The health of the black population in Primary Health Care: a misunderstanding that legitimizes inequality in times of COVID-19

Saúde da população negra na atenção primária: incompreensão que legitima iniquidade em tempos de Covid-19

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ABSTRACT Primary Health Care is the regulatory axis of care in the Unified Health System. Its understanding is a condition for resolute actions. This article aims to reflect the understanding of Primary Health Care among managers, professionals, and users, as well as the implications of health inequities experienced by the black population in the context of COVID-19. Qualitative research was carried out in three municipalities, in which 58 people were interviewed. The analysis showed the lack of understanding of the Primary Health Care. Managers and professionals only associate it with disease prevention actions and provision of services. Users associate access to services and report the poor quality of care to racial and class belonging. The misunderstanding of Primary Health Care by the actors involved in its operation compromises the assistance of the black population regarding COVID-19, as well as other demands.

KEYWORDS Primary Health Care. COVID-19. Health of ethnic minorities. Healthcare disparities. Health policy.

RESUMO *A Atenção Primária à Saúde constitui o eixo regulador do cuidado no Sistema Único de Saúde. A sua compreensão é condição para que as ações sejam resolutivas. Este artigo propõe refletir sobre a compreensão da Atenção Primária à Saúde entre gestores, profissionais, usuários e as implicações das iniquidades em saúde vivenciadas pela população negra no contexto da Covid-19. Realizou-se pesquisa qualitativa em três municípios que foram entrevistadas 58 pessoas. A análise mostrou a incompreensão da Atenção Primária à Saúde. Gestores e profissionais a associam apenas a ações de prevenção de doenças e disponibilização de serviços. Os usuários associam ao acesso a serviços, e relacionam a má qualidade da assistência ao pertencimento racial e de classe. A incompreensão da Atenção Primária à Saúde pelos atores envolvidos na sua operacionalidade compromete a assistência da população negra com relação à Covid-19, bem como em outras demandas.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Covid-19. Saúde das minorias étnicas. Disparidades na assistência à saúde. Política de saúde.*

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Introduction

The Unified Health System (SUS), the result of various social articulations, known as the health reform movement, has some prerogatives that became normative principles that characterize it as one of the most humanitarian health systems in the world. However, in practice, there are a number of challenges to be overcome so that these principles result in a better quality of life for the Brazilian population.

The principles of universality, comprehensiveness, equity, and social participation and control have been trampled by a parallel system of health commercialization. These principles establish that all Brazilians should have access to health, regardless of their social condition, that all health needs of the individuals must be considered in the care process and that such needs vary from individual to individual, and these specificities need to be respected. It is argued that the above principles are not effective if the subjects for whom they are intended do not participate in the process of planning, deciding, building and monitoring health care.

This has been seen in the tensions experienced by the Primary Health Care (PHC). Recognized as the first contact of the individual with the system and responsible for organizing care, as for the above principles, PHC should focus on the individuals and their demands in an integral way, and not on the pathological and technological specificities, which are costly to the public treasury and do not solve much. This scenario reflects the social and political context experienced in Brazil, but not only in the country, with the resurgence of right-wing ideologies that are not very humanitarian and the lesser accountability of the State. The changes in the National Primary Care Policy (PNAB) show the weakening of primary care and, consequently, of the public and universal system, favoring the health market[1].

The challenges to implement a decisive and accessible PHC to all people were designed and strengthened with the change in the health care model in 1994, consolidated by the Family Health Strategy (FHS). Even with major obstacles to be remedied in the management process, with difficulties in understanding its proposal by professionals, managers and users of the system, is a successful model of care, ratified by several scientific studies[2-4].

One of the pros of this new model of care was the importance of social determinants in health as fundamental indicators to understand health, illness, and care process. From this perspective, it is necessary to understand how social, economic, cultural, ethnic/racial, psychological and behavioral factors influence the occurrence of health problems and their risk factors for the population, in addition to how health inequities are a consequence of social inequalities experienced by various groups. Equity, then, would be the strategy to guarantee good health conditions, considering social, ethnic, economic, and cultural disparities[5]. In the case of this study, it is interesting to discuss racial inequalities influencing the health of the black population.

There are several studies that report on how the black population is most affected by health inequities, how racism determines the living and health conditions of this group and the need for targeted interventions[6,7]. This has also been expressed in the current global epidemics, with COVID-19 affecting more, and more severely, the black population, as reported in the COVID-19 Bulletin of Bahia[8], as well as in studies in the area[9-12].

