


Popular Health Clinics from the perspective of entrepreneurs and representatives of the medical profession


Clínicas Populares de Saúde a partir da perspectiva de empresários e de representantes da classe médica

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Abstract

The objective is to understand the perspective of entrepreneurs from Popular Health Clinics (PHC) and representatives of the medical profession on services offered by the sector; impacts resulting from the COVID-19 pandemic; and future of the medical job market. This is a qualitative research, in the area of collective health, focused on social representations. Semi-structured interviews were carried out, from March to July 2021, with four local entrepreneurs and three representatives of the medical profession from a municipality in the Northeast region of Brazil. PHC offer assistance services restricted to consultations and exams and with financialized logic strategies. The PHC are presented as an “alternative” to the SUS, a supposed “gap” between private health plans and public services, and as a “new” medical work. Companies offer consultations with specialists at “popular” prices and without a waiting list. The assistance provided is restricted and professionals have no guarantee of labor rights. For those interviewed, access to healthcare represents geographic and temporal accessibility of services at a reduced price. The universal right to health and SUS principles are confronted with the defense of the autonomy of clients and professionals targeting their needs: health and work.

Keywords: Outpatient Care; Medical Specialties; Private Sector; COVID-19 Pandemic.

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Resumo

Este artigo pretende compreender a perspectiva de empresários de Clínicas Populares de Saúde (CPS) e representantes da classe médica sobre serviços ofertados pelo setor; impactos decorrentes da pandemia covid-19; e futuro do mercado de trabalho médico. Trata-se de pesquisa qualitativa, da área de saúde coletiva, com enfoque nas representações sociais. Foram realizadas entrevistas semiestruturadas, entre março e julho de 2021, com quatro empresários locais e três representantes de classe médica de uma cidade da região Nordeste do Brasil. As CPS ofertam serviços assistenciais restritos a consultas e exames e com estratégias de lógica financeirizada; se apresentam como “alternativa” ao SUS, uma suposta “lacuna” entre planos de saúde privados e serviços públicos, e como “novo” trabalho médico. As empresas ofertam consultas com especialistas a preços “populares” e sem fila de espera. A assistência prestada é restrita e os profissionais não têm garantia de direitos trabalhistas. Para os entrevistados, o acesso à saúde representa acessibilidade geográfica e temporal de serviço a preço reduzido. O direito universal à saúde e princípios do SUS são confrontados com a defesa da autonomia dos clientes e dos profissionais visando suas necessidades: saúde e trabalho.

Palavras-chave: Assistência Ambulatorial; Especialidades Médicas; Setor Privado; Pandemia Covid-19.

Introduction

The Brazilian health system, based on the Brazilian Federal Constitution of 1988 (FC)¹, defines health as a public good, a right of citizenship and a duty of the State, and is organized as a National Health System (SUS), with actions and services maintained by the Government. The Constitution recognizes the participation of the private sector in the management and provision of services for the SUS, generating a set of public-private interactions and articulations between institutions with different logics of action. Private organizations, for-profit or non-profit, can perform functions that are outsourced by SUS or paid by direct disbursement. There is also the private health insurance market that concentrates care resources, accentuating inequalities between different population groups and regions of the country (Bahia, 2009; Giovanella et al., 2018; Paim et al., 2011). In this context, users move between these services, and the possibility of payment can facilitate or hinder access; and healthcare providers can work in different services, engaging in multiple labor relations.

In recent decades, the private sector has been investing in a model of clinics with specialized medical consultations called Popular Health Clinics (PHC) (Almeida et al., 2018; Campos et al., 2023; Ferreira et al., 2019; Godoy, 2015; Jurca, 2018; Lapa 2014; Soares, 2018; Victalino, 2004; Violante, 2021). They are medical companies for outpatient care that offer consultations, exams, and medical-surgical procedures of medium complexity, for diagnostic purposes, at so-called popular prices and paid by direct disbursement.

The service access occurs by direct demand of users (CFM, 2018) or by informal referral of patients (from PHC and/or the public service) by physicians who have a dual labor relation, working in public and private services (Campos, 2023; Victalino, 2004). The profile of the PHC patients comprises people with income corresponding to classes C and D (Jurca, 2018; Lapa, 2014).

