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The practice of Family and Community Medicine in Brazil: context and perspectives

A prática da Medicina de Família e Comunidade no Brasil: contexto e perspectivas

La práctica de la Medicina de Familia y Comunidad en Brasil: contexto y perspectivas

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In order to understand and discuss the practice of Family and Community Medicine in Brazil, it is important to know the context in which it has been developed and the daily challenges it faces. Brazil is a country with continental dimensions and heavy socioeconomic inequalities between the various regions and social strata. The country's government is organized according to a federative model that assigns important autonomy to states and municipalities in the management and control of public policies, favoring heterogeneity in the ways such policies are expressed in the territory. The country has two health systems that have coexisted for nearly three decades: one public, with universal access, the Brazilian Unified National Health System (SUS), and the other private, representing the private health insurance and health plan market.

Created in 1990, the SUS was conceived to guarantee universal access for the Brazilian population but has suffered from chronic underfinancing alongside limited efficiency in public spending and is still short of expectations by the nearly 160 million Brazilians that depend exclusively on the public system to care for their health. Public opinion polls have consistently identified health as the main problem faced by government in Brazil. Despite this scenario, the numbers in SUS are impressive: 4.1 billion outpatient procedures a year, 11.5 million hospital admissions, and 530 million medical consultations (Brazilian Health Informatics Department. Informações de saúde. http://www2.datasus.gov.br/DATASUS/index.php?area=0201, accessed on 21/Jan/2018). The SUS also has internationally acknowledged expertise in such programs as immunizations, HIV/AIDS treatment, and transplants.

Meanwhile, Brazil's private health plan market now has more than a thousand operators serving 47 million users [1] and concentrated on medium and high-complexity care, leading to high costs for the system. Historically, the operators' response to rising costs has been to readjust the monthly rates the bureaucratization or outright refusal to authorize more expensive procedures. In a recent move, some plans have invested in hiring family physicians in order to dissuade users from turning to specialists or hospitals for their first care.

Family and Community Medicine in Brazil is still practiced predominantly in primary care in the SUS. In 1981, the National Commission on Medical Residency officially recognized the specialty (known at the time as Community Generalist Medicine), three years after the *International Conference on Primary Health Care in Alma-Ata*, Kazakhstan, in a context characterized by several nations' efforts in the World Health Organization in the search for solutions to the crisis in the hegemonic health care model, viewed as fragmented, expensive, and inefficient.

The Family Health Program (PSF in Portuguese), created by the Brazilian Ministry of Health in 1994, can be considered Brazil's response to the Alma Ata recommendations in the public health policy field [2]. The program was initially selective and targeted to the populations and regions with the greatest risk and vulnerability, later expanding its scope, and with the creation of the Family Health Strategy (ESF in Portuguese) it became the proposed portal of entry into the system, supplying comprehensive health care for the entire user population of the SUS.

With the ESF, primary health care in Brazil has grown in the last two decades and now has 42,000 basic health units (UBS in Portuguese), covering 72% of the country's territory. The most frequent team format, promoted by the Brazilian Ministry of Health and representing more than 90% of the total in primary health care, is the family health team, consisting of a medical generalist, nurse, nurse technician, and community health agents. Although fewer in number, there are still also "traditional" teams consisting of medical clinicians, obstetricians/gynecologists, and pediatricians, the predominant team format in Brazil in the 1970s and 1980s.

Importantly, primary health care in Brazil is more than teams with physicians, and also includes oral health teams (consisting of a dentist and dental assistant and/or technician), Family Health Nuclei (NASF in Portuguese; with teams of psychologists, physical therapists, and nutritionists, among others), providing matrix-based support to the core family health team, discussing cases and/or providing joint clinical care, besides the so-called Street Clinics, multidisciplinary teams that provide roving care to the homeless.

