

Health promotion programs within supplementary healthcare in Belo Horizonte, MG, Brazil: concepts and practices

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This study aimed to analyze health promotion programs developed by healthcare plan operators. This was a multiple case study with a qualitative approach. The data were obtained from interviews with forty participants, comprising managers, professionals and beneficiaries of six healthcare plan operators in Belo Horizonte, Minas Gerais, Brazil. Observations were made among participants in health promotion programs. The analysis showed that a behavioral approach towards health promotion is prevalent. The characteristics of the programs made it possible to differentiate them as traditional, transitional or innovative. The findings suggest that there have been changes in the logic of healthcare production, but with reduced potential to initiate transformation. It was concluded that there is a need to support operators regarding the concepts and models of health promotion so as to induce changes and innovations.

Keywords: Health promotion. Supplemental health. Qualitative research.

Introduction

Supplementary health is formed by the health actions and services provided by the private sector to the Brazilian National Health System (SUS). It started in Brazil in the 1970s, during the crisis of the social security medical model and a strong increase in the provider-company modality¹.

The regulatory framework of supplementary health took place in 1998, with the publication of Federal Law 9,656, which regulated the private health insurance plans in Brazil. Subsequently, in January 2000, Federal Law 9,961 was published, which created the National Supplementary Health Agency (ANS) to develop the national public regulation strategies^{2,3}.

In order to align the actions and services provided by supplementary health to the guidelines of public health policies, the ANS created, in 2005, a change induction process in the health care rationale. Among the strategies used by the regulating agency, qualification of care through incentives to the incorporation of practices that go beyond the clinical medical care, which is prevalent in the sector, stands out⁴.

One of the efforts to influence the quality of care provided in supplementary health may be translated by the Qualification Program of Supplementary Health. In this program, evaluating the performance of providers is accomplished through the Supplementary Health Performance Index (IDSS), calculated by using indicators defined by the ANS, among which there is the registration and monitoring of health promotion programs⁵.

Health promotion programs are one of the strategies the ANS has to influence changes in the organization and provision of services offered by providers of health insurance plans⁴. However, despite recognizing the incorporation of new practices, it is pertinent to ask questions about the dynamics and concepts that support them. Despite the definitions of the ANS, it is assumed that the limitations of supplementary health are related to the concept of health promotion with a repercussion in the programs developed within this field.

The health promotion ideas refer to theoretical and conceptual ideas, political and ideological, which may be taken as possibilities for reforming the sector⁶. The conceptual framework introduces some guiding categories, among which stand out: empowerment, autonomy, and multiple accountability. These categories are taken as *sine qua non* conditions for promoting health, as they

represent the ability of individuals to make choices and create ways to address issues related to everyday life, which are more creative, supportive, and movement triggering⁷.

It is believed that the increase in health promotion proposals in the supplementary network may represent a significant positive impact on the health of beneficiaries of health insurance plans. However, although there is interest in expanding and regulating health care practices that break with the biomedical and hospital-driven paradigm, programs developed by the supplementary sector are still little known and poorly analyzed⁸.

Moreover, considering that supplementary health in Brazil is characterized as an industry supported and permeated by an economic rationale and made up of agents with opposing interests, it is assumed that programs aimed at promoting health and preventing disease may be sustained in a disciplinary conception of surveillance and control whose primary goal is reducing costs.

It is worth emphasizing that health promotion may produce positive outcomes in supplementary health through the incorporation of programmatic actions directed to people with chronic and degenerative health problems, besides the implementation of transformative practices with intervention on the social determinants, to the detriment of the main demand for spontaneous care that has marked work both in the public and private subsystems.

To support a discussion about the potential of health promotion to generate change, a study was conducted in order to examine health promotion programs developed by providers of private health insurance plans.

Methodology

Herein, a qualitative and exploratory study was conducted, anchored in the theoretical and methodological framework of hermeneutics-dialectics. Concerning the interaction between hermeneutics and dialectics, both refer to praxis structured by tradition, language, power, and work. However, while hermeneutics emphasizes unity of meaning and consensus, dialectics is aimed at the search for obscure and contradictory cores to support some criticism^{9,10}.