1 Constitution of the Federative Republic of Brazil: originally published in *Diário Oficial da União*, October 5, 1988.

After the political and economic crisis of 2014-2015, the increase of PHC has also been associated with the inclusion of other consumer segments: people who lost the health plans funded by their employers (Lapa, 2014; Russo et al., 2020). The overlapping of crises imposed a set of challenges on Brazil and the adoption of economic adjustment policies resulted in unemployment increase with impacts on the health sector (Pochmann, 2015).

PHC have been expanding in all regions of Brazil with a standard model of outpatient services. In terms of location, they were initially located in central neighborhoods with intense circulation of people and commercial movement. However, they are currently installed in middle-class neighborhoods and shopping malls (Campos et al., 2023; Jurca, 2018). Its development led to its regulation by the Federal Council of Medicine (CFM), according to Resolution No. 2,170, in force since 2018. At first, the regulation prohibited the disclosure of advertisements that indicated consultation prices and payment methods, as it was considered a practice of unfair competition, trade, and customer acquisition. However, in 2019, the resolutions that prohibited such conducts were revoked, enabling practices of other commercial segments in the health sector.

In Brazil, the organization and functioning of PHC have aroused interest in different areas of knowledge: collective health (Campos, 2023; Jurca, 2018; Victalino, 2004), economics (Lapa, 2014), geography (Godoy, 2015), and administration (Almeida et al., 2018; Ferreira, et al., 2019; Soares, 2018). Part of the academic production positively evaluates this model as a success (Almeida et al., 2018; Godoy, 2015; Lapa, 2014; Victalino, 2004). Such ideas are based on the assumption that public health services are insufficient in quantitative and qualitative terms, and, therefore, responsible for the creation of care gaps and repressed demand. This view corroborates the common sense discourse that the Brazilian political-economic crisis of the last decade represented an “opportunity” to expand the private sector, which now supposedly occupies a space left by the State.

Analyses of PHC characteristics and their relation with SUS oscillate between those that defend their contribution to healthcare, reducing the repressed demand for the “gaps” left by SUS (Almeida et al., 2018; Ferreira et al., 2019; Godoy, 2015; Lapa, 2014; Soares, 2018; Victalino, 2004;), and those who consider that healthcare model unable to meet the population needs, due to its commercial logic, which is ineffective in terms of care (Campos et al., 2023; Jurca, 2018; Russo et al., 2020).

This article seeks to understand the perspective of PHC entrepreneurs and representatives of the medical profession from a municipality in the Northeast region of Brazil regarding the services offered by those companies. The impacts from the COVID-19 pandemic are also part of this analysis, as well as their expectations about the future of the medical labor market, for this article aims to contrast their representations of health with others from the constitutional definition of the right to health and from the organizational principles and guidelines of the SUS functioning.

Methods

A qualitative research, in the area of public health, linked to a multicenter project entitled “How does the current crisis reconfigure the health system in Brazil? A study on health services and workforce in the states of São Paulo and Maranhão,” coordinated by Queen Mary University of London (QMUL), University of São Paulo (USP), and Federal University of Maranhão (UFMA).

The Regional Council of Medicine (CRM)² and the National Registry of Health Establishments (CNES) were initially consulted to discover the number of companies entitled Popular Health Clinics (PHC). Several categories were found to designate health companies (specialty centers, polyclinics, specialized outpatient clinics), but PHC was not found as a category to identify a specific type of company; therefore, it was impossible to identify the exact number of companies operating in the investigated municipality.

2 Available at: <http://cnes.datasus.gov.br>. Accessed in: July 3, 2023.

Another methodological strategy consisted of inviting (via email) self-entitled PHC companies and representatives of the medical profession to participate in the research. There were no responses from the entrepreneurs. In view of this difficulty, five entrepreneurs were contacted via the researchers' professional and personal relationship networks. Only one of the entrepreneurs did not formally agree to participate in the research.

