The Inequities in Health Shaped by Political Forces: *A Critical View*

Dionéia Motta Monte-Serrat★, Russell Kabir★★, and S.M. Yasir Arafat★★★

About the author(s)

★Dionéia Motta Monte-Serrat is a Collaborating researcher at IEL-UNICAMP. Doctoral degree in Psychology, FFCLRP-USP. Doctoral degree program partly completed at Université Paris III, Sorbonne Nouvelle (2010, CAPES-BEX). Internship at École des Hautes Études en Sciences Sociales, Paris (2012, FAPESP). Lawyer and faculty member (Assistant Professor in the Undergraduate Law Program) at RibeirãoPreto University (UNAERP) since 2013. Professor in the Master's Program in Health and Education at University of Ribeirão Preto (UNAERP) since February 6th, 2017. For correspondence: E-mail di_motta61@yahoo.com.br

★★ Russell Kabir is Senior Lecturer in Research Methods, Department for Allied and Public Health, Faculty of Medical Sciences, Anglia Ruskin University, Chelmsford, UK. Editor-in-Chief of International Journal of Perceptions in Public Health. Email: russellkabir@live.co.uk ,russell.kabir@anglia.ac.uk

★★★ S.M. Yasir Arafat is Resident, Department of Psychiatry, Level 11, Block-D, Bangabandhu Sheikh Mujib Medical University, Shahbagh, Dhaka-1000, Bangladesh. MD in Psychiatry at BSM Medical University, Dhaka, Bangladesh. Editor-in-Chief- International Journal of Perceptions in Public Health; Editorial Member - International Journal of Psychiatry, EC Psychology and Psychiatry, South East Asia Journal of Medical Sciences; Scientific Advisory Member-Journal of Behavioral Health; Adjunct Faculty at MPH Program, ASA University Bangladesh. Email: arafatdmc62@gmail.com

ABSTRACT

The aim of this paper is to analyze critically how the State Power is formed and influences health. We use Discourse Analysis Theory to analyze, in discursive materiality (laws, regulations, determinations) as indications of the ideological effects that prevent citizens from perceiving the fact stated in the WHO report (2008). That report places the State in a paradoxical situation: as responsible for changes in the social determinants of health and, at the same time, as the main cause of health inequities. Ten years after WHO report on this subject was still being produced as a letter of intent on the demand for new ways of thinking and acting on health. How can this happen: the State itself is one of the main causes of health inequities and seems to be another political institution being challenged? In analyzing the topic of "health inequities", we can shed some light on the effects of meaning generated by this ambiguity: the category of a legal subject is subjected and its action of challenging the unfair distribution of social resources must necessarily take place according to the laws, within the limits set by the State itself. The appearance of an "object of choice" is in reality located within limits, leading subjects to misery. How to get around the inequities in health brought by the State? We believe that the way out lies in the construction of such social conditions to promote solidarity. It is in this context that health promotion becomes an end in itself and legitimates actions in health that overcome inequalities.

Key words: Health; Inequities; Political Forces; Discourse Analysis

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1.0 INTRODUCTION

WHO (2008) establishes that there are inequities in health, avoidable health inequalities, which "arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness". It also establishes that the conditions in which people live and die are shaped by political, social, and economic forces.

The mentioned report was promoted by World Health Organization (WHO, 2008) through the Commission on Social Determinants of Health (CSDH), titled "Closing the gap in a generation". Its conclusion is that "social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death". Although inequity in power interacts, according to WHO, in four main dimensions: political, economic, social and cultural, we focus our attention on the role that the *State* plays *as one of the major causes of inequity in health:* "poor and unequal living conditions are the consequence of poor social policies and programs, unfair economic arrangements, and bad politics" (WHO, CSDH, 2008). The Commission on Social Determinants of Health indicates a better distribution of power within society as a solution in the following cases takes as example:

> "[…] Urban planning […] that produces sprawling neighbourhoods with little affordable housing, few local amenities, and irregular unaffordable public transport does little to promote good health for all (NHF, 2007) […] trade policy that actively encourages the unfettered production, trade and consumption of foods high in fats and sugars to the detriment of fruit and vegetable production is contradictory to health policy, which recommends relatively little consumption of highfat, high-sugar foods and increased consumption of fruit and vegetables" (Elinder, 2005). (WHO, 2008, p. 10).