A study of multiple cases having a methodological pathway divided into three stages was conducted: exploration, field work, and interpretation of data.

In the exploratory stage, we seek to identify and recognize the providers that develop programs to promote health and prevention disease in Belo Horizonte, Minas Gerais, Brazil, and/or its

metropolitan area, through search in the database of the ANS. In this survey, 79 providers were identified, among which the 39 that met a range of over 5 thousand living beneficiaries were selected.

In the universe of 39 providers, we tried to identify those that offer programs to promote health and prevent disease. This identification proved to be very challenging, since the information on the promotion and prevention programs by the providers are not overt and not all of the programs developed are registered in the ANS.

Out of the 23 providers that confirmed by telephone the development of programs to promote health and prevent disease, 6 accepted the invitation to participate and they were included in the second stage of the study.

Fieldwork was conducted in two phases: in the first interviews were conducted with representatives of the providers' management and/or health promotion and disease prevention programs' coordinators; the second consisted of participant observations of the activities of programs under analysis and interviews with professionals and beneficiaries, in order to improve knowledge on the phenomenon under study.

Thus, the empirical corpus of the study consisted of 4 interviews with providers' managers, 5 interviews with health promotion programs' coordinators, 1 interview with a manager of an outsourced provider, 14 interviews with professionals, and 16 interviews with users, totaling 1,013 minutes in audio recording. The corpus also included 33 pages of notes in a field diary, related to observations of the practices under study.

The interpretation of the set of 6 cases studied was carried out through the synthesis of a crossed cases strategy proposed by Yin¹¹. Following the author's guidelines, the thematic categories deriving from the cross-reading of the 6 case studied were discussed by establishing links between data and the related scientific production, setting movement, at the same time, comprehensive and critical, supported by the hermeneutic-dialectic framework. In this process, empirical data were compared and related to other studies.

To ensure the anonymity of institutions and agents in the study, social and business names have been omitted. Thus, the characterization of providers was organized into a random number sequence (1-6) and codes were assigned to the agents interviewed, according to the following example: Manager Prov1 and Physical Therapist Prov1 correspond to the interviews with a manager and a physical therapist from provider 1.

All stages of this study complied with the ethical precepts of research involving human subjects and the project has been approved by the Research Ethics Committee of the Federal University of Minas Gerais (UFMG).

Results

Through the analysis of programs of the six providers of health insurance plans, it was possible to identify the diversity of themes and ways of working that make up the health promotion field within supplementary health.

The incorporation of health professionals without Higher Education in Medicine and group activities are striking in the programs. In addition, the study revealed that there is a heavy investment in programs aimed at physical activity, the elderly, and obese patients. This information is summarized and displayed in Table 1.

Table 1. Summary of health promotion programs analyzed in the providers under study (Belo Horizonte, 2013)

Prov	Program	Objective	Methodology	Professional	Beneficiaries	Observations
01	Adolescentes	Prevent biological and psychosocial risks	Group discussion, group dynamics	Psychologist and adolescent's physician	Young individuals aged from 11 to 17 years	Interactive discussions on behavior and habits
01	Physical fitness	Fight sedentary lifestyle, promote socialization	Aerobic and anaerobic activities	Physical therapist	Predominance of the elderly	Affection and bond between beneficiaries and professional
01	Postural awareness	Improve flexibility and	Aerobic and anaerobic	Physical therapist	Predominance of the	Affection and bond

		strength	activities		elderly	between beneficiaries and professional
01	Memory workshop	Exercise memory to prevent deficit	Dialogued exposition, written and verbal exercises	Psychologists	Predominance of the elderly	Encouraging self-care, cooperation, and socialization
01	Elderly dancing	Concentration, memory, and flexibility	Group choreography	Physical therapist	Predominance of the elderly	Pleasurable activity that promotes socialization and bonding
02	Obesity treatment	Behavioral changes in pre- and post-bariatric surgery	Dialogued exposition, psychological support, group dynamics	Psychologists, nutritionist, and invited professionals	Obese patients with surgical indication	Collective discussions with sharing of experiences and self-help methods
02	Food reeducation	Changing habits	Dialogued exposition, psychological support, group dynamics	Psychologists, nutritionist, and invited professionals	Overweight, without surgical indication	Collective discussions with sharing of experiences and self-help methods
03	Occupational	Occupational	Group	Physiotherapists	Employees of	Alternative

