Denial, disdain and deaths: notes on the criminal activity of the federal government in fighting Covid-19 in Brazil

Negacionismo, desdém e mortes: notas sobre a atuação criminosa do governo federal no enfrentamento da Covid-19

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THE COVID-19 PANDEMIC IS A GLOBAL HUMANITARIAN and health crisis that, in Brazil, takes on an even more dramatic face as the country experiences an unprecedented political crisis. The federal government constantly adopts a criminal stance, denying science, concealing data and disdaining the suffering and mourning of thousands of Brazilians. As such political aspect is of utmost importance, we cannot fail to express our position.

The government reinforced social inequality, already so huge in our country. The pandemic unveiled Brazilian inequality. And inequality kills: data reveal higher death rates among lower-income population and among black people. A national serological survey conducted by the Federal University of Pelotas (UFPEL) revealed that the disease incidence among the 20% poorest population (4.1%) more than doubles the incidence among the 20% richest people (1.8%).

In Rio de Janeiro, the pandemic shifted from the richest areas, from the city south area and the top of carioca elite – from the parties of the sophisticated Ipanema Country Club – to the areas housing lowest–income populations; from the asphalt to the hill, the slum, the suburbs and the overnight surrounding cities. But the slum and its insurgent movements also resist, anticipating the non-existent government and developing solidarity strategies, such as the Complexo do Alemão Crisis Office, an initiative of Papo Reto Collective, such as the social communicators of Voz das Comunidades and the collective Mulheres em Ação pelo Alemão, which actually connects more than 30 community organizations in defense of life by means of solidarity actions in the community. Local Family Health Strategy (ESF) teams support the movements rendering substantive information, fighting fake news.

The social and working lack of protection furthered by the current government due to increasing informality, precariousness of labor relations, reduction of Bolsa Família coverage and cancellation of benefits, reduction and delay in granting pensions, sickness benefits, and maternity leave dreadfully shows its most perverse face exactly when sanitary actions still require social distancing so to reduce contagion, suffering and deaths.

A government uncapable even to distribute emergency aid. Rather, it's not just about unskillfulness – because they were quick-moving in freeing up resources for banks and large companies – but the purpose to create difficulties by requiring apps, smartphones and the web as way to access aid, leaving out the poorest amongst the poor. They delayed the distribution, caused agglomerations of persons, and probably, contributed to internalize in the country both the pandemic and the reduction of social distancing. Aid expansion and extension until after the pandemic is essential to

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assure life and to support social distancing – the struggle is for a minimum income that enables for citizenship –, to grant economic and social rights, to ensure the right to health and the right to life.

As if humanitarian, health and economic crises were not sufficient, we currently experience a day by day unprecedented political crisis in Brazil. We have an unruly government that secretes data and information, that overjoys the suffering and death of tens of thousands of Brazilians and disdains the mourning of more than 120,000 families, foments necropolitics, exterminates indigenous people, murders blacks, destroys lives. They profit from the pandemic to extinguish rights, heighten privileges, destroy the environment, confront democracy.

The national government, by lack of sensibility and compassion toward suffering and human pain, starred in scenes and regrettable decisions. Amid the worsening pandemic, on April 16th, the Minister of Health (MS) was dismissed by the President of the Republic for following the measures recommended by the WHO in dealing with the pandemic. He was replaced by a government-aligned health entrepreneur, who resigned after a month without rendering any service. As of May 16th, the MS is managed by the armed forces, being the Minister of Health a general carrying no experience in health. Two ministerial changes were followed by an acting minister who recommends the use of proven ineffective drugs[1] and hides data.

The most possible precise and transparent information on the evolution of cases and deaths number is crucial to control the epidemic. The daily report on pandemic evolution was interrupted, and, after protests published in the press, it became disclosed only late at night so to not being spread out by the night television news of most audience. To the problems of underreporting for lack of tests was added the mistrust in data disclosed by MS, in a way that the mainstream press started to count the data.

If it were not for actions of some governors and mayors, the National Council of Health Secretaries (Conass), the National Council of Municipal Health Secretariats (Conasems), and public institutions of various fields, the pandemic spreading out, which worsens every day – we are writing in mid-August 2020 – would have been much faster and more devastating.

Many institutions and professionals are endeavoring to fight the pandemic. However, the absence of unambiguous national direction and of a national health authority widely legitimized, guided by the best knowledge produced on the disease propagation, harms importantly, causing excess of suffering and deaths that could have been avoided.

