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The Doctors for Brazil Program: on the road to privatization of primary health care in the Unified National Health System?

Médicos pelo Brasil: caminho para a privatização da atenção primária à saúde no Sistema Único de Saúde?

El Programa Médicos para Brasil: ¿en el camino hacia la privatización de la atención primaria de salud en el Sistema Único de Salud?

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Introduction

Provisional Measure 890 [1], issued by the President of Brazil to the National Congress on August 1, 2019, established the Doctors for Brazil Program (PMB in Portuguese) and announced the creation of the Agency for the Development of Primary Health Care (ADAPS in Portuguese) with the purpose of "*increasing the provision of physician services in difficult-to-serve communities or those with high vulnerability and promoting the training of medical specialists in Family and Community Medicine*". It is essential to analyze and scrutinize the Provisional Measure in order to understand the current context of health policies in Brazil and particularly the organization of primary health care (PHC) in the Brazilian Unified National Health System (SUS). This article calls attention to the risk that this legislation will favor the transformation of PHC in the SUS into a commodified space for patient care; additonally it will lead to setbacks in the training primary care physicians.

The context of Provisional Measure 890 and the Agency for the Development of Primary Health Care

Provisional Measure 890 was issued in a context marked by a crisis in the supply of physicians in PHC due to the withdrawal of Cuban physicians from the More Doctors Program (PMM in Portuguese) and serious acute and chronic underfinancing of the SUS, with a budget allocation in 2019 lower than that of 2018 [2]. Brazil's current overall context is marked by ultra-neoliberal policies under a far-right government, with the loss of labor and social rights, alongside growing initiatives towards privatization that impact the health sector, among others. The Provisional Measure is also based on a narrow concept of PHC, understood as merely the first level of care. Although the order's wording mentions family health, there is a total absence of the attributes of community and family orientation and cultural competencies of PHC, central to guaranteeing comprehensive care and a population-based approach.

The PMB that aims "*to increase the provision of physician services in difficult-to-serve communities or those with high vulnerability*" [1] will be executed by the ADAPS, which will sign a management contract for this purpose with the Ministry of Health. However, the responsibilities of the ADAPS, as provided

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in the Provisional Measure, are broad and extrapolate the execution of the PMB, including: implementation of the PHC policy and services provision; development of activities in teaching, research, and extension; and the development and incorporation of health care and management technologies, among others [1].

ADAPS will be established as an "autonomous social service" (SSA in Portuguese), a private non-profit organization. Although in charge of developing a national health policy, it will not be subject to direct government administration, nor will it be similar to such regulatory agencies as the National Supplementary Health Agency (ANS) or the Brazilian Health Regulatory Agency (Anvisa). According to Miranda [3], the choice of the "autonomous social service" model represents a form of "corporate mediation", allowing it to raise funds besides government budget monies. The SSA model is purportedly a quasi-governmental model, an ancillary body to the government's function. Since the SSA is not an Indirect Government Administration, it is not obliged to comply with public administrative rules.

Due to the expanded power of ADAPS, participation by the private sector is explicit: ADAPS builds *"linkage between public and private bodies and organizations;* (...) *contracts with public and private bodies and organizations, including teaching institutions;* (...) *contracts with physical or legal persons for services provision"* [1]. The relationship with the private sector is further strengthened by the composition of the ADAPS management board, including four representatives from the Ministry of Health, one from the National Council of Health Secretaries, one from the National Council of Health Secretariats, and one from the private health sector. Meanwhile, there are no seats for the National Health Council or representatives from patients' or health professionals' associations. Further attacks can be expected on social participation, a founding principle of the SUS.

There is a clear adherence to the new management modalities inspired by the guidelines of the "new public management" [4]. This policy move comes in the wake of the state reform policies from the perspective of the liberal utopia, a central point of which is the transfer of social services provision to the private sector. The arguments for the new management modalities in the public sector are to achieve purportedly greater flexibility, autonomy, and agility in the management and expansion of partnerships between the state, market, and civil society. One key feature is hiring personnel with flexibility, under market conditions, without their incorporation under the single labor regimen and the corresponding retirement pension systems, in addition to not being subject to the limits of hiring personnel according to the country's Fiscal Responsibility Law. Still, in the Brazilian experience, greater flexibility in such management modalities has usually been achieved without guarantees, with limited government control, and with little capacity for institutional and social oversight [5].

