Interfaces between territory, environment and health in primary care: a bioethics approach

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Resumo

Os desafios éticos da saúde pública são atravessados por determinantes macro e microssociais, exigindo que o serviço esteja focado no território de abrangência e nas necessidades de sua respectiva população. Por isso, entender as interfaces entre território, ambiente e saúde é importante. Território é o espaço das sociabilidades cotidianas do grupo social que o habita, não reduzido aos limites administrativos. Saúde depende tanto do micro território quanto do macro ambiente natural e societário, pois ambos configuram os determinantes sociais da reprodução da vida. Assim, o primeiro desafio ético é a construção de um modelo de atenção que integre cuidados primários e conhecimentos da vigilância sobre as necessidades em saúde daquele território. Outro, é a construção de ações intersetoriais politicamente articuladas e pactuadas para enfrentar os determinantes sociais e os danos ambientais que afetam a saúde daquela população no sentido da melhoria de sua qualidade de vida.

Palavras-chave: Bioética. Saúde pública. Atenção básica à saúde. Vigilância em saúde. Território. Ambiente. Determinantes sociais da saúde.

Abstract

Interface between territory, environment and health in primary care: a bioethics approach

Ethic challenges of public health are traversed by micro and macro social determinants, requiring the health service to be focused on the scope and its population's needs. Therefore understanding the interface between territory, environment and health is important. Territory is the space of the daily sociability of the social group who inhabit it, not reduced to administration limits. Health depends both on the micro territory and the macro natural and social environment, since represents the social determinants of life reproduction. So, the first ethic challenge is the construction of an assistance model which integrates primary care and the surveillance knowledge on the health needs of this territory. Another challenge is to build intersectoral actions, politically jointed and compromised to face social determinants and environmental damages that affect the health of population, improving their life quality.

Key words: Bioethics. Public health. Primary care service. Health surveillance. Territory. Environment. Health social determinants.

Resumen

Las interfaces entre territorio, ambiente y salud en la atención primaria: una lectura bioética

Los desafíos éticos de la salud pública están atravesados por determinantes micro y macro sociales, exigiendo que el servicio esté enfocado en el territorio de abarcamiento y en las necesidades de su respectiva población. Por eso entender las interfaces entre territorio, ambiente y salud es importante. Territorio es el espacio de las sociabilidades cotidianas del grupo social que lo habita, no reducido a los límites administrativos. Salud depende tanto del micro territorio, cuanto del macro ambiente natural y societario, ya que ambos configuran los determinantes sociales de la reproducción de la vida. Así, el primer desafío ético es la construcción de un modelo de asistencia que integre cuidados primarios y los conocimientos de la vigilancia sobre las necesidades en salud de aquel territorio. Otro desafío ético es la construcción de acciones inter-sectoriales políticamente articuladas y acordadas para enfrentar los determinantes sociales y los daños ambientales que afectan la salud de aquella población en el sentido de mejorar su calidad de vida.

Palabras-clave: Bioética. Salud pública. Atención primaria de salud. Vigilancia en salud. Territorio. Ambiente. Determinantes sociales de la salud.

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Declaram não haver conflito de interesse.

Long standing ethical conflicts on hospital clinics were reflected by medical ethics and, more recently, by clinical bioethics, having as prevailing guidelines the traditional bioethics principles and the Code of Medical Ethics (CME) standards. Usually the bioethics tendency to solve cases by applying principles was called principialism - which was criticized for its insufficient attention to the social context and the circumstances of the particular case. Due to the difference between the hospital logic and the expanded primary care clinical logic, it is not possible to consider the ethical problems of the latter in the paradigm of the first, once both are characterized by their own specificity[1].

In primary care, health needs and ethical issues resulting from the attempt to respond to them are always fundamentally traversed and configured by the user's and the professional's subjectivity, by their environment and their respective social and cultural contexts. Therefore, the reality of primary care requires an ethical hermeneutics to interpret and ponder critically from the facticity of the context in which ethical problems happen, configuring them as ethical challenges – the base to find paths to the solution.