Although measures of social distancing were early determined by governors, the absence of a national coordination and the denial of the pandemic by President Bolsonaro undermined states' strategies of social distancing. Diminishing the pandemic to a flu, he went out to the streets hugging and kissing people even after 17 persons of his entourage received positive results for Covid-19 after a visit to President Trump. Such denial weakened the measures for social distancing, reducing the population adherence to the strategy. The social distancing rate on April 4th was superior to 50% in eight states, and the national average was 54%. On May 28th, the national average rate fell to 41% and only a single state rate remained above 50%[2].

The pandemic reinforced the need to strengthen both the state health authorities and the regional cooperation among municipalities toward the effective construction of health regions, demonstrating the importance of the Unified Health System (SUS) to offer universal, free access and services across the country. SUS' principles of universality, integrality and equity, together with the extension of its services throughout the national territory, would carry the potential to deal with the pandemic, although chronically underfunded and harmfully defunded by the Amendment to

the Constitution (EC) 95, which froze social spending for 20 years. The EC 95 imposed significant losses to federal health funding in recent years, and cut 22 billion reais from the 2020 budget.

SUS' permanent underfunding reduces health public investments to less than 4% of GDP, and the public share in total health expenditures to less than 50%, despite the public spending substantial increasing by 2015[3]. Other national health systems providing universal access similar to SUS' apply at least 7% of their GDP in public health funding and 70% of their spending comes from public money[4]. In Brazil, health funding is worsening every year due to EC 95. It froze the Union's primary expenditure for twenty years (until 2036) and defined SUS' minimum federal participation as for new parameters, emphasizing the decreasing trend of the Union's participation in SUS funding, deepening funding problems and further overloading state and municipal governments, which already apply percentages much higher than the constitutional obligaton[5].

During Covid-19 pandemic, the MS low funding of new resources to health was added by a great delay in transferring resources to the states and municipalities[6]. Although the MS proposed a contingency plan as early as February and gave some drive towards actions to cope with the pandemic, was not able to implement. Health was allocated 39 billion reais, equivalent to only 11% of the total federal expenditures allocated for Covid-19, which was 338 billion reais[7].

Of the 39 billion allocated to health, only 11 billion had been used until June. That is, after more than three months of pandemic, 67% of the resources to be urgently applied remained in the budget of MS without even be committed. Of the resources for the Covid-19 emergency actions, 3.9 billion had been transferred to the states and 5.6 billion to the municipalities by June 2020. Resources have been committed very slowly despite the great speed demanded by the pandemic framework.

There is no doubt that coping with the pandemic relies on the strengthening the SUS in all its components: health surveillance, care at all levels, promotion, prevention and research. We need 'More SUS and More State to have More Health'.

The central concern is to save lives. This serious moment requires strengthening the SUS – public, universal, of quality –, so to provide the best possible responses to fight the pandemic, leaving a 'positive legacy' for SUS.

International experience confirms that measures of social distancing have managed to decrease contagion, prevent exponential growth of cases and reduce suffering and deaths, provided the observation of adequate, timely testing, identification of cases, search for and identification of contacts, home isolation and quarantine, and adequate protection of health professionals. Consistent evidence of reduced transmissibility related to social distancing is laid down. A study by Imperial College reveals that transmissibility reduction is related to greater social distancing, assessed by mobility automated measures over time in several countries[8].

The study reaffirms that the reduction of social distancing restrictions should be considered very carefully, because small increases in mobility rates can rise again the epidemic, even in places where Covid-19 is apparently under control[8]. The gradual reduction of restrictions should be accompanied by alternative interventions applying case identification and effective contact tracking, support for isolation and contacts with active health surveillance in the territories[9].

In the control of an epidemic, both the community approach as the ensuring of individual care are needed. The reduction of deaths for Covid-19 requires timely care with oxygen saturation monitoring by oximeter, exclusive sanitary transport, intermediate hospital beds to avoid worsening of cases, positive oxygenation, and even supply of equipped ICUs. Our Primary Health Care (APS) teams, especially ESF teams, know their territories,

their population, their vulnerabilities and, by and large, act from the health surveillance perspective, crucial to control contagion.

