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Family and Community Medicine in the supplementary health system in Brazil: implications for the Unified National Health System and for physicians

Medicina de Família e Comunidade na saúde suplementar do Brasil: implicações para o Sistema Único de Saúde e para os médicos

Medicina de Familia y Comunidad en la salud complementaria de Brasil: implicaciones para el Sistema Único de Salud y los médicos

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This article aims to problematize the interaction between Family and Community Medicine and the supplementary health system (private healthcare services and private health plans) in Brazil's current scenario. The point of departure is a historical contextualization, proceeding to some central aspects in this movement.

In the history of health policies in Brazil before and after the creation of the Unified National Health System (SUS), one of the greatest challenges has been public-private relations. This process shaped a field of interests, actors, and disputes that weaken the possibilities for achieving health as a civil right and the SUS as a social policy of the State [1]. While arguments indicate that inclusion of the private sector in health was a condition for the approval of the chapter on health in the 1988 *Federal Constitution* [2], different forms of incentives have been granted by the state to the private sector, while major underfunding still exists in the SUS [3]. Added to this is the symbolic and imaginary construction in Brazilian society, positively valuing the private health sector to the detriment of the public sector.

Primary healthcare (PHC) has been one of the key strategies in the implementation of the SUS, considering the guarantee of universal access. The principal model instituted in 1994 was the Family Health Program, later reconceptualized as the Family Health Strategy (ESF in Portuguese). The ESF was expanded and improved in the subsequent decades and currently has 42,000 teams (with general medical practitioners, nurses, nurse technicians, and community health agents), covering 63% of Brazil's territory [4]. In addition to internationally acknowledged attributes such as access and first contact, comprehensiveness, continuity over time, and coordination of care [5], Brazil's PHC also features multidisciplinary teamwork and a strong territorial approach. This is seen in the population's modes of enrollment in the system, in the approach to collective health problems and risks, and in the community health agents [6].

The main challenges in the history of the implementation of the ESF have been training, distribution, hiring, pay scales, and development of health professionals, especially physicians [7]. In this sense, although Family and Community Medicine has existed in Brazil since the 1970s [8], more intensely since 2011 [9], national policies were formulated that targeted the physician workforce in PHC. The More Doctors Program (PMM in Portuguese), with its components of emergency provision and training (undergraduate medical education and residency) was quite emblematic, with a central focus on Family and Community Medicine in national law and on the government agenda [7,10].

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The history of Family and Community Medicine in Brazil has witnessed political clashes marked by different forms of discursiveness [11,12]. These range from the change in nomenclature to disagreements between individual clinical priorities and collective practices, management, and planning in the work by family and community physicians. Some of these clashes have occurred in tension with the actors in Collective Health and the Health Reform [8,11]. International references served as the basis for the recent adoption of a liberal perspective in the profession, including incentives for strategies for Family and Community Medicine to enter the private sector and relative unimportance assigned to the need for a public and universal system [13].

In 2000, Brazil created the National Agency for Supplementary Health (ANS in Portuguese), with the responsibility of regulating the private sector. Some 48 million Brazilians are currently covered by private health plans and insurance [14]. These plans offer different types of healthcare coverage, such as outpatient and hospital plans with and without obstetric and dental care. There are different types of operators, such as insurance companies, medical cooperatives, and managed care, as well as individual and group plans. There is also a private supply of healthcare services, not circumscribed by the health plan and health insurance segment, as well as hiring of private and charitable services by the SUS itself, in complementary fashion.

The Healthcare Fund of Banco do Brasil Employees (CASSI in Portuguese) was pioneering in reorganizing part of its services in 2003, focusing on PHC and the coordination of care for beneficiaries. The ANS has incentivized the adoption of strategies similar to PHC in supplementary health, featuring Family and Community Medicine [15]. The first policies to induce PHC were created in 2005 through programs aimed at health promotion and prevention of diseases (PROMOPREV), focused on risk groups and chronic diseases, supplying management of care through multi-professional teams with regulation of access to specialties.

Given the inefficacy of the current model with fragmented care, the alleged financial unsustainability of health plans, and the potential for case-resolution capacity of PHC and especially of family and community physicians, multiple strategies have been deployed in supplementary health. The new operations that have been laid out feature tying a list of patients to the same service with family and community physicians, voluntary adherence of beneficiaries with more attractive monthly premiums, mechanisms for accreditation of plans with PHC, differential compensation for providers, discounts on the amount of the operator's solvency margin based on developing PROMOPREV programs, and partnership with the Brazilian National Economic and Social Development Bank (BNDES in Portuguese) to foment the structuring of private PHC services [16].

In the international sphere, it is important to recall the health sector's rising costs, with inflation in the sector outstripping the overall national inflation rate, the high degree of specialization, technological development, and strong participation in the economy as the object of financial interests in the equipment and pharmaceutical industry, for example. The development of managed care in the United States started in the 1970s under strong financial motivation and with measures to control professional decisions, aimed at rationalizing costs and increasing profits for insurance companies. Mechanisms were adopted for this purpose, with fee-for-service procedures and the use of family and community physicians as the system's gatekeepers [15,17].

