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Dialogue with the authors: agreement and controversies on primary health care in Brazil

Dialogando com os autores: concordâncias e controvérsias sobre atenção primária à saúde no Brasil

Dialogando con los autores: concordancias y controversias sobre la atención primaria de salud en Brasil

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The instigating article by Arthur Chioro and Luiz Cecilio, researchers that circulate comfortably and skillfully between training, administration, and research in the field of Collective Health, highlights several key issues in the debate on basic care/primary health care in Brazil. Without overlooking that the political struggle in the defense of the Brazilian Unified National Health System (SUS in portuguese), the right to health, and democracy is at the center of current concerns and that it precedes any debate in this restrictive political context, with dismantlement of the SUS, I will focus my remarks on reflections produced by the authors, which extend beyond the circumstantial boundaries of the ethical and political constraints we now face in the country.

With good reason, I agree that it is necessary to overcome dogmatic and insufficiently (self)critical stances in what I call the space of primary health care in Brazil in order for us to make progress in consolidating an ethical and political project for "basic care" in Brazil. Our task at this juncture is not "*to simply reproduce the principles and guidelines of the ambitious and generous basic health care proposal in Brazil* (…), *a health policy proposal which apparently suffers no outright opposition, at least in terms of its formulation and premises*".

The recourse to genetic analysis for the production of concepts is certainly an important strategy for an epistemological break to understand the phenomenon, namely, the process of building Brazil's primary care. This involves formulating policies for basic care, but also the movement of actors and disputes in this field, the gains and obstacles, and the set of epistemological and political agreements that were negotiated explicitly and implicitly among researchers and intellectuals constituting the scientific community, administration, and political activism working on various fronts, in institutional and academic spaces and in the sphere of social movements, in the struggles for the right to health and for organizational reforms.

Therefore, the use of a genuinely Brazilian term – "basic care" – was justified and is defended by the authors as a function of the necessary distinction between a reductionist view that reproduces international experiences and formulations and basic care that "*must not lose sight of comprehensive care, necessarily connected to networks of services with different technological levels*".

While it is true that in the sphere of the democratic and militant left in Brazil's Health Reform Movement, this debate originally produced a fertile discussion on the best primary care model for the SUS, it is also true that the adoption of such a model does not solve the conceptual and political problems in the dispute between different projects for primary care. Such disputes also prevail in the

international scenario, showing a clear opposition between more restrictive (selective) models in relation to health problems and/or population subgroups (selective primary health care), approaches circumscribed to health services (primary care), as opposed to conceptually comprehensive approaches that evoke integration with the health system and highlight social determination of health and intersector linkage as part of the intervention in primary care (primary health care).

In other words, in addition to not dialoguing with the debate and the international literature, the adoption of the term "basic care" is incapable of elucidating the divergences and nuances in relation to the primary care models implemented in Brazil: divergent conceptions and models between opponents and proponents of the Brazilian Health Reform; and distinct conceptions and models between different actors in the Health Reform Movement itself. I thus contend that it is not very useful to limit the disputes in the sphere of primary care to the polarization between "basic care" and "primary care". Meanwhile, Brazil's diversity in terms of population size, resources, and institutional learning fails to explain all of its contextual diversity. There are enormous differences between municipalities with similar historical, geographic, and economic characteristics but distinct political and institutional experiences in building the SUS, especially in the shaping of relations with local social actors and specifically in the links with the private sector in the management and provision of basic diagnostic and therapeutic services. There are also distinct configurations in the relations between so-called traditional basic care and family health teams, coexisting with logics that can be different or complementary in turn, in the local health systems in different municipalities.

One interesting aspect is the degree to which the diversity of models in primary care reveals the weakness of policy-making to deal with the complexity of real-life situations or even the degree to which the disconnect between formulation and implementation results from the national policy's incapacity to grasp the actual limitations or "conditions of possibility" of the real world (the municipalities in this case).

The relevant questions raised by the authors merit debate and in-depth investigation of the Brazilian reality. Numerous studies have demonstrated the effectiveness of primary health care to deal with a series of health problems that are amenable to solution at this level, where the Family Health Strategy (FHS) has a positive effect on the use of basic health units as the main source of care, contributing greatly to the improvement of health indicators (infant mortality, under-five mortality, and hospitalizations due to acute and chronic primary care-sensitive conditions, for example). Some of these gains reveal the synergy with other public policies (e.g., the FHS and Brazilian Income Transfer Program; the connection between the More Doctors Program and Requalify-SUS and Brazilian National Program to Improve Access and Quality – PMAQ-AB), reinforcing the importance of inter-sector linkage in more comprehensive interventions for achieving better levels of health for population groups. The results stemmed from the Brazilian National Basic Health Care Policy (PNAB, versions 2006 and 2011) and the inductive role of central government. Meanwhile, although the policy's formulation was marked by some contradictions resulting from different projects vying within the Health Reform Movement, it proved capable of materializing proposals that were consistent with a reform project based on the principles of universality, comprehensiveness, and equity in health (absolutely distinct from the 2017 version of the PNAB. Would Brazil have achieved such success if we had not adopted the FHS as the priority for reordering primary health care?

