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Poverty and social inequality: tensions between rights and austerity and its implications for primary healthcare

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Abstract *The relationship between poverty and healthcare is evident in Brazilian society, constituting one of the faces of the inequalities resulting from a perverse social context. Focusing specifically on primary healthcare, this review of the literature on health policy highlights the tensions between the social question, social rights, and current austerity policies, and the latter's effects on healthcare for the poorest segments of the population. The 1988 Constitution represents a social pact that goes against the principles of austerity policies imposed by neoliberalism. With the deepening financial crisis and approval of Constitutional Amendment 95/2016, social protection policies such as those underpinning Brazil's national health system ("Sistema Único de Saúde") find themselves under threat, with direct consequences for the country's population. Despite the country's achievements in improving access to healthcare for the poorest, austerity measures are likely to strengthen barriers, seriously threatening the progress made in operationalizing the right to health. Therefore, considering that primary healthcare is a differentiated care model, this study reiterates the relationship between primary care and the social dimension, given that the impacts of the dismantling of social policies on population health are already being felt.*

Key words *Poverty, Austerity, Health inequalities, Primary Healthcare, Family Healthcare Strategy*

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Introduction

The relationship between poverty and health is evident in Brazilian society and the country's health services. Historically and structurally ingrained in society, poverty and inequality are faces of a perverse social context and, thereby, affect health.

From a healthcare production perspective, this social context imposes itself both epistemologically and in everyday practice. By defending that health is socially produced, the field of public health emphasizes that social determinants of health provide the basis for understanding health/disease processes. Viewed from this perspective, the understanding that democracy is the cradle of universal, comprehensive, and equitable healthcare shapes political positioning in pursuit of a process of "articulation between the social (determinants of health) and the technical/scientific dimensions of health"[1], generating tensions with hegemonic conceptions of health. In the same vein, Cohn[2] asserts that "recent years has seen the depoliticization of health in the country, whether in relation to knowledge production or in the implementation of the SUS (Brazil's national health system)", adding that there is a greater focus on "technification" as a way of increasing the effectiveness of health policy and programs.

It is important to recognize, however, that, in face of a social context underpinned by capital accumulation and growing concentration of wealth, citizenship and the social policy agenda pose increasing challenges. The implementation of social policies, even those enshrined in the Constitution such as social security, constitutes a field of ongoing tension between the state and society permeated by varying interests.

Deepening inequalities in Brazil go hand in hand with increases in poverty in the country, making disparities in income and between genders, races/ethnic groups, and regions all the more evident. Brazil has one of the highest concentrations of income in the world. In a country with a population of over 200 million, 75% of the richest 10% earn up to 20 minimum salaries, while 1% (1.2 million people) earn over R$ 55,000 per month[3]. The proportion of the population who earn up to half a minimum salary ranges between 15.6% and 21.5% across regions, except for the North and Northeast, where half the population earn only up to half a minimum salary. With respect to the per capita household income, 77.3% of people living in private households in the Northeast Region earn up to a minimum salary, 76% in the North, 50.2% in the Southeast, 52% in the Center-West, and 42.3% in the South[4]. With regard to the labor market, according to the Brazilian Institute of Geography and Statistics (IBGE), the first six months of 2019 were very hard for Brazilians. The national unemployment rate was12.7%, with the 14 states with rates above the national average being located in the North and Northeast, Rio de Janeiro, São Paulo, and the Federal District.

The statistics illustrate the magnitude of the social question in Brazil, with deepening poverty and widening social inequalities resulting from the concentration of wealth in the hands of a privileged few. Regional inequalities are stark, with the North and Northeast regions at a significant disadvantage compared to other regions.

Revisiting the discussion of the relationship between poverty, inequalities, and health, in the face of the resurgence of regressive politics and austerity measures, the questions raised by Schraiber[1] and Cohn[2] are a timely call to reexplore the social production of health and disease.

Underpinned by a broader perspective on health and healthcare, Brazil's national health system (*Sistema Único de Saúde* – SUS)emphasizes the impact of the social and historical context on health. By providing that healthcare "is a right of all and duty of the state", the 1988 Constitution, a major achievement for public health in Brazil, states that health is influenced by determining and conditioning factors and highlights the need to ensure the "physical, mental, and social well-being of individuals and the community"[5]. Within this context, primary healthcare (PHC) is core concept underpinning practices in the area, gaining in complexity in the face of the social determinants of health and disease.

Poverty therefore poses a major challenge to healthcare processes, both for service users living in poverty, who carry in their bodies and subjectivities the marks of "social suffering", and health professionals, affected by difficult working conditions or who feel powerless in the face of the sheer size of social problems[6].