Four PHC entrepreneurs and three representatives of medical organizations participated in the study: the Regional Council of Medicine (CRM), the Brazilian Medical Association (AMB), and the Physicians' Union. The selection of participants was based on their privileged positions in decision-making, whether regarding their own business or in the scope of regulation/standardization of companies.

Regarding study location, we adopted the generic designation of a municipality in the Northeast of Brazil to ensure the participants anonymity. This methodological stance is based on the ethical commitment to preserve the identity of members of a very restricted social group in the study location, which are, therefore, easily identifiable. Regarding local characteristics, data from the Brazilian Institute of Geography and Statistics (IBGE)³ report that 38.8% of the population has a monthly *per capita* income of up to half a minimum wage. And regarding health, the Family Health Strategy (ESF) coverage is below 50%⁴.

Individual interviews were conducted based on a semi-structured script, from March to July 2021, in person or online, by arranging date and time with the participants. They were recorded in audio or audiovisual, with an average duration of 1 hour and 30 minutes. The interviews were preceded by the application of a sociodemographic questionnaire and the reading and signing of the informed consent form. The interviewees were referred to as entrepreneurs or representatives, followed by a number. In theoretical-methodological terms, the understanding of this group's worldview was supported by the notion of social representations (Adam; Herzlich, 2001; Deslandes, 2002; Herzlich, 2005).

In a study on the "utility" of the concept of social representation in health, it is defined as a way of thinking related to action, which underlies the cognitive categories and their respective relations of meaning. Social representation can also be seen as an attribute of social groups that can identify, perceive, create alliances, or reject themselves by representations. Thus, we seek to understand the perspective of a social group in order to gain access to its conceptions, values, and practices around the notion of health and its social relations (Herzlich, 2005). In other words, it is a matter of "categories of thought that express reality by explaining, justifying, or questioning" (Minayo Deslandes, 2002, p. 40; free translation). This collectively shared code guides individual conduct and refers to a social order, but also contributes to its construction.

Local entrepreneurs and medical representatives have similar social properties, with reciprocal influences of their positions in the social space. With this view, their narratives were analyzed, without losing sight of the relations of alliance, cooperation, and competition established internally among the social agents investigated.

Results

The interviewees are male and worked as physicians, business administrators, or university professors. Regarding the age group, the entrepreneurs were around their 30s and 50s and the medical representatives were around 50 and 70 years old.

The interviewees' reports were grouped into sections that address different temporalities. In the subsection "Popular Clinics or for the poor: then and today," we sought to present care models that, in the entrepreneurs' view, inspired the current model and also the arguments that support the idea of PHC as alternatives to SUS. In "Characteristics of the healthcare model," the type of service offered, the location, forms of customer loyalty, and the

³ Available at: <https://cidades.ibge.gov.br/brasil/ma/sao-luis/panorama>. Accessed in: July 3, 2023.

⁴ Ministry of Health E-manager (Primary Care information and management system). Available at: <https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaAB.xhtml>. Accessed in: July 3, 2023.

differences between companies are addressed. In “The COVID-19 pandemic, telemedicine, and expansion expectations,” we discuss the impacts on services supply, the losses, and the new perspectives resulting from the pandemic. Finally, in “Medical labor: the business machinery,” we discuss the forms of recruitment and admission of professionals, the working day flexibility, and the wages dissociated from labor rights. This group’s perspectives are analyzed within the backdrop of tensions between conceptions of health as a consumer good and/or as a collective good of universal right.

Popular Clinics or for the poor: then and today

According to the entrepreneurs, the current clinics would have been inspired by physicians’ care proposals, who worked in distant neighborhoods or countryside cities and offered cheaper consultations to those who could not afford the market values. Nowadays, the PHC business model maintains a convenient service at an affordable cost to the customer.

[...] At that time, there were small clinics, but in a very incipient way, a very [...]. The physician who owned the clinic, he provided cheaper care in the neighborhood [...] we wanted to give access to this population that only had the SUS, to provide healthcare at a lower cost, but with a clinic model in which they have air conditioning. So, a different business was needed. [Entrepreneur 2]

Another incipient experience for the PHC development is the health task forces, which are itinerant actions of physicians of various specialties to provide specific care to the population in need.

