

## Dialogues between the Astana Declaration, the Right to Health and Family and Community Medicine training in Rio de Janeiro, Brazil

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**Abstract** *This paper discusses and fosters concerns in light of the repercussions of both the 40th anniversary of the Alma-Ata Declaration and the Astana Declaration, discussing the possible influence on Family and Community Medicine training, as per the lenses of two Residency Programs of three public institutions, namely, State University of Rio de Janeiro, Federal University of Rio de Janeiro, and the Oswaldo Cruz Foundation. These are inserted in a historical and social context, between the world of work, public policies, international organizations, the population and subjects involved in the construction, maintenance, and consolidation of the Brazilian PHC. Thus, in a brief historical revival, we contextualized which Primary Care was a practice setting and where we might be headed. We concluded that the willingness to ensure the Right to Health would be threatened by the concept of Universal Coverage, advocated by the Astana Declaration, which leads to essential discussions: ensuring state-provided services, advocating for equity and integrality of actions, reaffirming the risk of generating inequality by creating multiple service offerings for different segments of the population, reiterating the relevance of access to health, and valuation of territorialization.*

**Key words** *Primary health care, Family and community medicine, Medical residency, Right to health*

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## Introduction

This paper aims stir dialogues between the Astana Declaration<sup>1</sup>, the Right to Health, and Family and Community Medicine training, considering the Medical Residency Programs of this specialty in two public universities, namely, the Rio de Janeiro State University (UERJ), Federal University of Rio de Janeiro (UFRJ), and a science and technology in health foundation in Rio de Janeiro, namely, the Oswaldo Cruz Foundation – Fiocruz, through the National School of Public Health (ENSP).

The city of Rio de Janeiro has been witnessing a growing plan for the training of family medicine residencies in Family and Community Medicine since 2009, pioneered by the UERJ, which, boosted and gaining even more representation, increased the number of residency vacancies. The ENSP/UFRJ residencies emerged, in partnership with the UERJ, and are working as a single program to this day, especially with the Rio de Janeiro Municipal Health Secretariat program, in the construction of Primary Health Care, focusing on medical training. Thus, a significant increase in the number of vacancies in Family and Community Medicine Residencies in Rio de Janeiro under the perspective of a conception of health as a Universal Right has been observed from 2009 to 2019.

The Unified Health System (SUS), provided for in the Brazilian Constitution<sup>2</sup> since 1988, has historically been underfunded<sup>3</sup>, along with a recent dismantling: the enactment of Constitutional Amendment N° 95, of December 15, 2016<sup>4</sup>, which now adjusted the level of public health resources by the previous year's inflation for 20 years. Inflation has been known to be lower than Net Current Revenue (NCR), a parameter previously used as a Public Health resource level. The significant consequence of Constitutional Amendment N° 95<sup>4</sup> will be to prevent public health investments from increasing in real terms for 20 years, harming most of the Brazilian population, the exclusive user of the SUS, and subject to use a neglected SUS in its ambiance, management and the qualification of its professionals<sup>5</sup>. Thus, we are witnessing a political project that aims to transform the social conditions of the subjects, through State interventions, in what Foucault<sup>6</sup> calls governmentality, that is, power relationships become a field of actions of multiple possibilities, but with the same nature: acting on a population, on the actions of others (government of others) and even on oneself (self-government). In governmentality, macro-

politics becomes inseparable from the micropolitics of relationships. Foucault<sup>6</sup> states that the articulations of a new power whose action is no longer on men confined to school, church, hospital, factory, or prison, are now exercised in an open space, namely, society. Governmentality must shape the state, and the state must shape society so that the market can exist and function. Thus, we are contemporaries of a society based on competition, on the indebtedness of subjects, a state in which the main concern is to promote governmental interventions so that the market can continue to exist. However, the assured existence of the market requires more than economic measures, and it is necessary to act on the social situation, the population, technique, learning, education, legal framework, and medical and cultural consumption<sup>7</sup>. The dismantling of the SUS is part of this process, mainly because if the Universal Right to Health conjures equity and integrality as conditions of citizenship and access to public health care, the Universal Health Coverage, as prescribed in the Astana Declaration<sup>1</sup>, among other issues, produces a break with the idea of social protection.