In light of the above, we might ask how do retrograde steps in the domain of social rights affect healthcare for the poorest in society, particularly in the context of primary care? Guided by this question, this article presents a review of the literature on health policy, focusing specifically on primary care, evidencing the tensions between the social question, social rights, and current austerity policies and the latter's impact on healthcare for the poorest groups in society.

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The right to health and austerity: tensions around the social question in Brazil

The social question emerged at the end of the eighteenth century with the advent of the industrial revolution, when capitalism brought a new dimension to poverty. The massive impoverishment of the working classes and deepening poverty, combined with the accumulation of wealth, are fundamental characteristics of the social question, underpinned by the relationship of exploitation between capital and labor.

Paulo Netto[7] stresses that "the social question is constitutive of capitalism", distancing himself from the idea that it is a transitory consequence or the result of moral weaknesses[8]. Poverty is thus a consequence of the limitless exploitation of labor by capital at a time of rapid economic growth. Against this backdrop, new social policy measures were created in response to pressure brought to bear by the workers' movements that were beginning to take shape. The government subsequently came into play at a time when voluntary aid and charity were no longer enough to address poverty, with actions focused especially on workers' health and tackling unemployment.

This movement is considered to be the embryo of social rights, which began to emerge in the twentieth century. Citizenship gained prominence, particularly in the post-war era, known as the "thirty glorious years" due to a sustained period of economic growth in Europe, the foundation of the welfare state in Nordic countries and part of Western Europe, and the momentum of the US economy. According to Paulo Netto[7], this new dynamic of capitalism "seemed to consign the social question and its manifestations to the past – a quasi-privilege of the capitalist periphery, grappling with their problems of 'underdevelopment'".

In the 1970s, a new crisis of capitalism began to take shape, characterized by the unrestrained accumulation of capital, more specifically the financial capital. The state and public spending were held accountable for the crisis, whose solution was a reduction in the size of the state and spending cuts. According to Fiori[9], the neoliberal offensive sought to dismantle the welfare state, resulting in an "ideological victory that opened the doors to and legitimized something of a savage revenge of capital against policy and against workers". Along the same lines, Iamamoto[10] points to the role of the state in the financialization of the economy, through privatization, the dismantling of social policy, commodification of public services, and loosening of labor laws, on the one hand, and the reduction of costs for business (reduction of the "labor factor" and an increase in exploitation) on the other. The minimal state means the maximum state for capital, imposing a paradoxical logic: exponential economic growth coupled with the deepening of all types of inequalities.

Claiming that flexibilization (of production and labor relations), deregulation (of commercial relations and financial circuits), and privatization are the three central pillars of this restorative project, Paulo Netto[7] cautions that while "it is evident that late capitalism has not liquidated the nation state, it is clear that it has been working to erode its sovereignty – however, it is important to highlight the differentiability of this erosion, which affects core states and peripheral (or weaker) states differently".

From this perspective, Brazil – a country that conforms to the dependent model of capitalism and marked by a colonial past – is uniquely embedded in this reality and also addresses the social question in a peculiar manner. Framing Brazil "within the late bourgeois revolutions", Guerra et al.[11] claim that "social change was under the near-monopolistic control of anti-social and authoritarian interests", where social policy was restricted to specific segments of the population, constituting strategies to legitimize the dominant powers. Thus, economic growth was detached from social integration, meaning that in the 1980s, Brazil, while figuring among the world's largest economies, was ranked among the three countries with the highest levels of income inequality[11].

However, the1988 Constitution laid the ground for the construction of a new proposal for social protection underpinned by the social security model. The underlying principle of social rights was the concepts of universalization of citizenship and social justice and social policy was organized to meet the population's needs. For Teixeira and Pinho[12], "the inclusion of social insurance and health and healthcare as part of social security introduces the notion of universal social rights as part of the condition of citizenship, previously restricted to the beneficiaries of the social insurance system". The new model was characterized by the "universality of coverage, recognition of social rights, state guarantees and duties, and the subordination of the private sector".

In the Brazil of the first decade of the twenty-first century, despite the contradictions of

the globalized world and the crisis engulfing the welfare state, economic growth was seen to be associated with poverty reduction. Increased income resulting from employment growth and economic expansion, combined with investment in social policy and policies aimed at increasing income-generating opportunities for people living in extreme poverty, are important elements in the recognition of the changes that Brazilian society went through[11].