Despite the indicators, there are those who question that talking about health for a specific group, such as the black population, would be a paradox in relation to the principle of universality, since 'health is for everyone'; therefore, there would be no need to think about specific strategies for a group. The principle of equity would thus be focused on economic and class disparities. Faustino[13] argues that, precisely because it seeks to face racial inequities, the health of the black population, expressed by its own policy, the National Policy for Integral

Health of the Black Population (PNSIPN), is in line with the search for the universalization of the right to access health.

The PNSIPN, established in 2009 by the Ministry of Health, aims to promote health equity from the understanding of racism as a social determinant of health. It is part of the dynamics of the SUS through solidary and participatory management, through the use of color in the production of epidemiological information, the expansion and strengthening of social control, the development of strategies of identification, approach, combat, and prevention of racism, in the training processes of professionals and the implementation of affirmative actions to achieve health equity and promote racial equality[14]. Its perspective of transversality depends on the strengthening of the SUS to become viable[13].

Considering the aspects outlined above, this article seeks to discuss how the (mis)understanding of PHC, in all its robustness, by managers, health professionals and SUS users, is related to the implementation of the PNSIPN and how this has been affecting access to an efficient and quality health service, reflecting the impact of the COVID-19 pandemic on the black population.

Purpose

This article aims to discuss the comprehensiveness of the understanding of PHC among managers, health professionals and SUS users in the state of Bahia and the implications of health inequities experienced by the black population in the context of COVID-19.

Material and methods

The Center for Studies and Research in Gender, Race and Health (Negras) carried out the research entitled 'Health Care and the National Policy for Integral Health of the Black Population', funded by the Research Program for SUS (PPSUS/Ministry of Health), the National Council for Scientific and Technological Development (CNPq) and the Bahia State Research Support Foundation (FAPESB). The study was an action research, divided into two stages. In the first stage, an investigative and exploratory process was carried out, based on a qualitative research; and, in the second one, an intervention was carried out through educational materials. This article will focus on the analyses of the first stage, conducted in 2019.

The municipalities chosen for the investigation were Salvador, capital of Bahia, Santo Antônio de Jesus, and Cruz das Almas. By summing the black and brown population, the municipalities have the majority of the black population in their composition, with an average of 80%, 75% and 70%, respectively. With regard to health services, Salvador has 367 health establishments, Santo Antônio de Jesus has 47, and Cruz das Almas has 24. Concomitantly, they represent 23.9%, 80.8%, and 77.62% of the PHC coverage. These data are important to understand how health care is being performed based on PNSIPN.

Semi-structured interviews were conducted according to assumptions defined and guided by Minayo[15] and Víctora et al.[16], by stating that interviews are means by which it is possible to obtain more subjective data, related to values, attitudes, and opinions of the interviewee, using a previous script (unstructured method) that allows the interviewee to freely discuss the proposed topic.

The selection of the participants of the research was done by sampling, in two stages. In the first one, sanitary districts representing the population diversity of the municipalities were chosen for convenience and, from there, two PHC units were randomly selected per sanitary district. In districts with FHS, at least one of these units composed the sample. In the second stage, health professionals, managers, and users were randomly selected to carry out the investigation.

We interviewed one professional who works in the management and two health professionals, one with a higher education level and one technician, who works in care assistance. Managers were those professionals who had a position of coordination and/or management of the unit. The number of users interviewed was equal to the total number of professionals in each unit. Participants who were hard of hearing, illiterate or under 18 years old were excluded from the sample. Members of the research team conducted the interviews, belonging to Negras, in Salvador and in Recôncavo Baiano.

The interview script was based on guiding questions, previously defined, discussed and trained by the team. The interviews were recorded, transcribed and adequately analyzed using content analysis. This analysis methodology allows us to infer practically and objectively, from the content of a communication, replicable to its social context. In this methodology, the text is a means of expression of the subject, in which the investigator seeks to categorize the units of text that are repeated, inferring an expression that represents them. From these categories, thematic analyses that integrate the set of techniques of content analysis were carried out, through which we seek to find a series of meanings detected by indicators that are linked to it[17]. The categories that emerged from the analysis were: health of the black population, national policy of the integral health of the black population, diversity in health and PHC. This article will approach the latter.

The ethical principles established by Resolution No. 510/2016 of the National Health Council were considered, and the research was approved by the Research Ethics Committee of the School of Nutrition of the Federal University of Bahia (Opinion No. 2,768,574). To ensure the anonymity of the people interviewed, the names used in the testimonies are fictitious.