Here, it is necessary to keep in mind the difference between ethical conflicts that often occur in the hospital clinic where there is a conflict between different possible solutions (eg., to shut down or not the devices which keep someone alive, but already in death process). To solve them, it must be considered the principles and duties involved in the case. Ethical challenges require broad answers that are not clear at first glance, demanding hermeneutics, debates and a collective pact for finding the way to respond to the requirement implicit in the challenge, since there are realities to be built (eg., how to meet a patient with chronic conditions).

The answer to this - ethical - challenge depends not primarily on duties or normative, but on the involved values, demanding the hermeneutic context. In most cases, this answer has a collective dimension. Primary care deals more with ethical challenges than with ethical conflicts. As a result, their response demands are more pragmatic than dramatic [2], given that it involves more challenges than ethical conflicts. In this context, this present article assumes a understanding of bioethics on primary care

Primary care has emerged to respond to a broader view of health needs, being the reference point to any ethics on primary care. All problems and ethical challenges are generated by the work processes and the organization of a system that will answer to these needs in a given territory and environment.

Needs are experienced individually and determined by its context, but must be thought and organized in the collective, once it is in the collective where the demand is socially configured. The seek for an answer of a need determines the demand and triggers work processes in an attempt to resolve it. In the current primary care model the responsibility for these processes belong to the team, not only the health professional. This work logic requires a new professional subjectivity which emerges from a training and health education model based on competencies as the democratic participation and co-management, once the practices need to go beyond clinical responsibility, reaching the scope of health responsibility.

These two determinations of the primary care logic - individual health needs, which have to be solved in the territory and in the collective and work processes organized as a team to respond to them - point to a possible ethics configuration to solve ethical challenges that may arise in primary care.

Considering the specificity of this health care level and the centrality that it assumes for the effectiveness of the health system, this article aims to show and reflect on the ethical challenges that are, above all, the interface between territory, environment and health. This general purpose unfolds, on the one hand, the discussion about the challenge of a team rethinking for a care model that addresses this interface and, secondly, to the need to build intersectoral actions to respond to the health needs of a given territory. To answer these concepts there are two central objectives: the understanding ecosystem health that arises from the interface between territory, environment and health, pointing to the public health surveillance model, and the vision of environmental justice that arises from the realization of the social health's determinants, requiring intersectoral policies beyond health sector.

Territory as a space of everyday sociability

In traditional geography, in the legal and political sense, territory has always been understood as a space limited by power structures [3]. Therefore it corresponded to the area bounded by the borders of a country, state, county or district. The limits artificially determined responded to an administrative con-

trol criterion - however, it is necessary to emphasize that territory also includes the ethological sense, alluding to the space required for animal survival.

The new geography is centered on a territory conception built by inter-relationships and exchanges of the daily social life of a specific society as a symbolic meanings space. This is the space concept proposed by the Brazilian geographer Milton Santos [4] as an inseparable objects system's set (fixed) and actions (flows) that are presented as witnesses of written past and present processes. On a natural environment, human social groups leave their marks on fixed material structures and on circulation and flows routes that build up the symbolic space of daily sociability and socio cultural identities. The territory is identified with the socially organized geographic space. Therefore, the territory is a social space, real and objective, crossed by values and cultural meanings of subjectivity, not having defined limits once it is characterized by its symbolic dimension, not identified by territorial administrative criteria [4].

Considering the mentioned issues, the territory thus formed is the construction and operation place of the social support networks in the community who inhabit it. Being part of this everyday sociability space sets up a factor that determines the people's identity as a specific group and defines the skills to participate in networks and access the services offered by this symbolic social space.

The vision of the territory in this perspective implies to give an intrinsic identity to the constitution of social life, either within the powers organization, either in the production and distribution forms of resources. Living and occupation conditions of territories in various social and environmental settings are a result of the relationship between economic and social development, from which derive the remaining life quality indicators of a given population. These indicators reflect the level to meet the life's basic needs that must be dealt with in the relationship state - society, through public policies and social regulation mechanisms. Among the basic needs, health appears as one of the most essential, in view of its permeability and influence not only in socio-demographic profiles of the population, but especially considering its social development potential.