However, Brazil has experienced major setbacks since 2016,including successive attacks on social policy, posing a serious threat to the social gains achieved in recent decades and undermining the living conditions and health of the population. As Paim[13] posits, despite an increase in income across all segments of the population, "the forces of capital orchestrated a parliamentary coup in 2016 to impose the onus of (structural) adjustment policies on the majority of the working population, with a new fiscal regime and social security and labor reforms".

Thereafter, the country has witnessed the promotion of apolitical project that goes totally against the democratic accomplishments of recent decades. As Pochmann[14] points out, the social advances and decline in inequality seen since the 2000s did not appease the whole of society. On the contrary, it generated deep dissatisfaction across the middle and dominant classes, aggravated by the deepening of the 2008 financial crisis. Thus, the coup of 2016 opened the way for a return to the project initiated in the 1990s – partially interrupted by the governments of the Workers' Party – realigning Brazil with US interests on the global geopolitical front and focusing on labor, fiscal, and social security reforms (such as Constitutional Amendment (CA) 95/2016) as a way of restoring economic growth, boosting employment, and promoting social well-being.

CA 95/2016 introduced a "new fiscal regime", freezing public spending over the next 20 years and read opting "austerity" as the underlying principle of public administration. This freeze did not apply to spending on public debt, however, which accounted for 40.66% of the 2018 federal budget[15]. Little is known about spending on servicing the public debt and its creditors and not even the terms of the contracts are questioned. Serving the interests of the financial system, securing a primary surplus is the aim of various governments, with a view to, in the language of the Central Bank, ensuring the government's capacity to honor its public debt commitments. Drawing on the reflections of Eric Toussaint described by Bovy[16], one might ask: is this debt legitimate, legal, and sustainable or odious?

Rossi et al.[17] claim that "a political decision that entails cutting social spending can also be a decision on the deprivation of access to rights". They ask: "what are the effects of austerity on the ground?" Teixeira and Pinho[12] also ask: "what are the impacts of austerity measures on the social protection network and the legacy of social security enshrined by the Magna Carta of 1988?"

These questions suggest that public debt lacks legitimacy. In their present form, austerity measures do not take into account their consequences for social inclusion and social policy – and particularly for the protection of the poorest, who "depend heavily on the state to increase their income and access health centers, hospitals, clinics, immunization clinics, crèches, and primary schools"[3] – further limiting the state's capacity to reduce inequalities and tackle poverty. In this context, it could be said that there is a "depreciation of social policy"[12], to enable the market to operate under its own laws, without regulation or social protection. Thus, questions about the direction the country is now taking hark back to the guiding principles underlying the right to health. How can we guarantee the right to health in the face of this reality, in view of the stark inequalities in everyday life and in access to healthcare?

Inequalities, social determinants and their effects on access to healthcare

Health is inextricably linked to the social question, reflecting living conditions and revealing to the extent to which the state is involved (or not) in tackling social problems[18]. Understanding social inequalities is a key for understanding human life, both in terms of disease, morbidity, and mortality and health and quality and length of life[19].

Within this context, the social determinants of health and disease framework is anchored in the idea that "the structural patterns of production and reproduction of domination, exploitation, and marginalization in concrete societies shape ways of life and are expressed in health/disease processes"[20]. From an emancipatory perspective, Breilh[21] suggests that, more than health, what is in evidence is "the social determination of life"[22] – social determinants that shape ways of living and, consequently, health and disease processes.

Thus, understanding how social inequalities influence health and access to health services is of

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the utmost importance since, as Barata[23] argues, "there are systems that worsen existing inequalities in social organization and others that seek to compensate, at least in part, the harmful effects of social organization on the most socially vulnerable groups".

It can therefore be inferred that the structuring of health systems can lead to tensions between different ways of understanding health/disease processes and approaches to healthcare. In this respect, Barreto[24] reminds us that the concept of social determinants of health coexists with concepts espoused by the field of biomedical sciences, under pinning biological explanations of disease and resulting and a "modern" system focused on prevention technologies, diagnosis, cure, and rehabilitation.

These two views jostle for space not only in the epistemic field, but also in the institutional and financial sphere, commonly resulting in greater investment in structuring health systems than in tackling the social and environmental determinants of health. According to Barreto[24], advances in health technology have not led to corresponding improvements in population health, particularly in marginalized regions and among disadvantaged groups, confirming that "it is no coincidence that the health status of poor countries is always worse than that of rich countries".

The author also underlines that it is increasingly evident that countries with broader social protection systems have achieved overall improvements to population health, reiterating Travassos et al.[25] argument that more equitable systems assure more equal access to health services according to people's health needs, regardless of social group. However, there are still many barriers[25] to access, which are mostly imposed on and experienced by the poorest segments of the population.