Recently, in the midst of political, economic, and social crises, the Brazilian Ministry of Health expressed support for deregulation of the supplementary health sector and the creation of plans with low healthcare coverage, so-called "affordable" or "popular" plans [14]. Insurance companies such as Amil and Unimed have been adopting PHC with family and community physicians and multiprofessional teams. Since Amil's acquisition by the United Health Group in 2012, the company has offered care in PHC in its own (and outsourced) units and reoriented its portal of entry, controlling referrals to specialists and the consumption of tests. That same year, Unimed inaugurated its first PHC clinic in Guarulhos (São Paulo State). The model was reproduced initially in Belo Horizonte (Minas Gerais State) and Vitória (Espírito Santo State), and has been deployed elsewhere in Brazil, backed by technical manuals and consultancy from the Committee for Comprehensive Healthcare created by Unimed-Brasil.

Family and Community Medicine became a useful workforce for the private sector. In fact, lower referral rates and rationalization in the use of complementary tests are relevant skills for the market's health plans and insurance companies. However, training focused on the community, group activities,

family therapy, and integrative practices are not among the priority (or even possible) skills in this scenario, so that the title of "family and community physician" is cleaved in its ideological construct. In addition, its action is disconnected from the social and territorial reality and conducted under a different logic (mercantile, and accessible only to those who can pay).

Among the health plan operators, the healthcare arrangements that can include family and community physicians generally demarcate PROMOPREV programs, homecare services, and PHC portfolios per se [18]. The latter include the formation of physician-centered teams, where nursing has a management role and little direct involvement in patient care, besides psychologists and nutritionists, with outpatient care having limited sharing between professions. Clashes tend to emerge with specialists and providers, based on the implementation of protocols that consider theories of quaternary prevention and questioning of excessive screening tests, reorienting users accustomed to being bombarded with unnecessary routine tests [19].

Meanwhile, the hiring model for family and community physicians tends to extrapolate both fee-for-service and fixed wages, and is structured on the capitation + performance logic. Under this logic, capitation (usually 70 to 80% of the total pay) corresponds to a value according to the number of referenced persons, and performance is the equivalent of a variable portion according to indicators and targets composed heterogeneously within the existing experiences. The usual approach is to combine access indicators and user satisfaction with healthcare cost indicators, with maximum targets for referral rates, reduction in the use of emergency care and hospitalizations due to PHC-sensitive causes, and the volume of claims in the portfolio. The variable component expresses the employer's induction towards PHC work, sometimes valuing quality of care, sometimes more market-oriented indicators, and with pertinent ethical issues opening a field to be explored in the national experiences.

Part of the Brazilian Society of Family and Community Medicine views this process with enthusiasm. There is a perspective of greater legitimacy for this specialty, especially in the middle class. However, for the vast majority of family and community physicians that have begun to work in the supplementary health sector, it is the result of public policies that have aimed to enable an increase in the supply of professionals with this background. The Brazilian State, which created the work market represented by the ESF in recent decades, pays the scholarships and incentives for residencies in Family and Community Medicine.

Since the number of family and community physicians with training and/or specific titles in Brazil is still very small, the opening of new job positions in the private sector tends to decrease the presence (or at least the dedicated work hours) of part of the family and community physicians in the SUS. This process tends to increase especially in the current context, which threatens the public system, and due to the new configurations of teams provided in the latest version of the National Policy for Basic Care, of 2017 [20]. The PMM contributed to confronting the chronic problem with healthcare provision and impacted the opening of medical schools and vacancies. However, the implementation of its legal provisions pertaining to training, such as the new rules for access to (and expansion of) residencies in Family and Community Medicine, were discontinued. In addition, the area of healthcare provision, even before being improved with new strategies for physician retention, has suffered major setbacks such as the recent loss of approximately 8,000 Cuban physicians.

The migration of family and community physicians to the private sector undermines efforts by the PMM and may represent a loss of energy and policy leadership for PHC in the SUS, where it is necessary to resist scrapping of services, workforce cuts, and threats of dismantlement, which cannot be done without political actors [21].

However, there have been evaluations in Family and Community Medicine suggesting that the success of the gatekeeper approach in the private sector could be reimported by local administrators in the SUS, in a kind of reverse legitimation. Still, we doubt the validity of this purported legitimation, not to mention the additional risk of loss of qualified (and already scarce) professionals. This underlines the need for regulation and effective reorganization of the health workforce by the state, democratically and oriented to society's needs. However, we do not overlook the fact that users of the supplementary healthcare system also deserve to be properly cared for, whether in the SUS (with reimbursement) or in paid services. This is a controversial and relevant point in this discussion, as is the effective regulation of supplementary health.

In this article, we have sought to highlight the potential implications of the absorption of Family and Community Medicine by the supplementary health sector (private services and health plans) for the SUS and for this specialty. We identified the risks especially for the SUS, that it could lose these professionals to the private sector and that the family and community physicians will no longer consider the ESF as an important space for their work. This trend appears to be in sync with the strengthening of a certain technical and political orientation in Family and Community Medicine. Since this is a recent theme, other elements in this process require specific studies, such as: the ideal of professional autonomy and a liberal profession for family and community physicians, the private logics within PHC in SUS, the wagers by the private sector when incorporating family and community physicians, and beneficiaries' reaction to the creation of new health plans with family and community physicians.

Contributors

H. S. V. Machado and E. A. Melo contributed to the study's conceptualization and design and writing, revision, and approval of the final version for publication. L. G. N. Paula contributed to the writing, revision, and approval of the final version for publication.

Additional informations

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