The socially configured territory determines the health situation of the population that inhabits it, being the health dialectically linked and determined by that social space, enabling the emergence of social support networks and interaction. Consequently, a full understanding of health includes the spatial conditions for the social life reproduction or life quality, since the social space offers the support, resources and tools to respond to any breach of the vital balance. Thus, health is resilience or ability to react - depending essentially on the collective environment that constitutes the geographic space.

Under this perspective, the healthcare system services must work in interaction with the social space. The effective access and response to the needs depend on their integration with the everyday sociability scenario, which is not simply identified as an administrative territory. This is the only way to detect contexts of vulnerability and to collect effective epidemiological data on the health status of that community. Therefore, the concept of territory management and health practice has always acquired greater importance [5], following the insights of Santos [6] about geographic space and the arise of a new knowledge field on the interface between geography and health [7].

This understanding manifests itself, for example, in the territories of the Family Health Strategy (FHS) staffs, understood as a daily sociability space and not as a territory defined by numerical and administrative criteria. The attention to the environment is one of the characteristics of the strategy and a role of the community agents. This environment is not only the natural ecosystem, but the suitable space for social use by the people and the projects that are part of it. This settlement answers often to opposite interests, generating conflicts that externalize environmental and social costs imposed on the health of members of that territory. This close interaction between health and geographic space requires thinking about the environment as a place of social life and health reproduction under an ecosystem perspective.

Environment and social life reproduction

Regarding the relationships between health and living conditions, the Argentine sanitarian Juan Samaja [8,9] understands the environment as a place of social life reproduction. For him, the health sciences aim *meetings and transactions between various valuations and regulations spaces of problems that social reproduction presents in all spheres of human social behavior: biosocial, social and cultural, social-economic, and ecological-political* [10].

According to the perspective of Samaja, *the object health comprises the concepts and practices of health workers of 'biocomunal' spheres (biological reproduction and environmental); 'commu-*

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nal-cultural' (consciousness and conduct); 'corporate' (associative and economic reproduction) and; 'state' (ecological reproduction policy). This health focus in the social reproduction of the living space goes beyond the pure discipline of medicine, leading to an ecological, anthropological, sociological, legal, economic and environmental epidemiology[11]. To Samaja, living conditions determine health situations. Therefore, under his interpretation, *health situations should be studied from the perspective of living conditions. This means that if the WHO definition of health is a complete state of well-being, then it is inseparable from the life conditions, and one can only define it as the control of the social life reproduction. In other words, health is itself the regular order of this reproductive movement*[12].

The understanding of the environment as a place with conditions for the social life reproduction, proposed by Samaja, is a macro expansion in size of what is said in micro size towards the area as a place of daily sociability, because, besides the natural, the environment includes cultural, social and political ambience. This is the difference between a socially organized and used territory and an environment as a wide living conditions' place. Health and life quality depend on both, the territory crossed by the social daily life and the wider social life reproduction environment.

To understand the environment as a condition set of for the social life reproduction it is advisable to incorporate the concept of social capital in its dealing with health. For Bourdieu, *social capital is the aggregate of potential or current resources, related to the possession of a durable network of more or less institutionalized relationships of mutual recognition and acquisition, or in other words, the participation in a group that offers to each of its members, the recognition of the capital owned by the community, giving them a credential that enables them socially in many senses of the word*[13].

Social capital comprises two aspects: the social dynamism of the supporting networks of a community and the accreditation for social participation offered by the community to its members. Therefore, from the perspective of Bourdieu, without consistent and dynamic social networks there is no credentialing and empowerment of the members for participative social relations. The two meanings of social capital are closely related: as the dynamism of social support networks (process) and as accreditation for social participation (product).

Social capital connects people, transforming relationships into a source of resources for a common wealth. While social disintegration results in attitudes for individual goals, social cohesion benefits all aspects. Cohesive communities will more likely support an environment where health behaviors are facilitated, as well as giving access to resources that may improve life quality. Thus, the importance of the social capital for FHS, once it recognizes the value of social networks, reciprocity standards, mutual assistance and trust. Each community has a set of norms and beliefs that can serve to create and sustain policies. Health promotion networks generated with community participation improve self-efficacy and trust of people in their ability to act. Allow people to make joint decisions and negotiate with their peers[14].