The expansion of primary health care in Brazil has not been accompanied by a sufficient increment in physician training or in the number of specialists in family medicine. This reveals a historical bottleneck in filling physician vacancies in the teams. Even with the implementation of the More Doctors program, which has allocated 18,000 new professionals to primary health care since 2013 (the majority foreign physicians), unfilled medical positions are still common. This problem involves a quantitative issue, since Brazil still has fewer physicians per thousand inhabitants than other countries with universal health systems [3], but also a problem with the profile of medical graduates, most of whom are channeled to hospital specialties.

By far the largest share of primary health care administration is done direct by the municipalities, who are responsible for maintaining the physical infrastructure of the UBS, plus supplies and workforce management. The hiring format for health staffers varies considerably, often with temporary contracts, especially in the smaller municipalities. Some cities, including Rio de Janeiro and São Paulo, Brazil's two largest, outsource the management of primary health care to non-profit organizations, the so-called Social Organizations. However, this management model has been criticized by social movements and specialists, citing problems with transparency in the contracts and precarization of labor relations [4].

Users' access to UBS is characterized by the health team's effort at arrangements capable of reconciling spontaneous demand with programs targeted to priority population groups. Due to the still-high population-to-team ratio (3,450:1), the team's mission often becomes dramatic, especially in regions with fragile health networks around the UBS and/or populations in situations of severe social vulnerability. In the authors' experience, the attempt has been to guarantee treatment of acute cases during the same shift and other cases within a week, but such targets have not always been met, due to the heavy pressure for care.

Primary health care as the coordinating force for care is still a distant reality in Brazil. To effectively achieve this role requires the ability to mobilize and decide on the network's existing resources (beds, procedures, specialized consultations, inputs). The rhetoric according to which primary care coordinates care as a whole does not stand up for a moment when the family physician attending a patient over time and completely familiar with the case recommends the patient's hospitalization, and in order to obtain a bed, has to refer the patient to another service (such as an Urgent Care Unit, or UPA in Portuguese).

Nurses play a central role in the primary health care work process in Brazil, with reasonable autonomy to diagnose diseases specified in public health protocols, order tests, and prescribe the respective medications. However, this sharing of prerogatives has been the target of disputes between the different health professions. Brazil has outdated, undetailed legislation on each health profession's exclusive and shared activities, and most of the existing legislation dates to before the SUS was cre-

ated. The situation is further complicated by weak governance mechanisms for regulating work relations in health, besides a lack of national-level public spaces equipped to mediate conflicts between the professions and to help resolve doubts on the possibilities and limits of each profession's activity, when such distinctions are often not provided for explicitly by law. In practice, this role is played precariously and sporadically by the ordinary court system.

Working in impoverished areas with severe social vulnerability (a common situation in Brazil) has been a challenge for all those involved. These areas are characterized by precarious sanitation, housing, and transportation, and in recent years by an explosion in unemployment and violence associated with the co-called "war on drugs", resulting from the population's impoverishment and constant clashes between the state police apparatus and the drug traffic. In Rio de Janeiro, for example, health professionals are frequently prevented from conducting work outside the clinics because of the risk of shootouts.

Given the situation as described, we wish to briefly list some of the possible contributions by family physicians to the development of primary health care and the SUS in Brazil. The first contribution was the consolidation and improvement of residencies in Family and Community Medicine, where there was an important increment in places since implementation of the More Doctors program (4,700 new places in the last three years). A central task at this stage in Brazil's history in order to guarantee consolidation of the health care model centered on primary health care is to take on supervisory positions in these residencies, invest in the supervisors' own training as professors, and lobby for improved opportunities for practical training.

A second contribution is the role of Family and Community Medicine in consolidating a new legal framework for regulating interdisciplinary health work in Brazil. Since family physicians have a strong tradition in the defense of multidisciplinary teamwork, they are in a prime position for dialogue and participation in legal and institutional arrangements that prioritize dialogue with other health professions, overcoming a conflictive relationship between professions that compete to reserve or expand their respective work markets.

