

The economic crisis and primary health care in the SUS of Rio de Janeiro, Brazil

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Abstract *This paper addresses the primary health care crisis of Rio de Janeiro public health system as of 2018. This municipality has experienced a robust primary care expansion since 2009, adopting Social Organizations for recruiting professionals and managing services, qualifying the infrastructure of units and prioritizing family and community medicine, as well as adopting management practices such as standardized offers, evaluation and pay-for-performance compensation, marketing, among others. Given the recent economic crisis, the municipal manager decided to reduce family health teams, considering the current National Policy of Primary Care and arguing that it is possible to optimize resources (doing more with less). In this process, he faced resistance that was not enough to stop him. Due to the resonance of this city (second largest in Brazil and prominent in the national press) and based on public documents and formulations on management, the crisis expressed in the primary health care of this city was debated around the implications of the adoption of Social Organizations in the sustainability of health services, conducting management processes and their rationalities, as well as the political action of social agents advocating for the SUS and primary care in particular.*

Key words *Primary health care, crisis, Rio de Janeiro, Brazil*

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Introduction

This paper aims to address the health management crisis, particularly in primary health care (PHC), in the city of Rio de Janeiro, starting in 2018. It begins with an appreciation of the implementation of the Brazilian Unified Health System (SUS), with a contextualization of the situation in the municipality from the late expansion of the Family Health Strategy (ESF), and a discussion on the exacerbating aspects of the recent political and financial crisis, affecting the sustainability of the municipal system.

This municipality's PHC has been on the rise since 2009, expanding access, attracting professionals from other states, and gaining national prominence. The recent crisis has been influenced by national and local lines and has mobilized different actors from civil society and some state bodies, and the discussion presented here is relevant due to the experience of PHC in Rio de Janeiro (second largest city in the country) and the possible effects and manifestations of the crisis on the SUS in other parts of Brazil it can reveal and anticipate.

SUS and PHC in the national scenario

Health is a fundamental right, a state duty, and is constitutionally guaranteed. However, SUS implementation has been experiencing underfinancing, low social legitimacy, limited access to specialized care, and difficulties in establishing regionalized networks and regulating the private health sector. Paradoxically, its operationalization includes advances in the field of immunization, HIV/AIDS, primary care, mental health, SAMU, among others.

Brazilian public investment in health is low – R\$ 3.48 (three reais and forty-eight cents) per capita/day, considering the three governmental levels. The State of Rio de Janeiro is the third-largest GDP nationwide and invests less in health than the Brazilian average. In 2017, the city invested R\$ 3.31 (three reais and thirty-one cent) per capita/day. Brazil's public health sector, which covers the entire population, is only 48% of global health resources, and contrasts with the public health costs of countries with universal access to health, such as the United Kingdom (94.2%) and Sweden (84%), and is close to the U.S. situation (47%), which favors the private system¹.

PHC's essential role for the organization of universal health systems (improved access, resolution, comprehensive actions and cost-effectiveness) justifies the investments made in countries that have preferred it in its structure, positively affecting health. Considering also the financial realm, PHC is a necessary condition for streamlining the system's expenses and organizing patient flows between different health services. People live longer and better^{2,3} in countries that invest in quality PHC.

The Family Health Strategy (ESF) is the primary modality of Brazilian PHC organization, and has also been recognized internationally in its more than 20 years of existence, despite its limits and challenges. The ESF has contributed to improving health markers such as access, child mortality, stroke mortality rate, and hospitalizations due to PHC-sensitive conditions⁴.

In 2013, Brazil faced a strong political instability, aggravated and complemented in the ensuing years by economic and social crisis, culminating, in 2016, in the impeachment of the President reelected in 2014, amid the emphasis on corruption, rising levels of unemployment and violence, the marked social polarization, fiscal adjustment measures focusing on social and labor policies, and societal and institutional processes that put democracy and politics at risk⁵.

Next, measures of more considerable effect on the SUS were adopted, such as freezing expenditures via constitutional amendment, the change in SUS funding blocks – which alters the logic of federal resource transfers with potential risks to PHC – besides advocating for low-coverage popular private health plans and supplementary health deregulation^{6,7}. In this situation, changes in the National Primary Care Policy (PNAB) were approved by the Tripartite Interagency Committee (CIT) in 2017, despite vigorous questioning from civil society sectors meeting within the National Health Council. The most substantial changes were the lower minimum number of community health workers (ACS) per family health team (EqSF), and the indication of more significant financial incentives for PHC formats preceding the Family Health Strategy (ESF), with the active representative role of municipal managers⁷.