A recent survey of Brazil's Family Health Strategy (FHS) conducted by Malta et al.[26] comparing data from the 2008 and 2013national household surveys, showed that coverage increased from 50.9% to 53.4%. PHC services reached 95% of municipalities in 2012 and had 33,404 family health teams, providing coverage to 55% of the population. However, the study identified inequalities in access to and the use of health services across different regions, with more than two-thirds (70.9%) of the population in rural areas being registered in PHC services, compared to 50.6 % in urban areas. Coverage was highest in the Northeast Region and lowest in the Southeast. In the Northeast, FHS coverage reached90% in the states of Piauí and Paraíba, 80% in Rio Grande do Norte, Sergipe, and Maranhão, and 73% in Ceará[26].

Although the authors recognize the importance of prioritizing FHS coverage for the most vulnerable social groups, they stress that increased coverage alone will not fully meet health needs, requiring other interventions (work process, inputs, flows, accessibility, equity) to boost the quality of service provision[26].

Municipal FHS coverage varies widely depending on population density, from 90.73% in smaller municipalities (up to 20,000 inhabitants) to 40.93% in large municipalities (over one million inhabitants)[27]. Giovanella and Mendonça[28] highlight that in small-sized municipalities the implementation of the FHS was rapid, while in large cities complex problems hindered implementation, including social structure and the fragmentation of traditional health systems.

This data shows the persistence of inequalities in access to healthcare and FHS coverage across different segments of the population. As Barata[23] highlights, "addressing health inequalities depends on public policies that are capable of modifying social determinants, improving the distribution of benefits, and mitigating the effects of the unequal distribution of power and property in modern society".

But how do we address health inequalities in the face of the austerity policies announced in the current conjuncture? Santos and Vieira[29] draw attention to the fact that the impact of austerity measures in Brazil tends to be more severe than in developed countries because, as mentioned above, it is one of the most unequal countries in the world and has a fragile social protection system.

Paes-Sousa et al.[30] suggest that the economic crises and austerity policies adversely affect both poverty reduction and the health of the most vulnerable, as evidenced by child mortality rates for example. The authors argue that, "while the country has been unsuccessful in reducing violent deaths, advances in health and social assistance programs have contributed decisively to reducing the residual prevalence of deaths due to malnutrition and diarrheal illnesses among children". They also mention a series of news stories published since 2018 signaling retrograde steps in health – such as the risk of measles outbreaks, drop in vaccination coverage, and the threat of the return of poliomyelitis – emphasizing that "less investment in health is felt in primary care, affecting health promotion, prevention, and care services"[30].

At this point, it is important to turn our attention to primary care, recognizing the complexity of this level of care, both in terms of service delivery and the everyday practices of health professionals, particularly in contexts of high vulnerability. Considering that the social dimension is one of the constituents of the production of health, what are the challenges posed to healthcare practices in primary care services?

The social dimension and Primary Health Care: [escalating] challenges in times of austerity

PHC has made historic gains both in terms of population health and the organization of the SUS. Despite broadening the policy between the first and second versions (2006[31] and 2011[32]), the revision of the National Primary Care Policy (PNAB, acronym in Portuguese) in 2017[33] generated tensions surrounding advances made and the consolidation of the right to health.

While the PNAB has preserved its guiding principles, recent debates about the new version[34,35]have highlighted changes that point to retrograde steps in the structuring of primary care that could have a negative impact on the health of the population, particularly among the poorest. These include: the weakening of the FHS, which is no longer a priority as the guiding element of PHC; changes in the functions of community health agents, whose inclusion in family health teams is no longer a compulsory; and weakening of health services due to the reallocation of funding.

This occurred notwithstanding the fact that the structuring of healthcare networks (*Redes de Atenção à Saúde* - RAS) reaffirmed the vital role played by PHC within the system, where it constitutes the main point of entry to the health care system, the center of communication of RAS, and a key element in the coordination of healthcare[36]. However, as Testa[37] highlights, the integration of PHC into the RAS poses a challenge for the system[34]. Counter posing the term "primary" care against "primitive" care, the author[37] defends that the former is integrated into the health system, serving the needs of the population, not a "second-rate service". In the same vein, the common representation of PHC as "medicine for the poor" or "low-cost simplified care"[37] deviates from its underlying principles, which state that it is the "first level of care and strategy for reorienting the health system"[38].