	health education	accident prevention	dynamics	pist and interns	a call center	and creative method to promote timely discussion
04	Obesity control	Prevent surgery and diseases, change habits	Physical activity, group meetings with psychologist and nutritionist	Physical therapist, physical educator, psychologist, nutritionist	Individuals with overweight and/or related diseases	Focus on changing lifestyle habits through activities, consultations, and group discussions
05	Pregnancy and puerperium	Educate about pregnancy and newborn infant care	Lectures	Obstetrician, pediatrician, dentist, and nutritionist	Pregnant women and their companions	Transmission of professional information for beneficiaries
05	Nutrition	Promote weight loss by changing habits	Lectures	Nutritionist and psychologist	Individuals with overweight	Transmission of professional information for beneficiaries ; change in focus
06	Yoga	Physical, mental, and spiritual well-	Classes	Professional trained as yoga	Predominance of the elderly	Interactive, participatory, continuous,

		being		teacher		and interconnect ed group
06	Physical activity	Healthy habit	Aerobic and anaerobic activities	Physical educator	Predominanc e of the elderly	Interactive, participatory , continuous, and interconnect ed group

Source: Prepared by the authors.

Educational health processes permeate all programs analyzed, but there are differences in the forms of approaching and the themes worked on. In this domain, programs such as Obesity (Prov4), Nutrition, Pregnancy, and Puerperium (Prov5) are characterized by keeping their focus on disease genesis and prevention, besides highlighting health professionals and vertical information transmission.

The lecture went on with unilateral speech by the nutritionist. Over time, pregnant women began to show fatigue signs, evidenced by restlessness, inadequate posture in the chairs, and inattentive look. (Observation notes for the pregnancy and puerperium program of Prov5)

In health, the individual studies a disease, treatment, disease progression, but forgets that people are unique, have their life history and habits. [...] If we had an hour to identify the profile of that group, to work for that group, rather than following a robotic procedure like we do... (Physician Prov5)

Besides, programs have been identified that, although keeping focus on traditional themes such as disease prevention and control, innovate by incorporating methodologies and dialogic and reflective work technologies, such as the programs for Adolescents (Prov1), Obesity treatment (Prov2), and Occupational health education (Prov3).

I think it is time to teach them to resort to self-care, I think everything starts in adolescence, with reflection. [...] We use group dynamics because it is more interactive, sometimes young individuals prefer to use creativity. (Psychologist Prov1)

Themes were created directing our work, such as food reeducation, anxiety, self-esteem... These themes were defined based on the demand by groups and they are worked on through group discussions and group dynamics. (Psychologist Prov2)

To finish group meetings, the psychologist performed group dynamics or reading of motivational thoughts to encourage attitudes to overcome challenges. (Observation note on the program obesity treatment of Prov2)

To start activities, after a relaxation moment, the psychologist introduced the themes of workshops through associations with everyday life situations or reflective text reading. The activities that make up the workshops include: exposition of themes, such as spatial memory and memorization techniques; use of images and exercises designed in data show to enable group activities with verbal participation; individual and written exercises that are shared with the group after construction; motivational reflection messages in the end of activities. (Observation notes on the program Memory workshop of Prov1)

Programs have also been identified that are not necessarily limited to issues related to diseases and patients, but their premise is promoting bonds and socialization of beneficiaries. From this perspective, we may take as examples the programs Memory workshop from memory and Dancing for people over 60 years (Prov1), Yoga (Prov6).

They recognize the benefit of dancing, but remain because of socialization, such a friendship. So, I think it strengthens the group. (Physiotherapist Prov1)

The dance group has impact on my emotional life, it is almost a family.
(Beneficiary 5 Prov1)

[...] it is very good, the group, teacher is excellent and we make such a good
friendship. (Beneficiary 2 Prov6)

They enjoy coming to the class, they are integrated, agree with everything, like
new things. (Yoga teacher Prov6)

Quality of life, memory deficits prevention, and socialization were revealed as motivations for beneficiaries' participation in the programs. The concepts of health for beneficiaries are related to good habits and living conditions, as well as motivations for losing weight and preventing complications and limitations posed by overweight. In addition, responsibility for self-care was attributed to each one individually, with family support.