The World Health Organization (WHO) supports Universal Health Coverage<sup>8</sup> by endorsing a worldwide movement of “pro-market reforms such as reducing state intervention, subsidizing demand, selectivity and focusing on health policies”<sup>9</sup>. What is at stake, therefore, is a political project that places public health as an expense rather than a state investment, thus denying the fundamental right to quality universal public health where guaranteed public funding with service offerings provided by the state is a priority.

In this sense, it seems to us that the Astana Declaration<sup>1</sup> hardly revives the principles of Alma-Ata<sup>10</sup>, valuing an economic discourse in which the association between high cost and health care seems to make a strong case for Universal Coverage. Is health in the process of implementing a market rationale where the accountability of individuals would imply the unaccountability of the state? Are we moving towards broader access to health insurance, with packages bound to people's ability to pay? What about the people's health needs? Will we assume the existence of selective and non-universal PHC<sup>11</sup>? What would be the perspective of a Family and Community training plan, from the perspective of a weak learning practice setting with low commitment and guidance of PHC based on the universal health system?

Countries such as Peru experimented with the Universal Coverage model. They faced several problems, such as the fragmentation of their health services, as discussed by Levino and Carvalho<sup>12</sup> and Pedraza et al.<sup>13</sup>.

If we look at the National Primary Care Policy (PNAB)<sup>14</sup>, enacted in 2017 by the Ministry of Health, we observe that it postulates essential standards and expanded standards for health actions and services provided to the population<sup>14</sup>, which supposes admitting a value, a hierarchy in this care offering, a service focus movement. The same edition of this PNAB ambiguously reiterates the presence of a Primary Care “fully and freely offered to all...”<sup>14</sup>, possibly reflecting the ambiguities of the Astana’s report.

Thus, we reiterate that, with a Public Health funded by Constitutional Amendment No. 95<sup>4</sup>, we have a universal right public system that does not have a corresponding tax system for financing a welfare state<sup>3</sup>. How not to build health inequities? How do we train family and community doctors in this perspective?

We accept, however, that in the SUS, the training of Family and Community Doctors conjures the consolidation of the social right to health, which connects us with the idea that citizenship, democracy, and community participation are axes of competence for Family and Community Medicine Residencies. Relevant areas of competence that are threatened by a model of care that does not ensure public funding with state-provided service offerings, which focuses on actions and services, does not advocate equity and integrality, creates multiple service offerings for different segments of the population, does not reiterate the importance of the proximity of PHC facilities to the housing of the population, and does not recognize the presence of the Community Health Workers promoting capillarity and territorialization.

Are the UERJ, UFRJ, and ENSP Family and Community Medicine Residency Programs prepared to address these issues?

### **Mapping Family and Community Medicine Residencies**

In definition, Family and Community Medicine (FCM) is a medical specialty that promotes continuous care to individuals (longitudinality), and a comprehensive approach and acceptance of all regardless of gender, age or type of health problem<sup>15</sup>. The document “The European Definition of General Practice and Family Medicine”

by the World Organization of Family Doctors (WONCA) in 2002<sup>16</sup> tells us that:

*Family doctors recognize that they have a professional responsibility to their community. When negotiating action plans with their patients, they integrate physical, psychological, social, cultural, and existential factors, drawing on the knowledge and confidence generated by repeated contacts. They play their professional role in promoting health, preventing disease and providing curative, follow-up or palliative care, either directly or through the services of others, depending on the health needs and resources available within the community served, and assisting patients, whenever necessary, in the access to those services<sup>16</sup>.*

In the formation chronology of the specialty, we have that Community Medicine (CM) marks the beginning of this area in Brazil, traversing Community General Medicine until the change to the current name of the specialty. CM emerged in the United States in the 1960s as part of the Kennedy administration’s anti-poverty policy, reinforced through the Medicare, Medicaid, and Compulsory Insurance Programs, which were focus measures<sup>17</sup>, which has been the subject of criticism during this period of growing discussions on the establishment of a national health system<sup>18</sup>.