[...] At the Santa Casa de Misericórdia de Santos/ São Paulo, this service was provided [...] to the population in need who sought but the SUS didn’t provide this service. So, we started [...], in the 1990s, a care work[...] we used to take physicians to the countryside, with the health task forces. At a certain point, we started to build structures to provide these patients with care here in the city. [Entrepreneur 3]

Despite the differences between previous and current proposals, the care work of providing access to health for the population that relied only on SUS seems to be a preserved element of these models throughout the time. Other arguments to explain the emergence of PHC are the reduced number of physicians per inhabitant in the state, the lack of specialist physicians in public services, and the low coverage of primary care.

[...] the permanence of Popular Clinics is due to the lack of management capacity in Primary Care, which does not coordinate care and monitor the patient at the local level. [Entrepreneur 1]

From the medical representative’s perspective, the PHC have two pillars: SUS inability to efficiently meet the demand on time, and the availability of people lacking the financial conditions to maintain health plan, but who can eventually afford consultations at low prices. In this case, the interviewee refers to a void that is filled by the PHC, by directly offering access to specialized services.

[...] to assist the segment of people who are unable to afford a health plan, but who consider the service of SUS bad, PHC would be an intermediate way, [...] to assist the population, to give a little more quality at a more affordable cost. [Representative 2]

[...] 10 years ago, some cases arose in Brazil. It was just by the time of the economic crisis, it coincided with a process that had a lot of health insurance loss by those who had it. Then, some cases with investor funds behind them arose and they had a huge media in Brazil. [Entrepreneur 2]

At a national level, the PHC increase is associated with the economic crisis of the last decade, unemployment increase, and the consequent reduction in adherence to health plans. From the entrepreneur’s perspective, the crisis represented an opportunity for this type of business increase, also with investments from foreign capital. In the research period (2020-2021), the PHC increased and expanded from the downtown region to shopping malls and middle-class neighborhoods of the investigated municipality.

Characteristics of the healthcare model

The main characteristics of PHC are offering outpatient service with various medical specialties and without waiting queue. These characteristics present an appeal in the strategy of attracting clients.

[...] You do not have to make an appointment, because there is no queue... and the price is cheaper [...] hence the name Popular Clinics [...] there are several, each neighborhood was covered, I think they distributed them to the whole city. [Representative 1]

With the increase in competition in the market, entrepreneurs have adopted other strategies to attract customers: diversification of consultations (medical specialties and subspecialties), direct payment methods (credit card, loyalty card, etc.); call center for scheduling appointments and exams; advertisements on social media. etc. The expansion of the range of specialty offerings was appealing to clients, who use the service on a one-off basis.

The high demand for specialized consultations and the reduced supply of specialist physicians are pointed out by the entrepreneurs as a characteristic of the dispute between the PHC for hiring such professionals, resulting in the high staff turnover of physicians.

[...] It is the turnover. It is a one-off service that the patient knows that he will probably only be assisted by that physician that one time, so the patient does not worry about bonding. Recurrence ends up being small in this Popular Clinic strategy. So, it turns out that the People's Clinic, here, it does not solve the person's problem as a whole, because it fails to diagnose, it fails when you need something beyond just a medical consultation. [Entrepreneur 1]

One-off service is another characteristic of PHC that has limitations in terms of resolution. If the client's problem boils down to a one-off medical appointment, their need has been met, otherwise not. Disease prevention or health promotion are not seen as profitable, hence the investments in specialized medical consultation.

[...] Inpatient or outpatient care or medical care does not solve anyone's health. It has to have all those basic variables [...]. So, if a popular clinic is going to promote health, prevent diseases, it would be improving the health of the population much more than simply medical care. [Representative 2]

Regarding clients, the proposal is not only to attract customers, but also to retain them. One strategy is to offer a discount card, which reduces consultations prices, by paying a prefixed monthly fee. According to one entrepreneur, the "discount" was not worthwhile, but, on the contrary, abusive.