In the perspective of the social capital, health and environment are closely interlaced, because the environment is identified with the space of social relations and living conditions that enable the social health reproduction. The lack of social capital determines an environment that does not provide the access conditions to the necessary resources for life and health quality. This close interaction between health and social environment leads to health understanding as an ecosystem.

Health understanding as an ecosystem

The ecological paradigm is a critique of the scientific reductionism, which breaks up the perception and hinders a systemic view of the environment, with its history of impact on its own understanding of human health. The relationship between health and the environment has always been a concern for a long time and replied the cause of diseases with the miasmatic comprehension. The disease was understood as a reflection of miasmas present in the environment. This was a primarily environmental explanation of the disease[15].

The bacterial revolution radically changed this conception because the diseases are not caused by pestilent air, but by microbes that reside in the patient's body. The environment continues to be important as a place inhabit by the diseases transmitting vectors. The disease is not carried by the miasma, but by the microbes' contagion of that environment. Thus emerges the medical ecology, which will study the interrelationship between the environment and the pathologies' vectors[16].

The bacterial revolution and the consequent medical ecology brought great benefits to humanity, but also brought a negative side effect: the regression in the social medicine mind–effect that contam-

inates the biomedicine until today. The new civilization diseases do not have a microbial origin, the environment acquiring new importance not only as a reservoir, but as an ecosystem with natural, social, political and cultural interdependencies that influence health and disease [15].

The microbial turn promoted public health campaigns fighting for the diseases eradication transmitted by contagion through the decontamination of the environments, without considering the social poverty and lack of sanitation context of the affected populations. It was a question to free the environment of microbes, without looking at the social life conditions of the people inhabiting this environment. The current proliferation of chronic not transmissible diseases forces again to consider the social and cultural context of disease processes.

To meet this challenge, it arises the understanding of ecosystem health proposed by MINAYO [17]. There is a focus change in this conception, because the environmental space is not something external that laterally conditions the health - disease process, but something that lies at the very essence of health understanding. This conception transforms the understanding of risks and health problems, because includes the environment as something fundamental to the production of the social life reproduction - thus combining environmental sustainability and social development as the basis to understand health and life quality.

This means, according MINAYO, *a construction process of new subjectivities by participating in change projects in a sustainable development perspective and of complicity with future generations. Although there are attempts to quantify indicators (...) The definition of life quality is essentially qualitative, it joins at the same time, the feeling of well-being, the finiteness vision of the means to achieve it and the willingness for solidarity to expand the present and future possibilities. Thus, the ecosystem approach to health and life quality is like an umbrella that shelters our desires for happiness, our standards of human rights, our commitment to push the boundaries of social rights and the conditions to be healthy and to promote health* [18].

This health ecosystem understanding strengthens the need for health care models that could cover the environmental territory in the programming of health actions and in the organization of work processes and their practices in primary health care. This model identifies itself with the health surveillance which focuses on health needs actions of a specific territory inhabited by defined population groups – a focus that becomes ethical concern of the teams in their practices' organization.

Ethical challenge of the integration between primary care and health surveillance

The ethical dimension of an action requires autonomy for that the subject is its protagonist and also requires accountability so that the results of the action are recognized as its own. To provide autonomy and responsibility opportunities in primary care practices it is necessary to reflect and become aware of the thinking and acting paradigm in health - which move these practices. Therefore, the importance to discuss the paradigm, expressed in the care model that organizes work processes, because this awareness enables autonomy and responsibility to act with ethical implications for practice.

Morin[19] calls the backstage of the paradigm thought *that holds for all discourses that take place under its rule, the fundamental concepts or master intelligibility categories, and to the same time as the type of logical relations attraction / repulsion (conjunction, disjunction, implication or otherwise) between these concepts and categories*. So, the paradigm contains on the one hand, the intelligibility categories which determine the formulation of ideas in the discourse and on the other hand, the logical operations that define the inclusion or exclusion of knowledge according to the truth concept contained in the paradigm. But the paradigm is empty and with no content, because *it is never formulated nor is inscribed nowhere. It is always virtual. It exists only in its updates and manifestations. It only exists 'paradigmatic', at the example which signals its paternity* [20].