We will critically analyze how the State Power is formed and the political aspects of the protection given by the State to health. These analyses will be made in light of the Discourse Analysis Theory (Pêcheux, 1988) which seeks discursive materiality (laws, regulations, determinations) indications of the ideological effects that prevent citizens from perceiving the following: the fact that the WHO report (WHO, 2008) places the State in a *paradoxical* situation, that is, places it as responsible for changes in the social determinants of health and, *at the same time*, as the main cause of health inequities.

The term "inequity in health" will also be analyzed under the methodology of the Discourse Analysis Theory in order to understand that the relationship between citizens and the State places the latter in a "supposed" role of achieving Social Well-Being. It is a "supposed" role because if we look at reality, many efforts have been put forward to propose new attitudes towards health since 2008. Texts on the subject were still being produced in 2013. We are in 2017, and there is a letter of intent on the demand for new ways of thinking and acting on health. There has been a discursive functioning hidden in the discourse of outlining strategies over so many years. The efficacy of ideology - related to this discursive functioning and "concealed under the strategy of reference to evidence" (Zizek, 1999, p. 13) -structures our perception of reality in advance, making it "indiscernible from its 'aestheticized' image" (Ibid, p. 21).

2.0 LITERATURE REVIEW

2.1 Concept of State

Before we proceed to the analysis, we need to make some statements about what is the State. Cesar Luiz Pasold (2008), in an article on the "Conception for the Contemporary State", affirms that the notion of State has not always been the same. For that author, the concept of State is historical and concrete, and it cannot be applied indistinctly for all ages, but only for the period in which the *idea and practice of Sovereignty* arose. According to Pasold, the Contemporary State is conceived as a

political institution whose purpose is the Common Good, and it places itself as an "effective instrument at the service of the Social Whole" (op. cit.).

Paulo Buss (2000, p. 174) also identifies that Sovereignty when he defines the Contemporary State as a "new conception [...] that (re)establishes the centrality of its public character and its social responsibility, that is, its commitment to public interest and common good". This State's sovereign power over citizen's life makes State interests prevail, whatever one claims that the State promotes well-being.

2.2 Health and the State

The topic of international health protection is part of the international protection of human rights, which is the responsibility of the United Nations Organization (UNO), an entity created at the end of World War II which currently comprises 191 of the 193 States of the world. Its purpose is to maintain peace, uphold human rights and fundamental freedoms and promote the development of countries on a world scale.

Human rights are protected in a comprehensive way, - including economic, social and cultural rights - and they are intended to protect the human being, not the State, by means of instruments, such as treaties and resolutions, applied both at global (UNO) and regional (States) levels (Batista, 2008). Regarding the application of human rights, Batista (2008) affirms that there is interaction between international law and domestic law, and "primacy is always given to the norm that best protects human rights". In order for international standards to be met, it is necessary for the States that have adopted them to undertake foreign and domestic policies so as to comply with what has been agreed upon (Batista, 2008).

In the interest of protecting human rights, States should report to UNO on the measures they have taken will be forwarded to the Economic and Social Council and specialized agencies so that they can draw up appropriate recommendations, to help solve problems and make decisions. With regard to health, the specialized agency to carry out this task within the United Nations is the World Health Organization (WHO). WHO was established in 1946, when it was necessary to fight epidemics internationally, since domestic measures were insufficient (Batista, 2008). Over the years the tasks became more complex and, in 1986, WHO produced the "Ottawa Charter", which became a reference for health promotion by innovating with the idea of community participation in actions aimed at improving quality of life and health.

> "The concept of health as well-being transcends the idea of healthy forms of life; health promotion transcends the health sector [...] the conditions and requirements for health are: peace, education, housing, food, income, a stable ecosystem, sustainable resources, social justice and equity" (Buss, 2000, p.170).

According to WHO, health is conceptualized as a state of complete physical, mental and social well-being (Batista, 2008). This organization has the task of promoting debate on health as well as the purpose of implementing, in the various States of the international community, Commissions on Social Determinants of Health (CSDH), composed of representatives of the most diverse sectors of society in order to "gather scientific knowledge and evidence, make a diagnosis of the main problems and define recommendations for coping with the situation" (Jornal da Ciência, 2008). Both WHO, at the international level, and CSDH, at the national level, play the role of giving general policy guidance related to the social determinants of health (SDH).