Thus, while we should distance ourselves from the notion of PHC as medicine for the poor, it is important to recognize that the social question is constitutive of Brazilian society, imposing (unfair) disparities in living conditions and access to health services spanning across healthcare productionprocesses[39]. Referring to healthcare work processes as encounters between subjects, bodies, and affection, Onocko Campos and Campos[40] stress that, in face of the reality in Brazil, healthcare in pockets of poverty is a consistently intense and unique experience. According to these authors, "[...] working to defend life is hard, painful, and harrowing in some regions. [...] Permanent contact with pain, risk, and suffering activate our own vital impulses"[40].

Tackling the expressions of the social question is therefore an intricate part of the SUS, both through the challenge of building a civilizing political project and in the everyday reality of health services, which need to be recognized as being valid within the existing relationship between the social dimension and sphere of health. Viewed from this perspective, the territory is fundamental, given that the actions promoted by the teams that make up the FHS and centers of support for family health are organized in closer proximity to people's everyday lives. More than a geographical limit, a territory is a "territory of pulsating life, conflicts, and differing interests, projects, and dreams. The territory in use in heal this simultaneously land and economic, political, cultural, and epidemiological territory"[41]. Like territory, the subjective dimension needs to be recognized in the composition of the singular co-production of health/disease/care processes, evidencing the (individual or collective) subject as a vital factor in the construction of public health[42].

It is therefore vital to recognize that health teams feel affected by social reality, often paralyzing more than enabling and inventing their actions and needing "disalienating devices"[6]. For the authors, the suffering produced in the face of the social reality experienced in the peripheries of cities reflect "fragile, precarious, abused, and violent subjectivities", calling for strategies developed on different fronts: sanitary, clinical, social, and productive. On the other hand, in view of the context of vulnerability, the authors suggest that however poor a given territory, it is the people who live there who are able to talk about local potentialities, distancing themselves from the idea of transforming care into population control and surveillance[6]. These observations reveal how the social tensions present in society affect

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everyday care processes, raising questions about which care pathways to take within PHC in the face of a reality of poverty and the dismantling of social policy, not only in the area of health, but also social security.

Against this backdrop, particularly with the intensification of austerity measures and the restrictions imposed by the CA 95/2016, primary healthcare finds itself threatened by regressive measures such as those suggested by the new PNAB (2017)[33]. Another substantial blow for PHC was the changes in the *Programa Mais Médicos* (More Doctors Program) made at the end of 2018, particularly the cancellation of the agreement with the Cuban government mediated by the Pan American Health Organization. The program led to significant improvements in access to health services for disadvantaged groups by hiring doctors to work in understaffed poor and remote regions[43], with the termination of this agreement undermining the health gains achieved by the program.

Sperling[44] reaffirms that "primary care is not just the first structured contact for patient care, it is also, without doubt, a field in dispute over the production of signifiers and meanings in the process of caring for human life", which is directly affected by socially produced inequalities.

Against this worrying backdrop, it would seem crucial to revisit the "democracy and health" discourse proffered by Sérgio Arouca at Brazil's8th National Health Conference in 1986asa political call to fight against the dismantling of the SUS[45].

Final considerations

This literature review sought to explore the inextricable link between the social question–the expression of the inequalities ingrained in Brazilian society – and healthcare and healthcare practices. The effects of poverty and inequalities condition healthcare and have taken on an even greater dimension given the current tensions between rights and austerity in the country. The ongoing clash between different political, economic, and ideological projects has intensified since the 2016 coup and recent studies have confirmed that they are present in the SUS. However, it is important to recognize that the political wrangling surrounding different SUS projects are part of its history.

The social dimension cuts across and is inseparably intertwined with health production. As the saying goes, "austerity is bad for health"; we might equally say concentration of income, the non-protection of constitutional rights, and lack of respect for diversity are also bad for health. Numerous doubts and uncertainties abound on the horizon, particularly when it comes to the health of the poorest, who have historically suffered most from the impacts of social inequalities. In times of austerity, it falls on society, as Arouca suggests, to find path ways to cooperation and dialogue to enable the construction of other perspectives on good living. It is important to stress, however, that austerity measures such as spending cuts and cost containment are not a solution to the crisis, since history has shown in various parts of the world that they only serve to aggravate it. We need to take the debate on health needs and priorities – such as the right to comprehensive healthcare – to the public, in order to secure the resources that guarantee social policies.

We conclude this review by recognizing the need for a more in-depth analysis of the issues addressed above and conjugating the verb 'hope', believing that it is possible to weave new threads into the country's social fabric to build a fairer and more equal society.

Collaborations

DF Pitombeira and LC Oliveira participated fully in study conception, drafting the article and revising it critically for important intellectual content, and gave final approval of the version to be submitted.

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