints and processes of reorganization of public management. In 2024, Previne Brasil was replaced by a new methodology for federal co-financing of PHC, established by Ordinance GM/MS No. 3,493/2024[41]. The program's experience, however, remains relevant to the analysis, as it demonstrates how this rationale can be incorporated into the SUS's own financing instruments.

Outsourcing in the health sector, through OSs, is a form of indirect administration of public resources by the private sector, highlighting the contradictions between the State and the market. According to Pilotto and Junqueira[42], the State of São Paulo is the unit of the Federation that concentrates the largest number of this type of administration, bringing negative consequences to the forms of management and the formation of bonds for the effective production of care.

The account of professionals from the USF do Mangue attributes the exacerbation of difficulties in accessing services and the insufficient hiring of professionals to the management of the new OS, in addition to the difficulty in renewing contracts with laboratories, generating waiting lists with no solution in sight, as reported in one of the workshops.

> *[...] what is detrimental to us is the system of the Health Department, the management of the OS. They don't provide the conditions, not only here at the health unit, but at the other units as well, to give better quality care to these people too! Because it's frustrating to go since December without having blood, stool, urine, or Pap smear tests! [...] the gynecologist only sees patients once a week! I always mention this: two doctors is far too few! There need to be three general practitioners!* (Workshop 6, Professional-F/Mangue).

In this workshop, the ACS said that service users 'know how to wait'. Such waiting experiences, imposed by state bureaucracy, according to Auyero[43], deprive marginalized populations of the power to intervene and modify their reality, reiterating and reproducing in their subjectivities the condition of subalternity and passivity.

The most affected by the neoliberal model in Brazil are the poorest or, as Souza[44] and Luna[45] state, the sub-citizens, who have historically been expropriated of their rights since slavery. For Luna[45], health institutions do not problematize the great conflict arising from slavery, which reproduces the condition of sub-citizenship of those individuals who traditionally did not have access to the privileges of the dominant classes.

Poorly structured territories, marked by an exclusionary logic, present conditions that determine the organizational model of institutions and directly impact the lifestyles of those populations. For Pessoa et al.[46], the political-operational dimension of the health system encompasses the territory beyond a spatial limit, considering its history and its demographic, epidemiological, administrative, technological, political, social and cultural profile, characterizing it as being in permanent construction. In this sense, the contradictions experienced in the territories mark the crisis of the neoliberal development model, expressed by the sociodemographic indicators of the territories studied.

In the mangrove swamp, the modes of appropriation of the territory are marked by the cluster of stilt houses. In a workshop with the ACS, the vulnerability imposed by the lack of infrastructure was highlighted.

> *Everything affects health and living conditions. For example, when the tide comes in, it sometimes floods the shack where the person is living. In some*

places, when the tide comes in, rats go inside the houses, especially the wooden shacks. So, this also affects diseases (Workshop 6, professional-F/Mangrove).

In this challenging scenario, coupled with the outsourcing of the SUS, particularly the lack of professionals and low salaries, there is an increase in employee turnover, which compromises the health practices produced by the ESF. This process is related to the incorporation of management models guided by principles such as cost reduction, flexibility in labor relations, goal setting, and performance evaluation – characteristics associated with the neoliberal rationality of health management. These dynamics can contribute to the precariousness of professional ties and the weakening of continuity of care[41]. During a workshop, narratives emerged that revealed the interference of the primary care management model by the OS in the precariousness of the practices of the ACS[47].

So, there are these connections: being a community health worker, you end up having this whole bond with the community... that's for a real community health worker, not these community health workers that are out there, right? Because these community health workers that are out there don't even do the bare minimum [...] The fault lies with the management, not even the government, it's the management (Interview M, Leadership-M/Mangue).

[...] the guy in my area fell and he really needs a physiotherapist who would come over. Will there be one? No way! And what am I going to tell the guy? [...] The other day, I told him: Look, your turn for physiotherapy has arrived, but with one detail... You have to go to Cubatão! [...] but how is he going to get to Cubatão!? I think that nowadays it's not that the humanization of the health center and the people who work there has ended! [...] There are many things you would like to have, but you don't! There's no investment for that! (Workshop 6, professional-S/Mangue).

The narratives express the need for care that goes beyond biomedical rationality. This care is based on the historicity of bonds built in the pursuit of improvements for oneself and for the community, and is grounded in different dimensions of human existence, shaped by positive encounters, individual and common strategies for overcoming and confronting social injustices and the fragmentation of these connections. Here, this care is understood as 'ethical-political care'[48].

The following accounts illustrate ethical-political care and the confrontation of neoliberal logic in the post-pandemic era. The former leader emphasizes the collective and solidarity dimension of care, which goes beyond individual responsibilities and manifests itself in the joint action of health agents and leaders. The health professional highlights the importance of strengthening bonds and support networks, both internal and external to the community. The recognition of the importance of social ties is opposed to the fragmentation imposed by the logic of the neoliberal market in health. The narratives reaffirm the importance of intersubjectivity, solidarity, and dialogue as a light technology[49] for the realization of ethical-political care.