2.3 Health and the Law

Under the focus of health and based on human rights, we see the State as the formulator of its supreme law, the Constitution, which outlines the fundamental guarantees of citizens. When the law deals with human rights, it discusses guarantees for life, freedom and social life, in the pursuit of happiness.

Such human rights have not always existed. They began to be discussed in the seventeenth and eighteenth centuries in order to ensure the rights and freedoms of individuals against the despotism of the state (Dirhum, 2008). Social rights, in turn, date back to the twentieth century and constitute guarantees for paid work and social assistance, which later evolved into universal health care (Idem). Rights and freedoms arose as limitations to the State's power over the individual and his private life, as they resulted from social movements which, in the mid-nineteenth century, aimed at protecting workers.

An individual's rights may be civil, political or social, depending on the institution that administers them. Social rights include the services rendered by the State to the individual in order to provide him with well-being, including the rights of education, work and health. The right to health is given a special category because its holders are not individuals, but the people, the family, the nation or regional groups (Dirhum, 2008).

Social rights gained from the "Constitution of the World Health Organization in 1946 and the International Covenant on Economic, Social and Cultural Rights in 1976" (Dirhum, 2008); and its strengthening took place in the twentieth century because, with the tendency to equalize individuals, they conflicted with the capitalist system of social classes, which was responsible for the growth of social differences (Dirhum, 2008). Once recognized, human and social rights began to be realized through public policies and State benefits in relation to the individual, both to recognize special rights for patients and to prevent health problems (Dirhum, 2008).

According to Buss (2000, p. 171), the discourse of health promotion blends with the idea of public sector accountability, "not only for the social policies that it formulates and implements (or for the consequences when it fails to do so), but also for economic policies and their impact on the health situation and the health system".

According to the WHO's final report, "Closing the gap in a generation" - organized by the Commission on Social Determinants of Health, (see WHO, 2008) - it is the State's responsibility to promote health and guarantee its necessary conditions.

However, such guarantees, which have a constitutional nature and are recognized by governmental entities, suffer limitations, since, in addition to the need for economic resources that are presently scarce, they require a limit of equilibrium between individual rights and freedoms (which implies in the State's not intervening in people's private lives), on the one hand, and social rights (which lead to State's intervention in individuals' private lives), on the other (Dirhum, 2008). There is also difficulty in making them effective, thus preventing health inequities from occurring. Although, for example, "women with no education are likely to suffer more from domestic violence than who have some education or higher education" (Ferdous et al., 2017), how the State could intervene in the private life of citizens?

> "Health, once recognized and proclaimed as the fundamental right of the human being, makes it possible, at the same time, to recognize the existence of duties and responsibilities of governments and the society in general [...] This implies, therefore, the State's obligation to establish a legal order such that the enjoyment and exercise of these rights are fully guaranteed [...]" (Dirhum, 2008).

The law imposes limits to the State's action regarding health: public policies are designed and outlined by law. Therefore, a policy is public only if it meets the requirements of the law (Dirhum, 2008).

2.4 Inequalities, Inequities and Determinants in Health

The concepts of "inequality", "inequity" and "determinants" are of crucial importance in the work performed by WHO and the National Commission on Social Determinants (CSDH). Inequalities, according to the World Health Organization report "Closing the gap in a generation" (WHO, 2008), are systematic differences in the health situation of population groups. Inequities are health

inequalities which, in addition to being systematic and relevant, are avoidable, unjust and unnecessary (Buss, 2008, CNDSS).

The social determinants of health (SDH) are perceived, according to Buss (op. cit.), in the comparison of differences or inequalities in the health status among individuals or between groups. The health of a group of young people, for example, differs from the health of a group of elderly persons due to inequalities caused by diseases that are typical for the age of members belonging to each of these groups. This situation is regarded as "natural" and results from inequalities arising from the social conditions in which such people live. These conditions arising from social inequalities are referred to by WHO (2008) as the Social Determinants of Health (SDH) and, unlike the "natural" inequalities, they are unjust and unacceptable and, therefore, called "inequities". An example of inequity in health is the greater likelihood of a child's dying before reaching the first year of life simply because this child was born in one region of the country and not in another or because his/her mother did not attend school.