Results

In the survey, in total, 58 people were interviewed: 38 in Salvador, 12 in Cruz das Almas and 08 in Santo Antônio de Jesus. Of these, nine were managers, 12 were mid-level professionals, seven were higher education professionals and 30 were SUS users. It is important to note that, in the municipality of Santo Antônio de Jesus, higher education professionals did not accept to participate in the research, which interfered with the proposed proportionality in the methodology. With regard to the profile of these participants, it was possible to identify, in relation to the age group, that 50% of the people were over 50 years old. Regarding gender identity, 77% of the interviewees identified themselves as cis women, 17% as cis men, and it is worth noting the presence of a trans woman. Regarding race/color, 87.9% of the people are black when considering the self-declarations of black and brown people (43.1% and 44.8%, respectively).

Based on the answers of the managers, it was possible to perceive that there was an association of PHC with the performance of actions to prevent diseases and grievance and as a means of access to the service by the users. However, the understanding of the differences between health promotion actions and prevention of diseases and grievances that this level of care is capable of enabling was incipient.

> *It is fundamental that people have this instruction from the FHP (Family Health program), which is done here. We teach how to brush teeth, how to prevent any problems that one might have. Because I think this is fundamental, in any activity you do, if you take care of a machine, what do you have to do first? Preserve the machine and try to prevent it from breaking. The same thing the secretary does when she creates a primary care unit. It tries to prevent before someone breaks down, and this is particularly important.* (Pérola).

The users' questions and demands related to the service were interpreted by them as

aggressiveness, as it was reported: *"... normally, people who are less educated are more aggressive... if you talk to them and explain, they understand"* (Pérola).

In general, higher education professionals limit their concept to health education actions and prevention of diseases and illnesses, thus disregarding the care process from the perspective of comprehensiveness/integrality. In addition, they highlight that the service is easily accessible and little explored by users, blaming them for not taking advantage of the care offered.

> *... I think that, in fact, we should deal a lot with prevention, but it ends up not being like that. The patients come to me here, they already arrive in pain, they already arrive with problems, although there is the prevention service, even though there are lots of spots in the waiting room and despite talking about prevention all the time. So, what we realize is that people tend to arrive in pain, and they have easy access to the service. The user does not take advantage.* (Safira).

In addition, there is a misunderstanding of the meaning of the term primary, with regard to the density of care, which accounts for meeting the needs of the population and providing a better quality of life, without having to access hard technological resources from other levels of care, but using a complexity of skills that need to be learned and incorporated into the care process. One of the interviewees stands out, stating that her performance is greater than a primary perspective:

> *... primary is a very... it's a very nasty word, I think, for what we really offer in this system in terms of, of... attention. I think this name could be changed, but I understand that you have to really pay attention to the individual's health, right? In an integral way, not only of a particular individual but of all their relatives, the people who live in their house, and that is health as a whole. You have to search for a solution, right... to treat these people.* (Esmeralda).

Mid-level professionals correlate PHC with services of low complexity and with a preventive bias, and still perceive this level of care as a way of identifying users who are sick in the territory. On the other hand, others see it as a field that offers continued care beyond the treatment of diseases. One of the interviewees even highlighted the role of welcoming in primary care, stating that:

> *Sometimes, the person arrives here at the unit and is not even sick. It is an inner disease, not a physical disease, nor mental illness. The person only wants to hear a word, only wants to talk to someone, to vent to someone, and then leaves here even better than before, without seeing a doctor.* (Diamante).

Most users have difficulty understanding PHC, but those who were able to respond associate it only with access to services, such as the home visit of Community Health Agents (CHA), the medical consultation carried out in the unit and the acquisition of medicines. On the other hand, the evaluation of this service, with regard to infrastructure, was pointed out by other users when reporting limitations regarding the number of services in order to meet the demand, the absence of doctors, the difficulty in scheduling appointments and even the lack of respect.

> *[...] the population benefits from it because it has access to the public health system, it has access to medical consultations, medical examinations [...].* (Cristal).

> *The team doesn't even have a doctor. Sometimes a doctor comes here, stays for a while and then leaves.* (Rubi).

> *[...] some things like that are missing... a matter of structure... sometimes, some device is missing... weighing devices... sometimes water is shut off. Water was shut off once [...].* (Ametista).

> *From what I understand, primary care is care. I come to the health unit, I receive care, that is, a*

> *Community Agent comes to my house frequently, I get to know if in the health units there is a doctor, a dentist [...].* (Opala).

he evaluation of the service offered also varied according to the service received. Within this scope, it was observed that diligent care was associated with having access to the service without racial discrimination: "*my wife is brown, the professionals go to our house, no one mistreats her. The doctor is white, but she likes her"*(Jade). Although this discrimination was present, even though not in the way specified by the user: "*we are kind of discriminated against by the doctor here*" (Turquesa). They also associate the poor quality of care received with the fact that the service is public: "*In the private sector, it would not be like this*" (Turmalina).