A third contribution is Family and Community Medicine as a discipline and in bridges with other fields of knowledge. As a medical specialty, Family and Community Medicine has invested in recent years in the consolidation of a core body of knowledge and practices characterized by person-centered care (rather than disease-centered), continuity, and management of individual and family treatment plans. The community dimension is addressed almost exclusively with an epidemiological view. Although crucial, this consolidation of the core discipline in Family and Community Medicine does not appear sufficient to elucidate new and old issues that impact family physicians' practices. For example, what is the difference between conducting expanded clinical practice in primary health care in the SUS as opposed to clinical practice under private health plans? What changes in the family physicians' clinical practice when their training is done in exclusively medical residencies (the majority of the residencies in Family and Community Medicine in Brazil) or when such training is done alongside graduate students from other health professions? How to work with emotional issues and sensitivities in family physicians' training? These and other questions can be answered better when interdisciplinary bridges are built with areas like collective health, sociology, and the performing arts, among others.

Finally, there are two worrisome situations with a potential impact on the current profile of Family and Community Medicine practices in Brazil. The first is the aggressive move by some health plan operators to hire family physicians to work in the private sector. This move may further increase the shortage of these professionals in the SUS and produce more inequality in access to health services. A second concern is the aggravation of the existing underfinancing of the SUS. Since 2015, a set of austerity policies has been implemented in Brazil, characterized by heavy budget restrictions in the social area, including budget cuts for health. The most controversial measures include a 20-year freeze on the federal budget for Health and Education, passed by the Brazilian Congress in 2016. According to estimates, this freeze will deprive the SUS of 197 billion dollars in budget funds by 2036 [5], the equivalent of approximately six times the total annual resources allotted to the system at present. More than constraining the expansion of services to an increasingly elderly population, the predicted effect of this drastic measure is the closing of health services, as indicated by some specialists [6], with an inevitable impact on the exercise of Family and Community Medicine in Brazil.

Contributors

G. C Coelho Neto and V. H. Antunes contributed substantially to the study's conception and design, wrote and critically revised the article, approved the final version for publication, and assumes full responsibility for all aspects of the work, including issues related to its precision and integrity. A. Oliveira contributed to writing the article, relevant critical revision of the intellectual content, and approval of the final version for publication.

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1. Agência Nacional de Saúde Suplementar. Perfil do setor – dados gerais. http://www.ans.gov.br/perfil-do-setor/dados-gerais (accessed on 11/Mar/2018).
2. Franco TB, Merhy EE. Programa de Saúde da Família (PSF): contradições de um programa destinado à mudança do modelo tecnoassistencial. In: Merhy EE, Magalhães Júnior HM, Rimoli J, Franco TB, Bueno WS, organizadores. O trabalho em saúde: olhando e experienciando o SUS no cotidiano. São Paulo: Editora Hucitec; 2003. p. 55-124.
3. Giovanella L, Mendonça MH. Atenção primária à saúde. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistema de saúde no Brasil. Rio de Janeiro: Editora Fiocruz; 2012. p. 493-545.
4. Oliveira FP, Vanni T, Pinto HA, Santos JTR, Figueiredo AM, Araújo SQ, et al. Mais Médicos: um programa brasileiro em uma perspectiva internacional. Interface (Botucatu, Online) 2015; 19:623-34.
5. Vieira FS, Benevides RPS. Os impactos do novo regime fiscal para o financiamento do Sistema Único de Saúde e para a efetivação do direito à saúde no Brasil. Nota técnica. http://www.ipea.gov.br/portal/images/stories/PDFs/nota_tecnica/160920_nt_28_disoc.pdf (accessed on 21/Jan/2018)
6. Reis CAA, Soter MAP, Furtado LAC, Pereira SSS. Tudo a temer: financiamento, relação público e privado e o futuro do SUS. Saúde Debate 2016; 40:122-135.

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