[...] we see them offering cards of R\$ 30.00 [...] The person pays thinking that they will be entitled to the consultation. When you get there [in PHC], it is actually a discount, and the person ends up feeling aggrieved. This is not an ethical way of working, according to the CRM code of medical ethics. [Entrepreneur 3]

The survey found divergences among entrepreneurs, including criticism of the service provision model and customer acquisition strategies. Such differences are part of competition between entrepreneurs; however, they share greater similarities, based on values and world perspectives.

Differences were identified between the companies, whether in terms of the number of service units, the offer of medical specialties (and subspecialties) and exams, or in the forms of communication with clients. Larger companies have multiple units (headquarters and branches), indicating brand growth and an expanding business model. A call center for scheduling appointments also provides feedback to the company on the provided services, including a category for the customer's "satisfaction," as an indicator of the service performance (fast service, air-conditioned environment, offer of specialties and subspecialties, discounts on exams). Smaller companies have only one service unit and the competition for customers is conducted by independent promoters, distributing pamphlets in the city center and in peripheral neighborhoods. Regarding medical consultations offering, both types of companies offer the following

specialties: cardiology, general practice, dermatology, endocrinology, gastroenterology, gynecology, obstetrics, pediatrics, psychiatry, and urology.

Chart 1 presents a comparative synthesis between two types of PHC identified in the research, called larger and smaller.

Chart 1 – Characteristics, forms of organization and performance of PHC

Differences Between Popular Health Clinics	
Larger Clinics	Smaller Clinics
Location	
Intense commercial circulation and public transport, located in populated neighborhoods. The larger clinics are also located in shopping malls.	
Infrastructure	
Large clinics, located in low-income and middle-class neighborhoods	Adapted houses located in popular neighborhoods
Service Units	
More than one service unit (headquarters or head office with branches)	One service unit (no branches)
Type of service	
Medical specialties and subspecialties ⁵	Medical Specialties
Exams	
Own network or outsourced with partner companies	Do not perform or outsource these procedures
Medical labor	
Increased demand for specialized medical services	Reduced demand for specialized medical services
Target audience ⁶	
Classes B, C, and D	Classes C and D
Attracting customers	
Social media and call center	Prices below the competition (promotions) and discount card. Distribution of pamphlets by independent promoters
Payment Methods	
Credit cards and cash payment	

The COVID-19 pandemic, telemedicine, and expansion expectations

If the social, political, and economic scenario enabled such companies to expand their operations in the market, the COVID-19 pandemic surprised the sector negatively. According to entrepreneurs, from April to May 2020, the loss was 70% of the income. This period coincided with social isolation measures, reducing users’ demand for elective health services.

This moment of economic downturn generated a loss between revenue, incomes from the attendances, and fixed expenses (payment of personnel and maintenance costs). This discrepancy was considered even greater because the value of the consultation “at a popular price” could not be readjusted, at the risk of compromising the business philosophy.

According to reports, dealing with the crisis, and staying in the market was possible thanks to the emergency benefit for employment and income

⁵ A subspecialty is a specific area within a medical specialty.

⁶ The delimitation of classes A, B, C, and D was mentioned by the interviewees when naming the PHC attending public.

maintenance funded by the federal government, which allowed to reduce fixed costs with employees. The physicians also suffered losses, since their salaries correspond to the volume produced.

[...] They (physicians) lost too, many physicians suffered losses in income. They could not work. One of the physicians [...] spent almost a year [...] working with telemedicine. [Entrepreneur 2]

Federal Law 13,989/2020 establishes the use of telemedicine in emergency situations, it was well received by entrepreneurs for opening new fields of remote care. However, this measure did not result in the expected revenue, as most of the PHC target audience did not have technological resources and quality Wi-fi connection.

In June 2020, after the normalization of local business activities, most PHC resumed their activities. The larger clinics dedicated units to the exclusive care of COVID-19, whereas other units covered further specialties.

[...] When April arrived, we had to close three units [...]. Then, we lost 70% of our revenue, April and May. June was when the recovery curve began, passing through that critical moment. Then, we opened one unit at a time. [Entrepreneur 2]

The telemedicine resource was perceived as an element to allow the expansion of the PHC service, without the corresponding increase in investment.