Therefore, to make explicit and conscious through knowledge what is implicit and unconscious it the paradigm is part of an ethical attitude in relation to knowing and acting, determining the configuration of knowledge and practices. Accepting that all knowledge is set paradigmatically, one gets a foresight about the conditions in which knowledge is used and certain actions are developed. Only in this way one can have an ethical positioning to the practices. This foresight educates for ongoing evaluation and continuous search for better solutions. The understanding of a paradigm points out at the same time to the knowledge and practice possibilities, but also to its limits. The uncertainty and the need of evaluation integrate the practice itself, because there is always the possibility of illusions and contradictions. Ethics requires realizing the possibil-

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ities and limits of knowledge and practices. This is only possible when the individual becomes aware of the paradigm in which he moves in order to know and act [21].

This finding points the need to discussing the paradigms and health care workers' models as a requirement of ethical evaluation. Promoting this discussion is configured as a primordial task of teams and managers, in order that they cannot be reduced to the system administration, but as promoters of the workers' co-management. Only thus enables the role in work processes and the healthcare team responsibility in relation to the users because they become subjects of their practices and not pure executors of procedures applied automatically without trying to understand needs and health problems. But the overcoming of procedures automation is only possible with the autonomy created by the consciousness of the paradigm and the model in which the worker moves, generating skills for creative decisions and adapted to the user's subjectivity.

With the implementation of the Unified Health System (SUS), the territory notions, as well as integrated care networks, became the organizing principles of work processes, especially in the primary care policy. These work processes depend on the care models that relate to the organizing way of health services keeping in mind the use of different technologies in healthcare practices. In the care model that focuses on the environmental territory and have consequently a health vision as ecosystem, surveillance becomes the Gordian knot of the service organization, because the knowledge produced by the surveillance about the health needs of that area becomes the base of this organization – a model named *health surveillance* at the ordinances of the Health State Department [22]. This health care organization chain emphasizes the creation of sanitary districts to meet the needs and specific health problems of that place. Its implementation depends on the ecological understanding of health as ecosystem and reorganization of different surveillances in the form of compartments in an integrated model with primary attention to health care.

The Ordinance 3252 of the Health Ministry created the National Health Surveillance System and intends to integrate the actions of different surveillances, inserting it in the construction of networks of health care, coordinated by primary health care, as a requirement of completeness. Article 1 of the Ordinance states: *Health Surveillance aims a continuing health status examination of the population, articulating a set of actions that are intended to control determinants, risks and damage to the health of people living in certain territories, ensuring care integrality, which includes both the individual and the collective approach to health problems* [22].

The integration with the primary care is a premise of the new conception, set out in Article 6 of the decree: *the actions of Health Surveillance, including promotion, must be inserted in the daily work of the Primary Care / Family Health teams, with roles and responsibilities defined for an unique work territory, integrating the work processes, planning, programming, monitoring and evaluation of these actions* [22] – which is a vision assumed by the new National Policy for Primary Care [23].

The model of health surveillance aims to overcome the pure systematization of the provided indicators, mainly by the epidemiology, for the systems and services' planning and organization in order to become a practice reorganization starting from the health needs. In this sense, it goes beyond the mere health districts' organization [24] to emphasize more the work processes and health practices from the surveillance perspective. Therefore, Paim states that *health surveillance points to the direction of overcoming the dichotomy between so-called collective practices, epidemiological and sanitary surveillance, and individual practices, ambulatory and hospital care, by incorporating the contributions of critical geography, urban planning, epidemiology, strategic management and social sciences in health, supported by a political and institutional process of decentralization and reorganization of health services and practices at local level* [25].