Look, I think I am responsible for my health, because if I do not do it, you know, my son, regardless of how much he likes me, cares for me, advises me, he will not do what I need. [...] Health means living well, eating well, sleeping well, and providing the mind with a healthy attitude, right? My motivation is the need to not losing memory, indeed, staying updated, because I had a very sad experience, I do not know if I told you that my husband had Alzheimer [...].
(Beneficiary 3 Prov1)

I had two strokes and I always put it aside, and I have a whole obese family. Now, age is coming, there will be knee pain, high blood pressure, then I said 'I do not want to be like this, I want to change', so, there is still time to change, and it was through this that I said 'enough'. Now, I am going to change my life.
(Beneficiary 2 Prov2)

I participate in the group for four years, I came here referred by my cardiologist. My blood pressure was high and I weighed 10 kg more. Here, we exercise under

good monitoring, you do not see it in gyms. There are also groups with a nutritionist and psychologist who really help us a lot. It is a set, you know. (Beneficiary 3 Prov4)

Despite the differences between programs, from the perspective of the providers' managers and the programs' coordinators it is usual to focus on controlling risks and behaviors, through practices to standardize life habits regarded as healthy, with a view to decreasing costs by reducing the consumption of a high-cost service.

We keep saying all the time to try convincing a mother that needs to change habits for that child in order to have healthy living, with a focus also on cost reduction. (Coordinator of the programs of Prov5)

I think it is a framework for the provider, because it is not every health care company that has a health promotion and disease prevention program. So, it is important, because you have a differential treatment to these beneficiaries. We can follow them up much better and there is cost reduction. (Coordinator of the programs of Prov2)

So, we have several activities whose goal is putting in people's minds the idea of healthy living. [...] Aging less sick, it might decrease the loss ratio of the portfolio. [...] It is clear that there is a human issue, the person actually has quality of life, but of course that is not all, there is a whole cost context involved there. (Manager of Prov6)

Take the case of a Chronic control patient: as it does not hurt, the disease, it is silent, they are undisciplined, so, they generate me a high cost during their treatment, because they do not come to my consultations, there is a very significant absenteeism. Then, working with this patient is difficult, because I lose my medical time that I could provide for someone else, who needs it. I

cannot bring this patient because he is not convinced of the importance. We also have the staff time demand, which is wasted. (Coordinator of Prov5)

The speeches below reveal that strategies related to health promotion programs aimed at changing the lifestyle of people involved, through scientific knowledge that point out the normality and health standards.

Promotion is access to information, offering a range of information for him [the beneficiary] there, so that he becomes aware and changes his lifestyle and he does not get sick. (Manager of Prov2)

The primary purpose of the groups we have today is getting them to actually change their lifestyle. [...] It is much more consistent when you work with health promotion by preventing disease than work on an already installed disease, something which is more expensive, harder, both economically and in terms of high-complexity time. (Psychologist 1 Prov2)

[...] If you do not know the people whom you are working with, you do not really works on the risk factors. [...] Changing the habits of a person who wants to quit smoking is very difficult. [...] Working with health promotion means changing lifestyle. (Coordinator of Prov3)

Disciplinary and controller focus, striking in the programs under analysis, it was revealed in the discourses that utter the goal of “teaching and convincing” people on healthy ways to live life and adhere to rules and standards:

It is teaching people to make smart choices, healthy choices. [...] That is what we want change, we want to get these people to have intelligence in choosing the best food, the best meals. In the first meeting, she asks them to write down their food choices and, in the second meeting, she discusses what is right and what is wrong. (Coordinator of Prov3)

Summarizing it all in an only word might mean talking of lifestyle change, this is what we are seeking. Then, the diabetic, who is a difficult patient to treat, we want to convince him about the importance of healthy eating, physical activity [...] The chronic control patient, as it does not hurt, the disease is silent, they are undisciplined, so they generate me a high cost in their treatment because they do not come to my consultations, there is a very significant absenteeism. Then, working with this patient is difficult, because I lose my medical time [...]. I cannot bring this patient, because he is not convinced of the importance. (Coordinator of Prov5)