[...] We have an internalization project [...] I do not have the conditions to go placing large clinics in the countryside, due to the high cost, but I can build some centers that use telemedicine [...] It is a time when we need to give these people access to health. [Entrepreneur 2]

After the pandemic, entrepreneurs identified an increase in demand, in general, and for some specialties in particular.

[...] With the pandemic, people from the lower classes began to feel the need to see a psychiatrist [...] The demand for psychiatry has grown a lot. [Entrepreneur 3]

[...] There is a range of people who do not attend the clinic because they have health insurance, who will need to come. So, this makes us believe that we will be able to follow our expansion plan [...] Another strategy of ours that is not yet on the market, [...] is that in the near future the clinic strategy will be combined with the primary care strategy. [Entrepreneur 2]

Regarding the future, entrepreneurs plan to invest in physical structure, technology, and digital platform to expand their public (class B), diversify their activities with new partnerships in the private sector, such as health plans, and with the public health sector at the municipal level.

Medical labor: the gears of the business

Medical labor is central in this type of company. Medical knowledge and competence are fundamental to these services, so in the 1990s, gaining these professionals' trust was considered the greatest challenge of the entrepreneur who adopted the strategy to co-opt local prestigious professionals to participate as the companies' "collaborators" with remuneration proportional to the volume of the clients' circulation.

As the companies grew, new professionals joined by referral of those who already worked in the clinics. According to the interviewees, the adhesion of experienced professionals transferred their credibility to the clinics; additionally, there was also a dissatisfaction with of the professionals with the remuneration amounts paid by the health plans.

[...] The following happened: there was a very large movement locally and nationally regarding medical remuneration, which was led by the Federal Council of Medicine and the Regional Councils of Medicine [...] it was that discussion about [...] the salary scale of health operators, SUS [...], and some physicians were critical of our remuneration [...] at that time it was R\$ 42.00 and we paid, let's say, R\$ 40.00 [...] But the clinics paid, passed it on to them every 15 days. So, the physicians said: "at least there is no delay, there are no denials." [Entrepreneur 2]

Currently, PHC hire physicians fresh out of residency, those in the process of retirement, and,

depending on the size of the company, those who are at the peak of their careers.

[...] As for the medical part, two different components can be observed: the performance of new physicians, and the performance of physicians already in retirement, who have closed their offices for various reasons and now work for Popular Clinics as an income complement or often as the main source of income as well [...] Depending on the profile, they [the clinic] are also able to attract physicians who are at the peak of their careers, but who work in the Popular Clinics. [Representative 3]

The forms of remuneration are differentiated according to the professional's position in the labor market: beginners, at the peak of their career, close to retirement. According to reports, most of these physicians have dual work contracts with the public and private services.

The working hours performed by physicians vary according to their schedule availability. The entrepreneur calls it "autonomy" and values it in his argument comparing the work in the clinic and in the SUS, in terms of working day length and amount received.

[...] The physician stays about 2 hours for care in this service, however, in the SUS, they stay at least 12 hours per shift. [Entrepreneur 4]

On the other hand, the employment relation between physicians and companies are the type of relations between legal entities, therefore, without labor rights, but remunerated by production volume.

[...] they are legal entities, they are partners, and they receive by the volume [...] There are physicians who say that if I tell him that he will not receive by volume, he will not work anymore [...]. [Entrepreneur 2]

From the perspective of representatives, the medical profession has been undergoing changes. In the qualification field, the number of private medical schools has increased in the country and the number of medical residencies is low, which enabled popular clinics to become a field of action.

In professional terms, liberal profession as well as work unrelated to labor guarantees, is seen as an irreversible change.

[...] Private colleges are throwing countless physicians out on the street every year without giving further preparation [...] they do not commit to offer residency [...]. Popular clinics are also a field of work for them, as well as for retirees. [Representative 1]

Physicians with careers [federal, state, or municipal employees] and/or those who have offices are being substituted by small entrepreneurs [legal entities], who work in PHC or health organizations. [Representative 3]

[...] the medical profession is no longer liberal, it has transformed into legal entities, everyone has to become a company to be able to provide services [...]. The physician will have to join a small company or he will work in popular clinics, in social organizations, in short, he will work wherever he is offered a job. [Representative 3]

From the perspective of representatives of medical organizations, there is some concern about the recent limitations in the training of new professionals. However, there are no questions about the path that the private sector (in education and medical labor) has been commanding on the health system. On the contrary, the character of the changes demonstrates this social group's values, perspectives, and actions, which are shared with the PHC entrepreneurs.