So, the model of health surveillance aims to reorganize the health services work, with reference to the territory, the health problems and the intersectional practice as means to integrate the operations of different health sectors regarding the complex dimensions of the health-disease process, emphasizing its eco-social determination in order to develop new operation possibilities for the health system. Focusing on the territorial context, it can be better defined health problems and its priorities, in a more articulated and integrated way. Thereby, health surveillance becomes a way to constitute the extended integrality and to promote health. One can also say that this model has a strong identity with the elements that comprise the ESF and represents a significant strengthening of this strategy.

Therefore, the object of the work process in health involves the problems to be known and the social health needs of the population to be served. For this reason, it is important to refer to the ter-

ritory as a space of social interaction where the problems and needs receive specific configuration - which is essential to consider in its response. In this sense, health surveillance adds to the clinical and epidemiological approaches once it analyzes the problems and identifies the needs, the eco-social approach that characterizes the historical process of economic, social and political development of the people, conformers of their problems and needs. This means that there is a diversity of public health surveillance objects, once problems and needs require a variety of angles and perspectives. It should be noted that this multiplicity of public health surveillance objects is reflected by the diversity of subjects and variety of needed actions [26,27].

The assumption of the health surveillance model implies changes in the way of seeing the object of work processes and, therefore, appears as an ethical challenge, since it is an attitude and perspective change of health practices and services. It means to introduce to the work processes the interfaces between environment and health within the territory, through the sustainability question, i.e., the establishment of social life reproduction conditions. This requires continuous planning and evaluation so that the assumption of this model incentives new ways of thinking and doing health.

Ethical challenge of the integration between social determinants and sustainability

Public health as a field of knowledge and practice that combines knowledge of health sciences and social sciences, moves towards the relationship between health and environment, starting from social and economic development processes that constitute the territory and impact on the social and cultural environment, determining conditions for populations' life quality. This view is based on an eco-social health approach, expressed in the health promotion policy and on the health surveillance model. For this perspective, social determinants are essential to understand health and determine the appropriate services practices [28].

The National Commission on Social Health Determinants (CNDSS) defines determinants as *social, economic, cultural, ethnic / racial, psychological and behavior factors, which influence the occurrence of health problems and its risk factors to the population* [29]. There are several ways to understand how these determinants affect concretely the health of particular individuals. This is the discussion focus of this view, because it determines how interventions should be directed to deal with these social determinants that affect life quality and engender health risks [30].

The World Health Organization (WHO) has been working intensively to incorporating this model of conceiving and planning health policies, challenging countries to implement essential environmental health standards in health care contexts. It develops protocol actions, at national, district and local levels, ranging from drinking water at sufficient quantity, basic sanitation, proper knowledge and application of hygiene principles and adequate ventilation, up to resources and funding strategies and awareness of managers, health workers and communities [31].

From the interfaces in the environment versus health, which is the approach of this article, and considering the social determinants definition of CNDSS, one can say that the social determinants form the territory in which the everyday sociability is woven in that community. In this sense, they configure the conditions for social life reproduction, which are expressed in health and life quality of individuals living in that environment. Stated differently, the environment as a determinant of health and even of survival, when threatened compromises human health and life quality globally and locally.

The socioeconomic processes are the most important environment conformers, causing damages which in many cases are pushed to territories inhabited by social groups made vulnerable by the lack of political and organizational strength to react to this social metabolism of the globalized economy, and the costs of which affect poor people. This configures the social phenomenon that is called environmental injustice that associated to socioeconomic stratification mechanisms and unequal wealth distribution, constitutes the social determinants of health inequities. Both affect perversely the outlying communities, circumscribing groups to high exposure and social vulnerability risks [32].

The social movement for environmental justice [33], introduced in Brazil at the Social Forum in 2005, inspired the creation of the Environmental Justice Network, whose primary purpose is to promote studies and reports on environmental situations of inequality that affect poor populations. The realization of these environmental injustices enables the people's articulation and organization not to accept the degradation of their environment, fighting for socially equitable environmental policy measures. This movement formulated the ethical principle that vulnerable groups should not bear the

disproportionate burden of negative environmental consequences arising from commercial, industrial or municipal operations or from the implementation of public policies at federal, state, local and tribal levels [34, 35].