However, since the 2016 parliamentary coup, and, particularly, since the 2017 Primary Care National Policy (PNAB), new difficulties have been added to the never-ending challenges[10]. The Brazilian APS care model, carrying a territorial and community approach, is being mischaracterized, nearing an individual assistance model, responding to severe problems, without bond, continuity, coordination or population responsibility[11].

SUS' Primary Care has been suffering threats and setbacks, such as:

— implementation of the 2017 PNAB and the consequent decrease in the number of APS and professional workload;

— completion of the Mais Médicos (More Doctors) Program, leaving again hundreds of municipalities without a physician;

— creation of the Agency for the Development of Primary Health Care (Adaps), an autonomous social service embodied as a private company, shifting the APS public management to the private scope at the federal level. By hiring private companies for APS provisioning and training under SUS, the government commodifies primary care, the care sector that, to date, remains the least mercantile, more public, and more efficient SUS sector[12].

— attempts to create a restricted service portfolio[13]; and

— very importantly, funding changes.

The APS new funding modality imposes drastic consequences for the universality and territorial approach by replacing fixed and variable amounts of Primary Care Minimum Value (PAB) regarding incentives to ESF and Family Health Support Centers (Nasf) for a weighted per capita payment, calculated by the number of people enrolled[14].

Eliminating incentives for ESF and Nasf meant abolishing Nasf and, actually, extinguishing the ESF priority by equivalently funding primary care and ESF teams by the number of enrolled people. The incentive aims to replace multidisciplinary teams by physician–nurse pairs. The initiatives discourage the very idea of multi-professional working team and the possibility of ESF' sharef interprofessional actions, both tending to disappear in the medium run.

By the lacking of a population and community-based care model, the result will be "any catchpenny primary care" [11]. In the pandemic, those initiatives already show their perverse effects. Without the possibility of expanding the enrollment of users and of complying with performance indicators, municipalities will be further defunded.

The pandemic has brought many lessons, well summarized by Fleury[15]. She showed the importance of multilateral cooperation embodied in the WHO so to define international parameters and protocols for coordinated actions in coping with the global health emergency situation. She showed the need for transparency by governments in disseminating information for making the most correct decisions. She showed the importance of States to be able to exercise their national health authority, by regulating, providing effective surveillance and supplying health care to all citizens. She showed that it is essential to have scientific competence, technical and production capacity to produce knowledge, equipment, resources, all delivered with sovereignty so to face the pandemic[15].

Although those lessons are being denied by the Brazilian government, regional initiatives have advanced coordinately, while state and municipal governments have sought ways to address the pandemic consonant the latest knowledge.

Non-pharmacological measures are essential until an effective vaccine is available.

Okell et al.[16] show that differences in Covid-19 mortality rate patterns are difficult to reconcile with the arguments of collective immunity among different countries carrying equally well-structured health systems, as well as are the results of very different seroprevalence studies among countries that have managed to control the epidemic so far. They demonstrate that differences in mortality are explained by the time and accuracy of social distancing and health surveillance interventions by means of timely identification of cases, isolation, and cases tracking and quarantine[16]. Although the impacts of current control interventions on transmission need to be balanced with economic impacts, easing social distancing measures should be accompanied by compensatory measures so to prevent new waves of transmission.

Governments and civil society urgent tasks concern heavily investing in health surveillance strategies to allow the identification and the prompt isolation of people with Covid-19 symptoms and their contacts; campaigns to raise awareness regarding the need to use masks; the avoidance of people gathering and the keeping of a two–meter minimum distance; and leaving home only when necessary while respecting physical distancing whenever possible.

We have to be clear that strategies choices taken today toward SUS and APS will bring consequences for SUS in the future. What legacy will it bring? Surely, many learnings, many successes and mistakes.

SUS good performance will lead to its strengthening. However, we can also move towards greater commodification and privatization depending on the choices made. We may leave the pandemic behind carrying a more comprehensive APS and a stronger SUS if we manage to develop in the APS integrated to the network, surveillance initiatives, patient care, continuity of routine activities and, above all, if we deepen the community attributes resulting from ESF[17].

It is a time of mourning, of immense sadness, when we need to express our affections, our solidarity and compassion: more than 120,000 deaths were accounted for Covid-19 in the country from March to August 2020, deaths that could largely be prevented.

Yet, it is a time when inequalities are no longer invisible, in which SUS importance was recognized, in which new forms of solidarity are exercised. It is time for democratic forces to join in alliances in defense of life! Health is democracy. Democracy is health.

Collaborators

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