The situation of PHC in the municipalities may be influenced by the new PNAB provisions, local projects and power correlations, and more general SUS constraints, such as aggravated underfinancing.

Health in the Municipality of Rio de Janeiro from 2009 and the current crisis

The hospital model has traditionally predominated in Rio de Janeiro, which had low ESF coverage and was organized in traditionally-shaped health centers (with primary care physicians attending to people without consistent enrollment, access, and follow-up mechanisms) until 2009. The elected management, re-elected in 2012, gave priority to the (late) expansion of the ESF. This was marked by the partnership with Social Health Organizations (OSS), the use of rationale and practices such as evaluation and pay-for-performance, quality improvement, standardization and seeking efficiency and transparency⁸, consistent with the assumptions of the state administrative reform undertaken in the 1990s, fed by the ideas of the so-called new public management.

This reality has been recognized locally and nationally by the standard of Family Clinics, and the increasing number of Family Health Teams (EqSF) deployed (from 128 in 2008 to 958 in 2016, according to MoH sources). Emphasis was also given to family and community medicine – with a higher number of medical residency vacancies and doctors trained with this profile – improved professional remuneration – without public careers – and innovations in the regulation of access and use of information and communication technologies⁸. It is noteworthy that there was no marked priority in shaping a service network, but in a central part of it: PHC. These initiatives were accompanied by marketing actions, giving it visibility, and family clinics were highlighted in the electoral proposals of several mayoral candidates in Rio de Janeiro in 2016. There is evidence of improvement in different health indicators related to this process, such as lower levels of hospitalizations for PHC-sensitive conditions⁹.

In 2017, the new municipal government, with a strong social base in sections of the evangelical churches and elected with the promise of “caring for people,” pointed to new health continuities and priorities, including the establishment of specialty centers, which did not materialize. By the end of 2017, 1,251 EqSFs were in place, and the 2018-2022 municipal health plan provided for a higher number of EqSFs in territories with greater social vulnerability¹⁰. Between 2017 and 2018, managers announced a municipal budget deficit, and in 2018, the payment of salaries of service professionals managed by some OSS in city areas was delayed, ACS were laid-off and

facility working hours were reduced. Besides the expected impacts on access, one of the likely effects of this process was the removal of professionals (notably doctors) from municipal PHC (to other municipalities/states and the private sector) and the lower levels of recruitment of professionals.

This period witnessed a resistance movement from municipal workers - “Not a single health service less”¹¹ -, with strong presence of PHC and mental health professionals, holding demonstrations and working with the union, legislative and judicial bodies. Strikes also took place, with partial disruption of services for several months. As can be seen, PHC management by different OSS (with different characteristics, statutes and incorporation and labor management policies)¹² in different areas of the city, placed some barriers to the workers’ political and union organization, besides generating layoffs without sanctioning them, and there are also reports of persecution of workers.

By mid-2018, a document from the Municipal Health Secretariat (SMS) – “Reorganization of PHC Services – Resource Streamline Study”¹³, among other measures, provided for the extinction of 184 EqSF and 55 Oral Health teams (about 1,400 jobs), and proposed a new team type based on the 2017 PNAB, with weak professional structure and high number of users per team, but presented as a strategy to qualify and streamline services. This proposal was marked by substantial interference by the Municipal Civil House and was made with the justification of the financial crisis and the accelerated expansion (for electoral purposes) of the ESF in the last year of the previous administration. The municipal management proposal also used the Lean philosophy (also called Toyota Production System), which seeks to eliminate waste –overproduction, waiting time, and over-processing, among others – through the improvement of flows and involvement of qualified and motivated people, believing that, by doing so, quality increases and production costs fall¹⁴.

The concept of productivity was central to this proposal, underpinning criteria to define team cuts and justify their permanence or change, and adopting schemes planned in the PNAB¹³. The document considered that there was a priori idleness in the teams that covered below 3,000 inhabitants, identified by the production of visits, despite strikes, possible effects of late payments on the performance of professionals, the fact that most of the EqSF work in territories affected by

armed violence, as well as the change in the information system underway in the city's PHC. Another element that stood out in the establishment of the criteria was team downsizing in privileged (middle class) areas, despite the presence of poor communities in such neighborhoods, the possible symbolic dispute when serving middle class people, the lower number of people with private health plans and other impacts of the crisis on people's health.