Some users reported that they do not know the activities carried out by the PHC; however, they stated that care is provided with lack of attention, communication, and adequate reception by health professionals:

> *But there was a time when I just came here to get angry, because there was no doctor, the girls all with their faces... Then I would say, 'Well, are we coming to feel worse?' [...] As soon as I went down, when I got home, I said, 'I'm not going there anymore, I didn't like the doctor, he didn't treat me well, he didn't even look at my face' [...] I mean, you come to get better and you get angry, you get angry.* (Quartzo).

The same user also highlights professional turnover as an issue to be considered, since several doctors have worked in the unit, but do not stay long in the place: "*I think this happens because people are poor, black, it is in the periphery, I think that is the case*."

The evaluation of the answers of the interviewees allowed us to understand the distance between the proposition of PHC and its effectiveness with regard to its assumption by managers, health professionals, and the ignorance of users.

Discussion

In almost 33 years of existence, SUS has advanced on several fronts, expanded actions to promote health, prevent diseases and grievances, invested in scientific research and technological development, implemented information and management systems, increased the number of workers and qualified the workforce, aiming at strengthening PHC. However, the result of the research in the three municipalities of Bahia makes us realize that there are still many paths to go along for the consolidation of PHC to be incorporated into SUS, playing its role in view of the needs of service users, especially for the reduction of inequities that historically permeate the health of the black population.

The potential of the PNAB is intended to guarantee a primary care solution, in line with the guiding principles of SUS; however, since its modification in 2017, it has been weakened and mischaracterized, especially with regard to the workers of this system. As an example, the precariousness of employment bonds, the reduction of CHAs in the teams and the non-priority of the teams of the expanded family health and primary care centers are mentioned, leaving this decision-making to state and/or municipal managers[18]. This becomes evident when the answers of the interviewees show that one of the problems reported consists in the turnover of professionals, especially those more socially valued, such as physicians, which, for the users, symbolizes a lower quality of care, even if this has been offered by other categories.

Still with regard to the PNAB, the FHS is the preferred model to reorganize primary care in SUS; however, during the COVID-19 pandemic, it was reduced to the treatment of diseases arising from the health crisis, failing to fulfill other attributions, as an organizer of health care, which involve the promotion, prevention, rehabilitation and treatment, also inherent to the pandemic scenario itself, which dialogue with pre-existing social and health demands

in the territories. In this sense, health actions should not be limited to a specific situation, no matter how relevant it may be since users of the system lack comprehensive care at various levels of care.

These recent threats were added to problems chronically faced in the Brazilian primary care, such as: the precariousness of labor relations in most teams; the outsourcing of the management of basic health units, which commercializes relationships and weakens bonds; organizational problems, with low articulation between PHC and other levels of care in the regionalized network, compromising the coordination and continuity of care, with the fragmentation of care; insufficient mediation of intersectoral actions to focus on social determination and reduce inequalities and promote health – these are some of the obstacles experienced by what should be the first level of assistance to SUS users at this time[19].

With the health crisis in place, changes were observed from the moment some PHC health units were adapted in emergency care units, units dedicated to treat the flu and units receiving those with COVID-19 symptoms, with the objective of meeting a specific demand, mischaracterizing what is expected from this level of care, as the care provided is related to another level of complexity, putting aside routine demands, characteristic of primary care.

> The work in the Family Health Strategy (FHS) – the gateway to the Health system –, already admittedly strenuous, has been changed in such a way that the very identity of the FHS is called into question. Users fear going to the clinic, they are not followed up, and their once-controlled conditions have worsened, causing chronic patients to become terminal patients. In addition, territorial actions may become inconceivable, home visits should be avoided, and family doctors are called to work on duty at the Emergency Care Units (UPA). Community health workers (CHWs) lose their roles as articulators for the health of the population and acquire the role of reporters of deaths[20(9)].

The actions and services that occur in the work process of health teams become, in most cases, the first point of contact between the population and the health system, so attention to other morbidities is as significant as to COVID-19. The various diseases that can affect the population are still present, and they need regular preventive care aimed at health promotion. At this atypical moment, in the municipality of Salvador, for example, the reduction in access to these services led to the need to carry out a joint effort to schedule appointments and exams in 2020 and 2021, on a weekend and an extended holiday, respectively[21,22], sacrificing health workers who were already exhausted fighting COVID-19, in order to guarantee the vaccination schedule. In addition, considering the predominance of black people in this municipality, these are the ones most affected by the difficulty of access to assistance, needing to wait in lines and agglomerations to get this service when they could be enjoying the right to rest and enjoy leisure time.

