

Reviewing the Brazilian National Primary Healthcare Policy at such a time?

Revisão da Política Nacional de Atenção Básica numa hora dessas?

¿Revisar la Política Nacional de Atención Primaria de Salud de Brasil en ese momento?

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Faced with progressive dismantling of the public face of the Brazilian state and its democratic institutions, public policies in general, and the Brazilian Unified National Health System (SUS) in particular, are being pressured to fully convert social rights in accordance with the logic of the market. In this setting, health becomes an essential subject in the fierce competition of the private sector for public funding, with a cunning purpose of turning the different dimensions of the human living in society into merchandise.

In the SUS, primary care has been the main focus for expanding public healthcare delivery to the population, particularly the working class, as well as the creation of jobs. However, its expansion comes in tandem with the outsourcing of the workforce ¹ and privatization of the management of healthcare facilities through the establishment of partnerships between the public and the private sectors, particularly in the form of Social Organizations.

In this paper we address two facts related to the proposition for reviewing the Brazilian National Primary Healthcare Policy (PNAB) that caused concern due to the limited perspective they present at a time the correlation of forces does not favor those who advocate health as a right. The first was the publication of *Ordinance GM/MS n. 958/16*, in May 2016, changing the composition of the minimum Family Health Strategy (FHS) team, allowing cities to replace community health workers (CHW) with nursing aids or technicians. Even though it was annulled, as an effect of the organized mobilization of CHWs, the ordinance clearly expresses a proposition that is still under discussion. The second fact is the indications for reviewing the PNAB published in the summary document of the VII National Forum of Primary Care Management ².

This Forum was organized by the Brazilian Ministry of Health Primary Care Department, and gathered a little over 200 people in October 2016, with the purpose of collecting inputs for the PNAB revision. The summary document of discussions presents ideas that deserve to be problematized considering their potential repercussions for the healthcare model and management of the work.

Regarding the healthcare model, we believe that by allowing the minimum FHS operated with nursing aids or technicians instead of CHWs, *Ordinance GM/MS n. 958/16* reflects a deepening of the biomedical, medicalizing perspective that associates increased resolution in primary care to the performance of simplified procedures. Thus, it evidences how difficult it is to overcome the narrow conception of clinical practice, in which effectiveness is related to healthcare in its most limited sense, and not to comprehensive care that understands health as a process that expresses social determinations.

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Another implication of this conception is the potential weakening of education and health promotion actions, the main challenges of which remain in the agenda, such as the development of non-fragmented actions and the exercise of intersectoriality³.

This retreat regarding the presence of CHWs in the teams means giving up the idea of training these workers on a technical level. The broad development of this proposition could prompt a revision of the scopes of practice of these workers concerning both healthcare needs and the qualification aspirations of CHWs and primary care teams.

Changes in the composition of the teams seems to be revisited in the 7th Forum summary document, where the creation of “*team modalities*” is indicated² (p. 2), with a proposition to differentiate types of work schedules, workload and types of hiring contract. The rationale for these changes would be the specificities of the different areas included. In a setting in which labor precariousness is widespread, to diversify and institute flexible labor contracts and work organization accentuates workers vulnerability, particularly technical and aiding personnel working in primary care – CHW, endemic-management agents (EMA), nursing aids and technicians, oral health aids and technicians –, oftentimes praised in speeches, always summoned at times of public health emergencies, frequently treated as subordinates in the development of long-lasting policies.

The public health specificities of the area are similarly used as an argument to make more flexible the primary care coverage, as it states: “...*the amount of people covered should be correlated to the public health needs of the area*”² (p. 2). Therefore, the revision of the PNAB would revisit the idea of a selective primary care delivery, in which part of the population would be destined to compose a private consumer and segmented market for services provided by health care plans at the expense of the principle of universal healthcare provision as envisioned in the Brazilian Sanitary Reformation project.

Under this perspective in which health is considered a commodity, the different social classes would have access to the quality of care they could buy. In turn, the public health system would serve the segments that navigate in the outskirts of these market dynamics, in a future without the SUS developed in accordance with Constitutional Amendment Proposition (PEC) 55 and its ramifications, in the counter-reformations conducted on the different levels of social policy.

The summary document presents another worrisome aspect, which is the association of these ideas with the proposition of a “*minimum services portfolio for the PNAB*”² (p. 6) and of “*inducing service portfolios that meet local needs and specificities*”² (p. 7). The principle of equity, that could inspire the proposition of attending occasional peculiar needs of the areas can only be achieved in a fair way if steered by the principles of equality and universality, this means, as long as a level of coverage and quality of care has been achieved so that the design of alternate contingencies represents a refinement of the system and its possibilities. However, before any of the challenges identified at the time PNAB 2006 was formulated, and refreshed in 2012 were overcome, the current revision initiative seems to re-address the agenda of “*minimums*” in different dimensions. In this setting, to include local specificities may imply in reinforcement of inequalities and justification for differentiated treatments, feeble bonds, and varied service “*portfolios*”, stratified or simplified.

The proposition to merge CHW and EMA into a single professional, as stated in the first and in the last item of the summary document seems also to meet the logic of “*minimums*”. With the justification of integrating care and surveillance, this proposition hides what is likely to be its core goal: reduction of costs by reducing jobs, and more intense work to the CHWs and EMAs who remain active. Once again we face a situation where change is intended without having achieved the benefits of integrating EMAs in the family health team, as established by PNAB. There is no consideration of the fact that integration between different technical areas/policies requires identification and specification of the points of interface of the labor process, promotion of integrating actions and spaces, such as in planning that combine the different possibilities of operation to reach common goals.

Another aspect to be considered is the proposition of strengthening non-punitive evaluation and monitoring of the day-to-day of the teams². Even though there is consensus about the capability of evaluation to collect useful information to redirect policies and practices, what is in place is, in fact, information systems-based monitoring practices that are, due to their structural features, limited. Hence, if monitoring is a matter for reflection, only the actual team work and discussion

about it can unfold them into complex questions typical of primary care characteristics, which will add to the development of collective knowledge, actually and legitimately capable of reorienting the work process.

Stating that the evaluation should not be punitive in nature and, at the same time, advocating the payment of an additional performance-based bonus in a setting of flexibility of global relations is nonsensical. If we consider assessment and monitoring as knowledge-production practices with a sense of usefulness, this sense only comes through when some conditions are assured. The most basic one is the strengthening of spaces for team exchanges – team meetings –, that were not mentioned in any part of the document. We caution that these meetings tend to be suppressed in the work process, in face of productivity pressures the Toyota production system logic, pillar of the managerial model, has disseminated on the management of healthcare services⁴.

Faced with such controversial issues, we revisit the question asked in the title: *Reviewing the Brazilian National Primary Healthcare Policy at Such a Time?* We make clear this is not an invitation for immobilism, as opposed to an impulse for ongoing changes which is typical of management, oftentimes led by immediateness that refrain from projecting a strategic horizon for SUS. We believe efforts should be coordinated, so that discussions on primary care can be, at the same time, deepened and widened, re-examining the idea of broad social participation. We also state that the basis on which this discussion should take place is the commitment to fulfill the healthcare needs of the population, and the responsibility to maintain the guidelines establishing primary care as a space of health institutionalization as a right for all and a duty of the State.

Contributors

M. V. G. C. Morosini contributed to the text proposition, preparation and discussion. A. F. Fonseca contributed to the text discussion and preparation.

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