The Environmental Justice Network defines *environmental justice as the mechanism by which unequal societies in social and economic terms, direct the greatest environmental damage burden to low-income social groups discriminated against, to traditional ethnic groups, to working-class neighborhoods, to marginalized and vulnerable populations* [36]. These mechanisms are possible due to the ever-greater economic and financial exchanges between countries, made possible by the global market that exports environmental damage from industrial processes, no longer acceptable by the citizens of the First World, metabolizing them socially and transferring their costs to places inhabited by low-income people.

Not knowing the side effects of these processes on the macroeconomic environment by the territories conformation, would make up the environmental and social degradation phenomenon in the peripheral countries. Underdeveloped countries are held accountable for environmental degradation in their territories, forgetting that it is the transfer of environmental damage from rich countries. Degradation, besides to exterminate ecosystems and biodiversity, affects the populations' health, destroying the natural and cultural environment - the basis for the social life reproduction [37].

The environmental wounds are manifested in the use of land for monoculture of exporting agribusiness, spreading green soy, sugar cane and eucalyptus deserts with the corresponding seasonal farm labor in sub human conditions, in the mineral exploration generating pollution and risks to ecosystems and neighbors; in the production of hydropower by building dams, extinguishing biomes and driving small farmers off their land; in social conflicts involving access to urban land to build houses and the industrial pollution and toxic waste in proximity to low-income neighborhoods [38].

These forms of environmental destruction become the spatial disparities more acute, contributing worldwide to the increase of health inequalities. Faced with the magnitude of this context, the integration of health promotion and environmental justice can produce powerful conceptual tools and strategies to confront the phenomenon, from the perspective of human development and responsible environmental sustainability [39, 40].

In this direction, and in the health systems' context, national and world literature highlights the approach of primary care as an inducer of these joints, together with social participation [41]. Its role is strategic because it leads to health care as close as possible to where people live and work, constituting the first link in the continued health attention process. Closer to their community, the health teams are strategic devices to drive networks and local cultures, at social participation processes, as well as may propose inter-sectored and cross-disciplinary actions on the territory and its connections to the system and other public and social control agencies. These features, added to the coverage level and care resolvability, are ethical challenges to be achieved in dealing with social determinants of health inequities.

Final considerations

To interpret the bioethics triad: territory, environment and health, includes the adoption of a health ecosystem vision, having as central category the life quality socially determined by economic, physical, chemical, biological and cultural environment factors - and their impact on territories, as social spaces of health and illness processes. This finding points to the paradigm awareness that supports theories and models of care and health management as an ethical requirement for people involved in the health services organization, once the promotion, prevention and surveillance actions focus directly on the determinants which affect the health of populations within the primary care.

The proposal of the health surveillance model aims to respond to this concern, reorganizing work processes and care practices in line with the population's health needs of the attended environment. There are two major ethical challenges to develop this proposal: the first is the construction of health surveillance integrated with primary care as a model. Therefore, it is necessary to introduce the method of co-management in the work processes and the consequent permanent education in primary care and surveillance inserted into the population's health needs of the attended environment. This is an ethical challenge for the teams and local managers, establishing reflection processes and evaluation on the everyday practices and awareness of models of care that go through the work process, creating the conditions to assume the responsibility for the answers to the needs of a given population - this is the ethical challenge of the relationship between

health and the territory understood as a space of daily sociability.

The second challenge is to build up intersectoral public policies that assume the social health determinants as conformers of the population's environment attended by the services in order to create better conditions for the social life reproduction. For this, a joint policy is required by the health managers, aiming to agree intersectoral actions such as inclusive education, employment and income generation, basic sanitation, parks, recreation and sports areas. These initiatives seem to have no relationship to health, but in long term are more effective than drugs and hospital beds to improve the population's health. This is the ethical challenge of the relationship of health to a macro-environment understood as a condition for the social life reproduction.

These challenges are ethical but also political, since they depend on decisions, agreements, joints and pacts at both the micro-level which is the service place and the macro-level of governance and relationship with networks and intersectoral activities. A bioethics that focuses on the challenges of primary care practices must take into account this double dimension: micro dimension for the territory and macro dimension of the environment in its dealings with health.

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