Provisional Measure 890 expresses both the possibility for transferring services provision to the private sector and elements for flexibilizing the workforce, since the initial physician contracts will be in the form of scholarships and will only be turned into formal labor contracts (CLT in Portuguese) after two years of service.

Importantly, there is no evidence that private or outsourced provision will be more effective or efficient than similar provision by the public sector [6,7,8]. Research on the subject is insufficient to conclude that these new management modalities in the health sector will produce better results in the quality or efficiency of provision (now so widely proclaimed), especially in middle and low-income countries, as demonstrated by Cochrane reviews [8], and some studies have pointed to negative impacts in high-income countries like England [9].

The creation of the ADAPS thus clearly suggests a pro-private approach to PHC in the SUS, which should occur to a greater or lesser degree depending on the quality of the management contract and the government's capacity and political will to effectively exercise control over implementation.

Another central dimension is the analysis of the public-private relationship, expressed here in the announcement of liberty to establish contracts with the private sector. There is a clear risk of double outsourcing, whereby *Provisional Measure 890* outsources the implementation of PHC in the ADAPS (a non-profit institution), and the ADAPS outsources services provision through contracts with the private sector (both non-profit and for-profit organizations).

The position by the CEO of Unimed, a private health plan company, expresses this public-private dimension quite clearly. Referring to the PMB, Unimed positions itself as a partner of the Ministry of Health for provision of PHC in the SUS, indicating the policy's pro-private orientation. The company glimpses a virtuous partnership between the Brazilian government and its self-described successful

experience with extending the Unimed system to the interior of Brazil [10]. Quoting the country's Constitution, the CEO concludes that supplementary health (private health services and private health plans) can legitimately occupy an important role in the country's public health administration, in a new age "*in which private initiative will be present, meeting the obligation to Brazil's public health*" [10].

"Doctors for Brazil": implications for the training and retention of physicians in PHC

The retention of physicians in PHC, especially in more vulnerable communities and remote areas, is a major challenge for health systems. Studies that analyze the distribution of general practitioners in the early decades of the implementation of the English National Health Service (NHS) and in other health systems concluded that one-off solutions are not sufficient to overcome this shortage, and that the systems require changes (not without conflict) and regulation of both the medical ethos and the disputes within the physician training system [11,12,13].

Brazil's previous policy for the supply of physicians, the PMM [14], not only provided emergency supply of physicians for PHC in regions with short supply and difficulty in retaining doctors, but included a training component for the SUS with investment in the regulation of specialist training, the creation of vacancies for undergraduate medical education and residencies, new courses of medicine based on revised curricular guidelines, Executive Master's courses in Family Health, and a special component focused on improvement of infrastructure in the basic health units (UBS in Portuguese) [14]. The PMM was established rather recently, in late 2013, but several positive effects were identified, especially in physician supply, with a reduction in the shortage and in inequalities in physician distribution [15,16,17,18], since 78% of these professionals were allocated to priority municipalities (counties) [19], a reduction in hospital admissions for PHC-sensitive conditions [20], and an increase in investments in construction and renovation to improve the infrastructure in the UBS [21].

The synergy between the three components of the PMM aimed to impact key factors for the sustainability and qualification of PHC through incentives for training via residency and improvement of the infrastructure in the UBS, also considered an essential element for physician retention. Meanwhile, the PMB only involves physician supply to remote areas and "in-service" training. To implement the program, the ADAPS will use public admissions to hire physicians accredited by the respective Regional Boards of Medicine and tutors who are specialists in either family and community medicine or clinical medicine. The selection process for family and community physicians will include a two-year specialization course, at the end of which the physician will take an exam to qualify for this form of two-year specialist degree. From this perspective, the Provisional Measure breaks with the requirement of residency and with the rule by the Brazilian Society of Family and Community Medicine (SBMFC), which requires four years of practice in PHC to qualify for the specialty's exam. Unlike the residency, in which the preceptor's daily presence is essential for the resident to acquire the skills in the FCM specialty, under the specialization course the preceptor will merely be replaced by a tutor. Despite the fact that the SBMFC highlights the importance of residency for training FMC specialists in Brazil, the society voiced its support for the PMB [22].