The relationship between SDH and their effects is complex, and it cannot be regarded only as a cause-effect relationship. The Social Determinants of Health (SDH) include cultural, environmental and socioeconomic conditions, as well as human conditions of life and work, such as sanitation, housing, health services, work environment and education. It is "the social, economic, cultural, ethnic or racial, psychological and behavioral factors that influence the health standards of individuals" (Jornal da Ciência, 2008). If a group in society is excluded from a benefit that should be available to all, according to the Constitution, that will reflect on the determinants of the health standards of such group.

Modifying this situation, which imposes differences of treatment among individuals, and interfering directly in these SDH imply assessing and exercising influence on State policies and programs. The necessary political support to that end will only be achieved if society is aware of the serious problem that health inequities The WHO report, "Closing the gap generation" (2008), states that the national government should strengthen the political and legal systems to ensure that they will promote the equal inclusion of all in the political process in order to strengthen health initiatives oriented towards equality in health.

WHO also points out the importance of social movements as to the fact that they should have space for *challenging and questioning*. It concludes by stating that a society that is concerned about better and fairer distribution of health is one that *challenges power relations* through *participation*, thus ensuring that all voices are heard and respected in the decision-making process related to health equity. (WHO, 2008, Chapter 14).

2.5 The juridical discourse on health

The State legislates on health. The fact that the legal discourse takes place in the juridical body, for enforcement purpose, implies notions of obligation, of the imperative of the law, which will influence the materiality of language and the origin of the subjects' enunciation. Law, as a science that is said to be "neutral", erases the historical origins of its impositions.

In this article, we seek to understand how the "neutrality" of Law emerged, going beyond the idea of transparency and legal idealism. Thus, we understand *Law as a mode of reproduction of a social functioning that reproduces the State*, and which, at the same time, wants to be seen as detached from social phenomena. Michel Pêcheux (1988) states that social phenomena are not explained politically or ideologically, but have a structural causality. Pêcheux proposes a materialist theory of discursive processes, in which he approaches the concept of "subject evidence" to the concept of "evidence of meaning" by stating that the unconscious and ideology have the common characteristic of concealing their very existence within their own functioning (Pêcheux, op . cit., p. 153) and that there is a play of ideological effects in every discourse: ideology, concealed by "use" and "custom", determines *"what is"* and "*what must be*" and the *legal subject* is constituted under such evidence (ibid, p. 160).

Thus, "the law progressively takes the lead, ensuring other more insidious forms of closure that will paradoxically pass through the apparent autonomization of the subject" (Haroche, 1992, p. 70-71). Such "autonomization" takes place by means of a new form of subjection. Ideology, which is present in language in an insidious way, leads to an 'internal' subjection of individuals, who are gradually constituted into "free legal subjects" (Haroche 1992, p. 71, emphasis added).

It is in this discursive functioning which Haroche claims that the "*juridical subject of linguistics*" exists, in whom there is an "*interiorization of the subject's dependence [...] on the ideology of power*". The term "subject" is taken according to the conceptualization given to it Althusser (1976, p. 121), with the following ambivalence of meaning:*1)free subjectivity*: a center of initiatives, the author is responsible his actions; 2) *a subjected being*, submitted to a higher authority, therefore, devoid of all freedom, except that of freely accepting his submission [..] it is no longer a situation of understanding or questioning, but only of understanding to submit oneself (Haroche, 1992, p. 84, emphasis added). Haroche explains that the specificity of juridical language is what guarantees the power of the State:

> "By establishing jurisdictions, laws and regulations, the real power develops the power of the State apparatus: it cannot, on pain of renouncing such establishment, vulgarize the meanings of juridical language, which is in fact its best guarantee" (Haroche, 1992, p. 87).

Wam (1980) states that the *subject theory cuts across the divisions of human and social sciences*, ranging from the metaphysical to the linguistic, *and takes part in a basic problem relates to the description and conception of the meaning of enunciations and discourses* to state that *"The legal discourse is one of those linguistic forms that express 'ideology', hiding the enunciating subject, but allowing, for that very reason, for him to subsist and retain his dominant ideology"* (Edelman, 1980, p. 15). Such subject is constituted for the Law, in the legal subject category. Althusser ([1970]1974, p. 29) adopts the thesis that ideology interpellates individuals into subjects. He also takes the idea that the term "subject" arises with the advent of bourgeois ideology and, above all, of juridical ideology (*the one who adopts the legal category of a legal subject to make it into an ideological notion: man is by nature a subject*) (Edelman, 1980, p. 20). Edelman (1980, p. 21) cites Althusser to state that the subject category is constitutive of all ideology.