The Municipal Health Council (CMS) stood out, both for the elaboration of a consistent document analyzing Rio de Janeiro municipality's proposal and deliberating for the non-reduction of the number of EqSF¹⁵, approaching health workers, progressive parliamentarians, prosecutors, health counselors, among others.

Worth remembering is that the Ministry of Health informed that the municipality of Rio de Janeiro, which at the end of 2018 had 1,177 EqSFs in place, has a maximum ceiling of approximately 3,300 federally-funded EqSFs, that is, almost three times the total of existing teams. In March 2019, the number of EqSFs dropped to 1,090, exacerbating team downsizing evidenced at the end of the previous year.

Some debates: OSS, managerial prospects and political action in the crisis

The current PHC crisis in the municipality of Rio de Janeiro seems to be the result of a combination of local and national elements (municipal decisions, PNAB, economic crisis, SUS crisis, and management advancement), a crisis set in a singular and contingent scenario linked to elements from other spheres and sites. It seems appropriate to discuss some aspects of this process.

The first concerns the OSS partnership, which intervenes in the traditional rationale of employment and employee representation with employers. The dismantling of PHC teams triggers an initial moment of resistance, including legal support guaranteeing the right to strike, late payment of salaries and dismissals, which is not sustained later on when OSS contracts are renewed.

Another aspect concerns PHC sustainability in the municipal experiences of the SUS, considering, for now, the implementation of the adopted legal management models. Recognizing the limits imposed by tax legislation, if the SMS had made an earlier effort to hire professionals through public examination (rather than OSS), how would the political-managerial conduct of

the current financial contingency be performed? How would this imply workforce management and health care? One should remember that the cost of an OSS employment contract (including other labor costs) is usually higher than that of a statutory employee with a similar position and working day. Also, OSS recruitment does not include a career plan¹².

The third aspect discussed refers to management prospects and their implications in the public health sector. The need to improve management or outsource it has been conjured continuously, sometimes ignoring SUS underfunding and health singularities. In the case of Rio de Janeiro, where managerial rationalities already had a prominent place, in the current crisis, one could see a primary flaw, in which a questionable health budget cut and particularly in PHC generated the need to be justified, giving rise to the production of discursiveness and decision-making scenarios – although it seemed to be based on a situational analysis to formulate a proposal for change –, “depoliticizing” the problem and individualizing it in the performance of professionals, with blatant paradoxical injunctions, that is, contradictory and incompatible orders, to be “administered” by the workers-subjects¹⁶, under the concreteness and ghost of dismissal in the case of this municipality.

The need to make good use of public resources is not questioned, nor is it assumed that health professionals always work at their maximum power, or that managers also do so. It is a matter of recognizing the political nature of management (as an exercise of power in organizations, where technique is one of its realms), by analyzing how extra-sectoral policy interferes in this process, how managers stand in discursive and practical terms to deal with contingencies, how they interpret them and consider (or not) the participation of other political actors in the search for solutions.

Also, one should bear in mind that, in health, despite technological development (which impacts on costs and types of care) and more structural influences, work is firmly based on relationships and is immaterial, intersubjective, where viewing workers as a simple resource ignores the presence of a robust ethical-political component (not only rational technical) affecting care relationships, as a field of power and subjectivation relationships¹⁷, not to mention the constraints and contingencies that work scenarios and the situation concretely impose on the health work process in times of crisis. Managerial rationali-

ties¹⁸ that infantilize workers, constrain them to be “collaborators” (collaboration as formal and moral status rather than construction), burden them with the responsibility of being creative and doing more with less tend to produce suffering, competition and even cynicism, whereas in the SUS, and particularly PHC, we require workers that protect people’s lives.

Final considerations

The PHC crisis in Rio de Janeiro materialized in late payment, restricted access to actions and services, layoffs and team cuts, addressed in this

paper, builds on the combination of local and national elements. As a city that profoundly resonates in the country (due to the presence of the mainstream media and because of its symbolism), the dismantling can echo or carry meanings beyond its geographical boundaries.

We highlight the implications of the adoption of OSS in PHC concerning the sustainability of services (although it is the product of more elements not considered here), the effect of managerial rationalities on health work (especially those informed by the managerial ideas) and conducting management processes in before the democratic institutionality of the SUS (respecting or ignoring control and social participation).

Collaborations

EA Melo, MHM Mendonça and M Teixeira participated in the design, drafting, review, and final approval of the paper.

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