During the training period, candidates will receive a training scholarship, and after approval in the specialization they will be hired under the CLT regime. Although the possibility of an official physician career plan in the PMB was initially announced by the media and applauded by medical bodies such as the Federal Board of Medicine (CFM) [23], *Provisional Measure 890* does not actually provide for such a career plan.

An important measure for retaining physicians in remote areas is the supply of training in the interior of the country, as provided previously under the PMM, prioritizing health regions with fewer physicians per thousand inhabitants for the creation of medical schools, a point that is overlooked in the PMB. This omission on undergraduate medical education appears to clearly show that reorientation of medical training is not part of the current government's agenda.

Not by coincidence, *Provisional Measure 890* repeals articles 6 and 7 of *Law n. 12.871/2013* [14], which instituted the PMM. By eliminating regulation of the FMC residency, the Provisional Measure shows that the government is unwilling to exercise its Constitutional prerogative to provide health person-

nel training for the SUS. In fact, the training it proposes exhibits two central limitations: the low capacity to train family and community physicians, since its target public will no longer be Brazil's annual supply of medical school graduates [24]; and the drop in quality, since medical residency, the "gold standard" for training, assumes service with constant supervision/preceptorship.

Another issue appearing between the lines of *Provisional Measure 890* is the change in the relationship between the federal government and the states and municipalities. The design of the SUS assumes specific responsibilities at all three levels of government, where the municipal level is in charge of management, planning, and provision of basic care. The ADAPS creates the possibility of a wedge interfering in municipal health management (contrary to the political foundations of the SUS), not only by the federal government via ADAPS, but also potentially by the private sector. In addition, since the focus of the Provisional Measure is the medical profession, Brazil is facing a proposal to "re"-create the outpatient clinic model from the now-defunct INAMPS (1977-1993), focused only on individual medical care. This fact is reinforced by the absence of the community and family dimensions in the scope of the PHC attributes under *Provisional Measure 890*.

The political scenario: disputes

In the political scenario, *Provisional Measure 890* was received with challenges and controversies. Following its submission, members of the Brazilian Congress drafted more than 300 proposed amendments: the opposition to the government aimed at expanding the debate on the SUS while the other congressmen focused on support medical corporation. A substitute amendment focused on changing the proposal for the creation of the Agency to a public management modality with social control was submitted by the leftist parties, in dialogue with the National Network of Grassroots Physicians, social movements in health, and council members and delegations from the 16th National Health Conference, providing the opportunity for a debate on the matter during the Conference. The congressional amendments focused on containing the encroachment of privatization and the precarization of teamwork, while preserving the public nature of medical training, including undergraduate education, specialization, and residencies through partnerships with public universities. Following the proceedings of the Brazilian Congress, the Provisional Measure was reviewed by a parliamentary committee which in its final report did not include the recommendations of parliamentarians allied with the SUS. In October 2019 the Provisional Measure had not yet gone to the vote in the Congress.

Final remarks

The competition on public funds by private companies (financial corporations that manage health plans, hospitals) has always been present in Brazil's history, but it becomes even more heated in situations of deregulation, as in the country's current situation. The creation of an "autonomous social service" (SSA) with the prerogative of hiring private companies for services provision turns PHC into a commodified space, in a logic close to the proposal of universal health coverage. Corporate mediation is also facilitated by the fact that private organizations sit on the management body of ADAPS, which means the inclusion of private players in policy decision-making on PHC. This opens the way for privatization of PHC, which has been considered the most public part of the services network in the SUS, a non commodified space, with an enormous non-mercantilist calling [25].

In short, *Provisional Measure 890* proposes dubious adjustments to provision, a privatizing agency, and abandonment of the historical agenda for regulating specialist training, expansion of the residency in family and community medicine, and reorientation of undergraduate training. Given these and other measures [26] that threaten the underlying principles of the Constitutional SUS – universal care, a public system, comprehensive care, and social participation – it is urgent to expand and strengthen the foundations for society's support in order to fight initiatives that threaten these principles.

Contributors

All authors participated in the conceptualization, analysis, and writing of the article.

Additional informations

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