Discussion

The proposal to understand the meanings and discursive uses of health by a specific group – PHC entrepreneurs and representatives of medical organizations – is based on the premise that their ideas express their relations with the social environment, define their experience, and guide their behaviors and practices. This research revealed that, if, on the one hand, the companies differ from each other in terms of size, variety of service offer,

and strategies to attract clients, on the other hand, entrepreneurs and representatives of the medical profession share conceptions and practices regarding access to health, the SUS, and the future of medical labor.

In the narratives of the interviewees, PHC are presented as a third way in the health market, an intermediation between the private health plans and the SUS, or even an option for “those who only have access to SUS” but wanted to have health insurance. This group’s discourse elucidates the market perspective that, we suppose, contributes to the understanding of health as a “force field” between groups with different interests, values, conceptions, and practices related to health, rights, universality, and autonomy.

Health for all: limits and ambiguities of the right to health

In order to analyze the narratives of entrepreneurs and representatives of the medical profession, we sought to historically situate the debate regarding the recognition of the right to health and the role of the State in guaranteeing access to care, internationally and nationally. In the 1970s and 1980s, the proposal of “health for all,” based on the expansion of primary health care, coexisted with a neoliberal discourse of questioning the competence of the State in the provision of goods and services to meet social needs. During this period, international organizations proposed, for Latin American countries, simplified healthcare systems, aiming at extending the coverage of basic services to populations hitherto excluded from healthcare. This proposal did not advocate a universalist perspective, but rather for a portion: the poor. Access to health also did not contemplate the needs of the populations but offered a “basic” version (Paim; Almeida Filho, 1998).

In the 2000s, the debate continues with the concept of universality getting more restrict. The proposal for universal health coverage (UHC), advocated by international organizations, was based on reforms aimed at reducing State action. Such a strategy was based on the conception of residual citizenship, as well as aligned with the neoliberal perspective and centered on care (Giovannella et.al., 2018).

In Brazil, since before SUS implementation, disputes have been expressed through a discursive plurality around health representation: as a public good that follows the principles of universality and integrality; or as a tradable good, in other words, as a commodity, aligned with a neoliberal model that has been changing the relations between the market and the State (Giovannella, 2018).

In the field of health, these changes have had an impact on the representations of the right to health and the right to work. The changes in labor relations, expressed by the precariousness and rupture of forms of social protection, accentuated a process of individualization marked by consumption and by the ideology of self-entrepreneurship, as described by Jurca (2018; 2020) in studies about users, managers, and workers of popular clinics and primary care.

To understand how changes in the way of consuming have altered the possibilities and ways of exercising citizenship is Canclini’s (2005) proposal to analyze the relation between abstract rights (equality) and differences (class), associated with the appropriation of consumer goods and the ways of using them. Being a citizen, in previous contexts, meant a form of belonging and a form of collective participation in the public space that compensated for social differences. The deterioration of this model due to the adopted changes has strengthened other perspectives on rights.

Based on a welfare-oriented discourse, the entrepreneur proposes to “*give (access to) health at a lower cost*” This discourse is consonant with the concept of coverage (UHC), which offers a minimum set, focusing on medical consultations and exams, as a fragmented, selective, and service-centered care. For these market representatives, SUS is described as “inefficient,” “incapable,” “bad,” “with gaps.” PHC, on the other hand, are referred to with a “language of success.”