It is true that the Brazilian government administration and decentralization of the health system were not accompanied by distributive reform (of either resources or power), and that administration at the state level remained strangulated and failed to occupy the institutional void to promote the necessary adaptation in the administrative decentralization and competent coordination of the training and technical support processes, capable of spawning essential autonomy in the municipal administrations. Nevertheless, various municipalities managed to conduct successful experiences on the path to a strong primary health care with case-resolution capacity and integrated with the health system as a whole.

It is also a fact that Brazil has made great strides in studying and formulating primary care policies, but that as a health movement, we have overlooked certain topics that now appear as epistemological obstacles to knowledge of the country's reality: research on the hospital dynamics and the inclusion of medium and high-complexity services in the network of care; analysis of the mechanisms in financialization of health; analysis of other mechanisms for regulation of health care practices (market

regulation and professional regulation, for example) which have enormous impact on the organization of services and the relations between services in the basic care network and other levels of the system.

In other words, there may be a need to review the excessive complexification of the PNAB, but two pressing questions arise at this stage: first, Brazil is experiencing systemic hidrance in the gains achived, while hints at flexibilization have themselves facored the potential for further setbacks; second, we need more in-depth analysis of the failures and shortcomings of primary care policies, questioning some conceptual premises or even "*a single watertight primary health care model*" [1] (p. 1793), but incorporating into the analysis other factors that explain the problems of linkage between primary health care and the network of care in local and regional health systems, which in my view extrapolate the limits related to the formulation of the PNAB, situated largely in the following: (a) the obstacles to regional reordering and the complex linkage within the network and between private interests and the health system, with direct impacts on the provision and regulation of primary care services, since the private sector has displayed great dynamism and the capacity to adapt to the new legal and institutional configurations in Brazil, with innovation in service provision modalities, which even explains the incorporation of disfigured and rationalizing projects for "primary care" in the provision of services by private health plans (as illustrated by the authors). As highlighted by Fausto et al. [2] (p. S80), the "*weakness of the regional level and limited inclusion of primary health care as a matter for federative inter-governmental agreements raise enormous challenges for linkage of care*"; (b) the force of professional regulation, especially that of physicians, who wield great political, technical, and symbolic power in the system, and who regulate practices both at the micro-organizational level (in the private physician-patient relationship at the point of care) and as collective players, influencing the formulation and implementation of policies (e.g., mobilization by the Brazilian medical profession for the approval of the so-called "Law on Medical Acts" and the numerous Congressional amendments and legal disputes over the law sanctioning the More Doctors Program, to cite just two examples); (c) the weakness of users' social participation in various forums within and outside the SUS, with users and their representatives showing limited capacity for formulation and intervention in health policies, and in these circumstances, little ability to express collective interests and intervene in democratic administration and user-centered models.

Inspired by Contandriopoulos et al. [3], in my view there are at least four distinct and competing logics operating in the Brazilian health system's regulation: the logic of instrumental rationality, based on rational planning and optimal resource allocation; market logic, backed by neoliberal economic theory, which views health goods indiscriminately from other market goods; a professional logic, placing health professionals at the center of the system of care; and democratic logic, placing users at the center of the health system, based on equity and social justice. The regulation of health systems is the result of power relations and negotiations between actors that manage resources and operate strategies as a function of their interests and according to each of these logics.

Studies on users' treatment itineraries in health systems have shown that the currently prevailing logic is not democratic, and that if users are left to their own devices, they rely on all the possible strategies, managing all the kinds of capital at their disposition (economic, social, political, symbolic, cultural) to overcome and/or avoid the barriers raised by health services, performing what the article's authors describe as solitary management of their own care. For effective strengthening of primary health care, local and regional systems, and more harmonious coordination of care, it is definitely necessary to create more intelligent and flexible and less bureaucratic systems that consider the specific priorities and needs of each territory and its inhabitants. But this can only be possible, in my opinion, with the reconfiguration of the system's regulatory structure and of the power relations in the health system, through more effective social participation. Self-regulatory mechanisms at the local, regional, and national levels, with heavy imbalance in power relations between the actors, not favoring the predominance of a democratic logic, advantageous to the health system's users. In this sense, the Brazilian Health Reform Movement needs to reclaim its links to social movements in the struggle for democracy and citizens' rights, including the right to health.

Finally, I agree with the authors on the idea that preparing "a new kind of health worker for the SUS" is still one of our most pressing challenges. Practices in primary health care entail major complexity, despite the low technological density. The set of knowledge and technologies used to deal with

the population's health needs is huge and requires a wide range of expertise. This profile, far from being achieved in general, runs into limits, since as Jairnilson Paim often highlights, the health system forms, shapes, and deforms health professionals [4], frequently placing important limits and restrictions on the exercise of health care practices that are more attuned to the innovative and committed perspective of a universal public system with quality. On this point, recent studies on professional practices by physicians in the More Doctors Program emphasize the limits to a more expanded scope of practices resulting from constraints on working conditions. In this sense, the training processes aimed at changes in health workers' professional profile need to be accompanied by other reforms, including the regulation and valorization of the workforce in primary care.

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