In Brazil, the 1988 Federal Constitution<sup>2</sup> provides, besides universal service, individual- and community-centered care. Thus, the idea of comprehensive care became a guideline, where subjects would be seen in their biological, cultural, social, and psychological realms. At this moment, observing the living conditions of each serviced place, health promotion started a narrative of not prioritizing the risk of illness, but valuing the idea of vulnerability; not the disease, but the collective individual<sup>19</sup>.

In parallel, at this moment, both in the international setting and Brazil, a search for changes in the care model in favor of addressing the health needs of the general population emerged. With growing large urban centers, increasing social disparities, several discussions around the concept of health promotion<sup>20</sup> were ongoing to break with predominantly therapeutic practices. Thus, the First International Health Promotion Conference held in 1986 in Ottawa was indeed a landmark. Thus, Health Promotion appeared as a possibility of being a coordinated action between civil society and the State, advocating the implementation of healthy public policies, the creation of favorable environments, reinforced community action, the development of personal skills and

the reorientation of the health system towards its possible realization<sup>20</sup>.

Along with these developments, we can say that medical education has accompanied some changing trends. Thus, in the 1970s, the ideas of prevention and health promotion and the multi-causality model of diseases gained visibility with the Lalonde Report in Canada in 1974, and a movement for learning that was not solely hospital-focused, but also targeted people<sup>21</sup>.

Similarly, while in some countries, such as the U.K., whose medical care's central element has been the general practitioner since 1948, we have seen a late approach to care in other countries. However, in the 1970s, in line with a new post-war world configuration and low-cost, high-efficiency health services, fragmented and restricted access care, medical education initiatives emerge in some universities with the establishment of community health medicine postgraduate studies, forerunners of the family and community medicine residency.

It is worth remembering that initiatives based on this direction observed in different cities of the country conjured the figure of the general and community medicine resident. Falk<sup>22</sup> states that this residency started the project in Rio Grande do Sul in 1975, and the UERJ Comprehensive Medicine started in Rio de Janeiro in 1976. However, the formalization of the Community General Medicine Residency Program occurred in 1981, when the National Commission of Medical Residency (CNRM) formalized this area as a specialty in Brazil, under the name of General and Community Medicine, and later as Family and Community Medicine in 2002, approved in 2003<sup>15</sup>.

In Rio de Janeiro, the Brazilian Society of Community General Medicine (SBMGC), based in Petrópolis (RJ), was founded during this period. In 1985, the First Meeting of MGC Residents and Former Residents took place in Petrópolis (RJ) – the first national event in the area, where it was decided that doctors trained in residency in the area should reactivate the SBMFC and apply for the Board of Directors of the SBMFC – which until then was assumed by the founders of the specialty in Brazil (psychiatrists, sanitarists, clinicians, infectologists, and others).

Medical Residency (MR) is known to be the gold standard for the training of doctors, which is also a reality for the formation of FCM in Primary Health Care (PHC). Four Medical Residency Programs (PRM) are in place in Rio de Janeiro so far: Rio de Janeiro Municipality (Municipal

Health and Civil Defense Secretariat – SMSDC), Rio de Janeiro State University (UERJ), Federal University of Rio de Janeiro (UFRJ) and the National School of Public Health (ENSP) of the Oswaldo Cruz Foundation (FIOCRUZ).

In 2008, when the PHC reform began in the city of Rio de Janeiro, PHC coverage was 3.5%. In 2015, it exceeded 55%, and 70% was expected for 2016<sup>23</sup>. The ability to train new FCM specialists also grew: 16 vacancies were offered in 2011. In 2016, they rose to 222, setting the possibility of strengthening a PHC in a proposed universal system, with FCM as the system's structural axis<sup>24,25</sup>.

So, what challenges structured Family and Community Medicine in the city of Rio de Janeiro?

### **Meaning networks in the construction of Family and Community Medicine: the city of Rio de Janeiro**

The effective elaboration of curricular reform proposals in medical courses in Brazil only developed after profound changes in the health system that, through some decentralization experiences, such as the Niterói Project and the Unified Decentralized Health System (SUDS), implemented the SUS. The reorganization of the health system corroborated the need to implement a new proposal and professional incorporation, challenging the health education hitherto structured. A new medical curriculum was a reality.