The reports analysis of popular clinics users (Jurca, 2018) shows that the right to health was also not part of this group’s discourse. On the contrary, they emphasized an individualistic perspective of the subject who takes care of himself, of his health needs, and does not depend (on the queues) of the State. Access to health, by the payment

of specialized medical consultations and exams, was emphasized based on values such as freedom of choice and autonomy to decide about one's own health needs. However, in this study, we discussed that the consumption of PHC care model to fulfill the needs is *“a failure when you need something more than just a medical consultation.”*

Autonomy and medical labor

Issues related to the autonomy of medical labor can be analyzed from the following dimensions: decision-making within the scope of the doctor-patient relationship; the “value” of labor in the market, including contracting models and wage composition; self-regulation of the profession by associations recognized by the State as capable of ordering their own actions (Ribeiro et al., 1994).

From the perspective of entrepreneurs, the conformation of medical labor in PHC boils down to a one-off care with no room for establishing bonds between professionals and patients, lacking autonomy regarding medical labor decisions. Medical labor is responsible for enabling such companies and making them profitable. The physician is the key player. In the municipality under analysis, there is a high demand for specialized consultations and a reduced supply of specialists per inhabitant in the state, below the national average (Scheffer et al., 2023). Due to the small number of local specialists, there is a dispute over the physicians' hiring (Campos, et al., 2023).

The contracting model occurs by professionals selling their services to these companies as legal entities. This hiring policy has advanced, especially in the private sphere, with the hiring of companies that provide medical services. From a legal point of view, it was supported by Precedent 331/1993 of the Superior Labor Court (TST), by sparse laws, and by changes in labor legislation (Law 13467/2017), which authorized companies to hire outsourced workers for the company's core activities.

According to this model, the medical professional enters the market as a service provider company. There is no employment relation between the self-employed provider and the contracting company/entrepreneurs, which are exempt from the responsibilities of taking

care of professional and health risks and labor charges (Levi et al., 2022).

The value of medical labor is tied to the provision of care. According to the interviewees, PHC represent a field of activity, in which physicians have greater “autonomy” in terms of flexibility of working time and of their salary composition. “When compared with SUS,” say the entrepreneurs, PHC physicians have control over their work schedule, the amount is paid per service, and *there are no denials!* The logic of “time is money” seems to be shared by physicians and PHC users as well. These self-employed consider that time is a value that cannot be wasted waiting for service (on duty) and in queues.

In this study, we observed that PHC constitute a medical workspace that has specific characteristics: defined financial gains according to the volume of care performed, flexibility of the workload, and precarious employment relationship. These aspects are associated with the idea of a new field of labor in the *the medical profession (which) is no longer liberal and has transformed into legal entities.*

The perspectives of the interviewees help to reflect on the ways in which the local private sector, linked to medical training and also to the medical labor market, is constituted in opposition to the logic of the public health system. The laxness of these companies' regulation is linked to another aspect of medical autonomy: the profession capacity of self-regulation conducted by institutions that order their own actions of standardization and supervision (Freidson, 1978; 1989 *apud* Ribeiro, 1994).

Final considerations

Having access to the conceptions, values, and practices of a group made up of subjects who occupy a privileged decision-making position (of their own business or of medical companies' regulation) and seeking to understand its meaning was fundamental for the problematization of the language around health. We found that, comparatively, there are more studies on “representations of disease” than “representations of health.” Therefore, this study can contribute to the understanding of the logic behind these companies' self-organization and expansion of their fields of action, favoring the growth of the sector.

The dimension of the SUS goes beyond medical care. The public health system fills the gaps in terms of actions and services that the private sector does not fulfill. In addition, SUS attends to 100% of the Brazilian population, however, the discourse of an alternative to the SUS seems to have an acceptance that, we believe, is worth further investigating.

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Authors' contribution

Sousa, M. N.; Oliveira, B. L. C. A.; Alves, M. T. S. S. B. and Carvalho, R. H. S. B. F. participated in the study design. Sousa, M. N. participated in conducting and transcribing the interviews. Sousa, M. N.; Oliveira, B. L. C. A and Carvalho, R. H. S. B. F. participated in reviewing the literature, analyzing and interpreting the interviews. Sousa, M. N.; Oliveira, B. L. C. A.; Alves, M. T. S. S. B.; Carvalho, R. H. S. B. F. and Andrietta, L. S. participated in writing, critically reviewing the content, and approving the final version for publication. Financing FAPEMA Processo COOPI 00709/18.

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