Here, we try to convince people that there is no use to sew the stomach, you have to change thinking. (Psychologist 1 Prov5)

People do that because they feel obliged to do so, because the world speaks today of health promotion. (Coordinator of Prov3)

Discussion

The dataset raised discussions about the health concepts and promotion practices observed in the programs of the providers under analysis. In this sense, the concept of guiding health concerning health promotion practices was identified from the perspective that sees health as physical and mental well-being, conditioned by biological and behavioral factors driven by the individual. The restriction of this concept to the proximal determinants of the health-disease process was revealed through the intervention of objects that are usually related to people's lifestyle, sick people, and those who are at an increased morbidity risk.

Regarding interventions on habits and lifestyles, the study showed programs focused on standardization of procedures, through recurring approaches to physical exercise and eating habits. Emphasis on these aspects is related to the goal of modeling the behavior of people in the name of health and quality of life¹². Other studies also discuss the limit of this action on lifestyles and habits, with a strong emphasis on individual accountability¹³⁻¹⁵.

The concepts of health and the interventions to promote it that emerged from data analysis are believed to encompass the focus proposed by the Lalonde Report, in the 1970s. The emphasis of this report was aimed at interventions on the lifestyle of individuals with a view to coping the high costs of medical care, associated with the State bankruptcy model of social welfare¹⁶. Thus, the responsibility for adopting healthy habits and behaviors had a strong individualistic nature, reflecting on moralizing and blaming actions.

It is also noteworthy that the results show that the programs named by providers as health promotion have essentially preventive features, as they are focused on preventing diseases and complications by changing behaviors to favor the adoption of habits preconceived as being healthy. The conceptual confusion within the health promotion field and the plurality of approaches that the field covers has undergone discussions¹⁷⁻²⁰.

By assuming plurality, we may distinguish three approaches within the health promotion field: biomedical, behavioral, and socio-environmental²¹. The first conceptualizes health as absence of diseases and sees biological conditions as major determinants in the health-disease process. The second adds the individuals' mental well-being to the concept of health and recognizes behavioral factors as health determinants. The socio-environmental approach, also referred to as 'new health promotion', expands the understanding of health by focusing on its social, economic, cultural, political, and environmental determinants, in addition to the biological ones⁶.

The behavioral concept, which is also addressed as a conservative perspective of health promotion¹³, is supported on the medical rationale that establishes normality standards and creates mechanisms that make individuals accountable concerning the preservation of their own health, regardless of the socioeconomic, cultural, and environmental factors, which are the distal determinants of the health-disease process.

In this light, the responsibility for developing diseases is directly related to risk attitudes with attribution only to individuals. The individualistic nature of this concept may result in blaming those who do not undergo or do not reach the decisions dictated by those who prescribe the correct and healthy way of living¹³.

In addition, the focus on risk translates a redefinition of the notion of danger from the viewpoint of the 'domestication of the future'²². To adopt it, mechanisms to control individuals are established, which become more appropriate to the relations of strength and the organization modes of

contemporary society, since the approach to risks is often dressed with persuasive and permeable subtleties, vascularized, almost invisible²².

From this perspective, the programs analyzed make clear forms of power over life, instituting ways by which people should live without considering their wishes or possibilities. They reveal, therefore, how biopolitical devices that, focusing on behavioral aspects, establish strategies aimed at controlling life in its various production forms, through prescriptive acts devised by hegemonies²³.

However, in the process of creating biopolitical standards, people assume the existence of a network of micropowers often operating in opposite poles that now tending to keep a conservative rationale, then introduces other perspectives in the field. Thus, the study revealed programs that signal changes at different depth spheres, with features that make it possible to differentiate them as traditional, transitional, and innovative.

The trend regarded as traditional was clearly revealed in the programs that use expository educational practices based on preventative ideals, which prefer to prescribe behaviors defined by health professionals, having no critical dialogue with the beneficiaries to clarify their possibilities and desires. From this perspective, individuals' autonomy, a principle of paramount importance for health promotion ideas, was not revealed in those programs. The use of a behaviorist education model was found, where the health professional figure is key to decide what should be taught.