This mischaracterization of the functionality of primary care is favored by the lack of understanding of its scope, revealed in the responses of managers and health professionals interviewed, weakening the operationalization of care. At the time of health crisis, the understanding of the attributions and competencies inherent to PHC becomes relevant since professionals and managers need to meet the demands of other health situations of the population. Therefore, a strengthened PHC will be able to promote comprehensive and resolute care for individuals and their families, in addition to contributing to the prevention of diseases resulting from the illnesses generated in the pandemic, enhancing the capacity of institutional response to the demands presented by the population.

The course and severity of the COVID-19 pandemic made many governments adopt high-intensity interventions, such as lockdown strategies, in order to contain the spread of infection and reduce the social burden of the disease and its morbidity and mortality. Such measures, however, brought about a sudden change in the lives of people and society in general[23]. With regard to the black population, unemployment increased, mainly for women (17.6%, according to data from the Institute of Applied Economic Research – IPEA), as well as informal work[24]. And, as a result, previously existing aggravations have intensified, such as domestic violence, mental suffering, suicide, requiring, therefore, that the characteristic actions of primary care become even more necessary to ensure the sustainability of healthcare [25,26].

Within this complex scenario, the black population, due to the characteristics that influence their condition of life and their health, with racism as an important social determinant, which structures relations, of not having access to rights, was also more vulnerable to the consequences of the pandemic, both in terms of contamination and social inequities, such as unemployment, hunger, and misery[10,11,25]. In this sense, the weaknesses pointed out put the health of the black population even more at risk, especially at the time of the current crisis.

> Having life threatened in their daily lives and having their mourning denied are expressions of the Brazilian necropolitics that expresses itself through 'small' massacres of the daily lives of the black and poor population[20](4).

The black population represents more than 80% of the users of SUS; however, the care received by this group in the PHC is characterized by negligence in relation to their specific demands, since the implementation of the PNSIPN is still incipient, in addition to being permeated by the various discriminations suffered by these people, as evidenced by the users interviewed, when exposing the quality of the care received. In addition, these users associate the inadequate structure, the irregularity of inputs, the reception not oriented to their needs, the turnover of professionals (which interferes with the establishment of bonds) with the fact that it is a public service aimed at black people, low income population, from the periphery.

When managers and health professionals demonstrate a limited knowledge of PHC, reducing its understanding to one or another aspect, such as preventive actions or treatment of diseases, as explained in the research results, the fragility of the system is revealed in daily practice, while in contact with health users, who in their testimonies show the dissatisfaction and precariousness of care.

How is it possible to provide adequate assistance to the black population and its sustainability when, even before the COVID-19 pandemic, their needs were already invisible[6,7]? How can a system weakened by the limitation of health professionals and managers, with regard to understanding the breadth and scope of PHC, facing an unexpected and incisive sanitary condition, fully and resolutely serve a population historically excluded from its rights? How can we change this scenario when these professionals do not know and do not consider the policy established to meet the specificities of this social group?

The recognition by users of their rights is fundamental for the exercise of social control and access to legal mechanisms of enforceability. However, the interviewees were little informed since they mostly associate the potential of primary care only with the possibility of access to the service and inputs. In this perspective, when the users of the system themselves do not have the understanding that this care needs to be more than just the guarantee of access, providing medicines or medical consultation, how and when will social control become active?

Final considerations

This study showed that the black population in the state of Bahia represents the group most affected by the consequences of COVID-19, reflecting not only in morbidity and mortality, but also in the other spheres of these individuals' lives, aggravating a historical process of neglect and social vulnerability. Considering such social determinants is important for the effective promotion of the health of this group.

In this perspective, primary care is the first instance of care, in which this promotion needs to be consolidated, in line with the doctrinal principles of SUS. The lack of understanding of its magnitude by the actors involved in its operability compromises the assistance provided to the black population, not only in relation to COVID-19, but also in other demands commonly related to the social existence of these people.

To the same extent, when users of the system are little aware of the scope that this level of attention can offer them, and also when they are little active in participation and social control, they are even more vulnerable to health inequities.

In a society with a public and universal health system that proposes to guarantee health as a right, with equity as a structuring principle, these are reflections that need to guide the implementation of public policies, planning and more inclusive, resolute, and sustainable health actions.

Collaborators

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