According to the theory of Discourse Analysis (Pêcheux, 1988), there is an identification of the subject with a dominant discursive formation which unconsciously subjects it. Discursive formation (DF), within Pecheutian Discourse Analysis, is a set of enunciations with similar formation rules which determines what can and what must be said in a historically determined social place. It will be under this perspective that we will approach the inequities in health. There is, according to Haroche (1992, p. 20, emphasis added), a "*passivity* of the subject" before the institutions: "*the power, the State and the law coerce the subject, insinuate themselves in him discreetly*"; there is "a form of power that classifies individuals into categories, identifies them, binds them, imprisons them in their *identity*". It is important to stress that the active participation of citizens in coping with inequities in health, WHO (2008, chapter 14) points to the right to a *legal identity* which is essential in this process, because people cannot claim their rights - access to education, social well-being, health care, civic participation and security - without a *legalized identity*.

According to the theory of discourse (AD, Pêcheux, 1988), the subject is not "born" and does not "develop", but he is constituted, and such constitution, which also includes the constitution of the subject of the unconscious, is articulated to the social plane, where there is the apparent autonomization of the subject, a "'freely consented self-repression' that is induced by the State in the individual" (1992, p. 26, footnote).

The notion of State, according to Filomeno's lesson (2006, p. 11), includes: "a territory, a population and the law, to which power is necessarily coupled". The simple sum of the individuals

who inhabit a certain territory does not correspond to the notion of State; there is something else that makes its unity possible:

> "Old customs would not suffice to define rights and duties in a society such as this, with its high standard of living, its unequal distribution of wealth, and the vast field that it offered to the fight for personal interests; new measures of social control would become necessary, measures that could hardly be put into practice by any means other than the institution of a government with sovereign authority and submission to that government; in other words, by the creation of a State" (Burns, 1959, p. 23, *In* Filomeno, op. cit., p. 9).

State and legal subject are interdependent concepts, therefore: the word subject means "submitted to sovereign authority", "which is subordinate" to the State (Haroche, 1992, p. 158).

3.0 DISCUSSION AND ANALYSIS

3.1 Discursive Analysis of Inequities in Health

The concept of inequity in health, as discussed in the WHO report "Closing the gap in a generation" (WHO, 2008), is explained in Part 1.0 above. Chapter 14 of the abovementioned report points to the State as the main cause of inequities in health. It so happens that Chapter 10 of the same report contains recommendations for the implementation of equity in health, and places the same State as responsible for it. We found the coexistence of such paradoxical relationship between public policies and health strange, as it generates harm instead of benefits; that is, it created "morbid social environments that produce sociopathies and psychopathies" (Buss, 2000, p. 173).

Within the concept of legal discourse (Pêcheux, 1988), we can "apprehend the paradoxical nature of these complex realities", the contradictory and paradoxical effects of the evidence of inequities in health, since there is the "invisible", the "absence" of a power working on "the relations of domination/resistance. We believe that such "invisible" power is inscribed in the linguistic forms of the juridical discourse in the literate discourse (Zoppi-Fontana, 2005, p. 55).

In its commissions, WHO defines strategies to promote public health (Buss, 2000, p. 172). The juridical discourse on health is, therefore, a technical discourse generated by certain members of society. It has a juridical nature. The WHO report (2008) offers suggestions and the treaty member States adopt these suggestions, which become law in their territories. These laws are not equally intelligible to "all subject", and they create the need for interpreters (Haroche 1992, p. 84), a role played by a "cultural elite" that uses hermetic language in which the juridical system misapprehends meanings and guarantees the submission of the subject to the laws (Haroche 1992, p. 87).

While suggesting strategies for promoting public policies for health, WHO (2008, chapter 14) places the State as a cause of inequities in health and makes suggestions for the solution to this problem by proposing a change in the distribution of power within society and the challenge to the unfair distribution of social resources. Here again, ambiguity *seems to be* present, a political institution suggesting that another political institution be challenged. There is even a suggestion that the State itself should implement a "*new social institutionality*" defined as "the set of state agencies charged with the design, coordination, execution and financing of social policies, including health policies" (Buss, 2000, p. 175). How can this happen if the State itself is one of the main causes of health inequities?