We regard as undergoing a transition those programs that, although keeping focus on traditional themes, innovate by incorporating rather relational technologies that appreciate the sharing of feelings and needs, through dialogued education processes and the use of instruments to encourage reflections, such as group dynamics, movies, and manual constructions. In these practices, professionals act as facilitators of the process, by instigating discussions and putting into question the issues addressed, but they leave some room so that participants themselves aim the discussions according to their wishes.

These programs keep their focus on individual guidelines and suggest the existence of a psychological approach to empowerment²⁴ as a strategy whose goal is strengthening self-esteem, besides developing self-help mechanisms and adaptation to the environment. Such an empowerment contributes, at most, to produce a regulated autonomy, where the feeling of power creates the illusion of an effective existence of power.

Within the programs that may be regarded as innovative, stand out the groups of yoga, dancing, physical activity (Prov1 and Prov6) and the memory workshop. In these, still remains the centrality in the individual, however, there are advances in the recognition that social interaction, the creation of bonds

and psycho-emotional well-being are strong for promoting health. Group activities help to strengthen the bond between participants in the practices and between them and professionals, expanding trust relationships²³, crucial for a transformative praxis in health work.

It is known that the complex proposal to promote health involves working with macrodeterminants, such as coalitions for advocacy and political action, but also the uniqueness of the individuals' subjective experiences, through the meeting with their peers and the relationship with themselves. Both dimensions are not mutually exclusive, but they complement each other in the understanding of all aspects that go through the health promotion field⁶. This article has deepened on aspects regarding health promotion microspaces in the context of health insurance providers and it reveals the need for further studies to explore issues on the political macrostructure and public regulation.

Concluding remarks

A qualitative study shows constraints for not allowing statistical generalizations, since it is the analysis of a particular reality. However, the results of studying multiple cases allow the creation and expansion of theories that may be compared and related to the results of other studies conducted in different scenarios.

In this study of multiple case, it is concluded that the growing incorporation of health promotion strategies in the supplementary health sector suggests the interest of providers to invest in changes in the supply of health care services. This analysis may be supported by the introduction of new working methods, which are developed in other spaces that go beyond the physical limits of hospitals.

In this domain, some programs include groups of beneficiaries who, until then, were perceived only when they sought clinical medical care for a spontaneous demand. The inclusion of new professional categories, in addition to the physician, also suggests change and it may contribute to an assistance driven by the principles of comprehensiveness.

In the analysis on the depth of changes brought about by health promotion practices, nuances were identified between programs that allowed classifying them as traditional, transitional, and innovative. The innovations shown by some programs are primarily related to the incorporation of working methodologies that go beyond the vertical transmission of information and allow a creative interaction between agents, as well as appreciation of the relational aspects of health care.

The innovations revealed herein have a potential to impact the hegemonic care model practiced in supplementary health, but need to be expanded so that they are not limited to those regarded as risk groups.

Despite the innovations disclosed, no evidence of transformations was identified in the conceptual and practical health promotion field, since there is a prevalence of a behaviorist approach. This proposition is grounded in the predominance of programs aimed at lifestyles, in order to prevent diseases regarded as expensive, to the detriment of the use of networking, beneficiaries' participation in decision-making, and interventions related to social determinants.

The transformation sphere covers the essence of the process of practices, the adoption of new paradigms, and the social determinants approach. In this sphere, there are interventions that result in global changes of contents, processes, and relations, featuring actual transformations in the health promotion field.

Thus, the changes revealed are incompatible with the most modern and transformative approach to health promotion, which takes the premises of empowerment, social commitment, holistic approach, intersectoral approach, equity, and sustainability. It is believed that the prevailing economic rationale in the supplementary health sector is contradictory with regard to the sociopolitical ideas of health promotion. This discussion points out the need to align the public and private subsectors, so that it is possible to achieve a health policy more consistent with the precepts of SUS.

Contributors

Andreza Trevenzoli Rodrigues and Kênia Lara Silva have worked together in all of the manuscript production steps. Roseni Rosangela de Sena has participated in the discussion of findings and general manuscript review.

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