Koifman<sup>26</sup> says that, while a process of curricular reformulation began in the 1980s, the final elaboration of a proposal for family medicine occurred in 1992, and was implemented in 1994. Despite evident resistance by departments and civil society, this implementation took place gradually and without interdisciplinary dialogue.

Thus, with political and technical possibilities of curriculum reformulation to train doctors for the needs of the country amid the implementation of Family Health with subsidies from the Ministry of Health to stimulate the training of PHC specialists, in the case of family and community doctors, nevertheless, one can observe that medical courses have a hard time promoting changes in teaching to meet the restructuring of health in the country and not to specific groups<sup>26,27</sup>. Governmentality acting in professional health education.

Thus, we face highly sensitive issues, as Universities and Science and Technology Foundation responsible for the formation of family and community medicine professionals: How do we deal with governmentality that challenges us for the

construction of a world of work increasingly subjected to government pro-market interventions, competition, indebtedness of individuals?

How can we discuss financing, integrality, and service package in a restrictive agenda, where comprehensive health care is one of the FCM's competencies? Are we thus making a pre-Alma-Ata<sup>10</sup> return, assuming a mixed model that refers to the "New Hygiene" era, inspired by the fragmented hospital practices and collective health of the 1980s, centered on "staple foods"? Are we thus voiding the field of practice of health professionals, especially the Family and Community Doctors<sup>25</sup>?

Promoting health goes against consuming health since self-care is what has value. How do we dialogue with a training that must be critical but which is inserted in this world of consumption, life medicalization, exalted individualism? Can our residency programs not be weakened by a still strongly curative, physician-centered, and under-offered Health Promotion medicine?

However, we have our support and are inspired by authors such as Campos et al.<sup>28</sup> who claim with us the need to move beyond the observation of social "risks", such as environmental problems, inadequate urbanization, extreme poverty, violence, drugs, endemic diseases, and others. We must challenge our governmentality. We try to emphasize intersectoral actions, seeking answers that collaborate with the population, reflecting from the place and its objects, interacting with and through dwellers, employing the possible devices to face their problems together. Utopias as targets we seek to achieve.

In 2013, with the implementation of the *Mais Médicos* ("More Doctors") Program for Brazil, an even greater promotion of the National Primary Care Policy to strengthen the specialty and qualify residents was observed. Despite resistance by

some medical entities and according to Oliveira et al.<sup>29</sup>, what stood out was a growth in the training, provision, and distribution of doctors in the PHC, even considering the idle vacancies found throughout the country. Are we facing forms of resistance?

Changes in municipal management are always threats to the continuity of Residency Programs that include municipal supplementation of resident's scholarship, payment of an additional amount to preceptors, a financial and administrative incentive for the training of workers, and training of masters and doctors in PHC. The logic of the market thus seems to us dissonant to the logic of a training that conjures community participation, the right to health, and the production of a real Family and Community Medicine.

However, since 2017, we have observed a progressive dismantling of primary health care in the city of Rio de Janeiro, based on the allegation of economic weaknesses and the new PNAB to ensure the economic feasibility of PHC in the municipality, as can be observed in the analysis of the report on the ABRASCO website, which states that:

*The reorganization of primary care services in the proposed form has a direct influence on the number of teams and their qualification, considering that it starts cutting 239 teams, 184 of which are family health and 55 oral health (1,400 fewer jobs). Also, a new classification/composition of Titled and Non-Titled teams by the presence of qualified doctors and nurses (without explicit allocation criteria for the different team types).*

Thus, we reiterate our agenda of struggles. We fight not to get lost. We strive for certain precepts of the Astana Declaration not to format us, deform us, or keep us from the commitment to form a medicine that can build health rather than a commodity.

### **Collaborations**

JE Teixeira Junior, VF Romano, MMV Izecksohn, E Faria Neto e MBP Paiva worked equally in the conception, research, and final drafting of the paper.

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