By discursively analyzing the topic of "health inequities", we can shed some light on the effects of meaning generated by the ambiguities above. A citizen can only claim for his rights if he has a legal identity conferred by the State, therefore, if he is a legal subject. The legal subject is subjugated; the term "subject" arises with the advent of the bourgeois ideology and of the juridical ideology. The category of a legal subject is ideological; man is, by nature, a subject (Edelman, 1980, p. 20). If the legal subject is subjugated, his action of challenging the unfair distribution of

social resources, as suggested by WHO (2008), must necessarily take place according to the laws, within the limits set by the State itself. Thus, there is the appearance of an "object of choice", but in reality, it is "a subjected-challenge" within the legal limits placed by the law-creating State. Within these limits the ideology of law is denied by its practice, showing to be "*the illusion of illusion: the belief that there may be a "revolutionary right*" (Edelman, 1980, p. 23).

Law, within the capitalist mode of production, emerges as the concrete and ideological organization of the circulation and functioning of market categories, "*whose names are freedom, equality or will*", and reveals the concrete content of legal humanism: "*The exploitation of man by man*" (Edelman, 1980, p.21, emphasis added).

The idea of the legal subject implies that "*in the universe of centralist institutions, there is only one possible discourse* and that no one can advance with an open face by having to hold one's own whishes" (Legendre *apud* Haroche, 1992, p. 158, emphasis added).

Therefore, we ask ourselves how a citizen, as a "legal subject" with a legal identity conferred by the State, can accommodate and subject himself to situations of miserableness in relation to health, financial, housing and education matters. Edelman (1980, p. 26-27) points out a pathway by stating that the loss of identity of the revolutionary class lies in the absorption of the bourgeois juridical and political forms by the proletariat:

> "The legal discourse is one of those linguistic forms that express 'ideology', hiding the enunciating subject, but allowing, for that very reason, for him to subsist and retain his dominant ideology" (Edelman, 1980, p. 15).

The legal subject, who is constituted from the State, in its image and likeness (Gaufey, 1998), as the big Other, lives his situation of miserability waiting for the State, so that the latter, with its strategies, will give such subject something that is not exactly what he expects. There is subjugation, but no challenge.

Contrarily to the *strategies* of the State, which tries to reaffirm its actions within productive processes marked by inequality, there are *tactics*, which consist in a subconscious and constant struggle against institutions (Michel de Certeau,1994).

When describing everyday practices, Certeau (1994, p. 45) asserts that the law and culture develop tensions, to which "symbolic equilibria, contracts of compatibility and more or less temporary commitments are provided", and he adds:

> "Hence, I prefer to use a distinction between *tactics and strategies*. I call "strategy" the calculation of the relations of forces that becomes possible from the moment the subject of will and power is isolable from an "environment" [...] Political, economic or scientific nationality has been constructed according to this strategic model [...] Contrarily, I call "*tactics*" a *calculation that cannot count on its own, and, therefore, nor on a boundary* that distinguishes the other as a visible totality [...] the tactic depends on time, watching to "capture in flight" possibilities of gain [...] It has to constantly play with events to turn them into "occasions". Without ceasing, the weak should take advantage of forces that are alien to him" (Certeau, 1994, p. 46-47, emphasis added).

4.0 CONCLUSION

The subjection of the legal subject is sterilizing and "places all emphasis on the subject's structure" (2005, p. 114). It involves a paranoid alienation in which the legal subject submits to conditions that are imposed by the State and lead him to misery. How to get around the inequities in health brought by the State in charge of implanting social well Well-Being? We believe that the way out lies in the suggestion by Certeau (1994, p. 46-47), in the tactic, which does not "count on its own", which is not a "subjected challenge", but transforms events into occasions by capturing in flight" the possibilities of gain. The *tactics* hide behind the mask of conformity. Would solidarity be a tactic to

combat State strategies in its "supposed" role of promoting social Well-Being? While the State continues to produce inequities in health, the subjects organize themselves in strategies of solidarity that make such social Well-Being a reality. We believe that the overcoming of inequities in health lies in the construction of such social conditions that promote solidarity. It is in this context that health promotion becomes an end in itself and legitimates actions to overcome inequalities.

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