It's not a lack of care on my part, but the care of a very large community. For example, everyone here is well-informed. There are health agents who are visiting homes, there are many leaders who are always working on this, you understand? Many people here already work, and today there are fewer people, but many people here have already rolled up their sleeves, already gone out into the streets, you understand? The care encompasses all of that (Interview with a former leader).

[...] the strengthening of partnerships that we need – we talked about this a lot in our meetings – first, getting to know the networks, what we have within the community, but how much we need to expand this and bring in resources from the outside to work together. I remember talking in our meetings about how much this helps me professionally and

> *how much I feel working together, more welcomed and in the sense of having support to be able to act, because alone we can't do anything. So, this bonding is important, with this network, so that we can develop better work within the community [...] For the benefit of this community* (Psychologist from the Family Health Unit at a GGP meeting).

The devaluation and precariousness of the territory's infrastructure affect health policy. The awareness of health workers in the territory is a result of the absence of actions by the authorities, not only locally, but throughout Brazil, prolonging the pandemic beyond the disease; the consequences were even more severe for vulnerable populations[50].

> *People lost relatives, people changed a lot, and it got worse. There was already a lot of depression, a lot of anxiety attacks, now it's worse. Who can handle this? How can they handle this? They can't, they can't. There aren't enough professionals for this, and the health policy itself doesn't invest in it. This doesn't win votes, that's it – that's the summary!* (Interview with a Community Health Agent).

The ACS's narrative highlights a daily experience of the devaluation of mental health in the field of public policies. By stating that "*this doesn't win votes*", the worker reveals how certain social demands remain invisible when they do not produce immediate political returns. Mental health, marked by prolonged processes of suffering, reconstruction of bonds, and transformation of living conditions, confronts a political rationality oriented towards urgency, visibility, and measurement of results. In this sense, the ACS's statement allows us to understand that the precariousness of care is not reduced to the absence of services or professionals, but is related to a management model of social policies that frequently shifts the responsibility for addressing problems arising from structural inequalities to workers and communities.

This dimension becomes evident in the post-pandemic context when vulnerable territories began to concentrate numerous experiences of loss, grief, and worsening of psychological suffering. However, such demands do not always find correspondence in institutional priorities, keeping mental health in the background within the public agenda. In this scenario, the ESF occupies an ambivalent position, simultaneously marked by the precarization of social policies and constituting a privileged space for the production of care based on connection, listening, and recognition of the subjects' experiences.

Thinking about care as ethical-political implies recognizing that caring is not just about offering technical resources, but about sustaining social relationships capable of producing belonging, protection, and participation[50,51]. Thus, the practices developed in the territory can be understood as forms of daily resistance to the processes of individualization of suffering and weakening of social bonds that intensify due to neoliberal rationalities.

Final considerations

Starting from the weakening of bonds, the methodological strategy of participatory research enabled the creation of dialogical spaces for collective reflection on and with the reality experienced by professionals, community leaders, and researchers. It was possible to consider care as a tool for fighting for rights and the ESF as a privileged locus for confronting the current context of suppressed public and social policies, which objectively and subjectively interfere with living conditions.

The findings indicate that policies such as outsourcing in the health sector and the Previne Brasil program, by introducing market mechanisms and prioritizing quantitative goals, have negatively impacted the comprehensiveness of care, weakening affective and social bonds, and undermining the social, collective, and political foundations of health care. Therefore, from an ethical-political perspective, health is understood, beyond its legal or juridical dimension, as an element

encompassing the three pillars of Brazilian social security (Federal Constitution of 1988) and a commitment to the dignity of individuals.

As a limitation of the study, the specificity of the geographical context and the qualitative nature of the research are recognized, which, despite deepening the senses and meanings, does not allow for generalizations. For future investigations, it is suggested that comparative studies be carried out in different locations, measuring the impact of policies on a larger scale and exploring strategies for strengthening the ethics of care in scenarios of increasing expansion of neoliberal logic. Historicity enables a dynamic understanding of reality, which is always changing.

Finally, health policy should consider the perspective of ethical-political care as a tool for exercising social justice, to seek the denaturalization of inequality in peripheral capitalist societies and to promote not only health, but also life, dignity and the guarantee of rights.

Authorship contributions

Castro-Silva CR (0000-0002-8880-1042)* contributed to the conception and design of the research, data analysis and interpretation, funding acquisition, drafting, and critical revision of the manuscript regarding intellectual content. Yagiu H (0000-0002-3860-2061)* contributed to the acquisition, analysis, and interpretation of the data, drafting, and critical revision of the manuscript regarding intellectual content. ■

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