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Editorial

Global crisis in primary health care

Crise global da atenção primária à saúde

Crisis global de la atención primaria

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Abstract

While the Global North is discussing a crisis in primary health care, the majority of countries have never managed to establish health systems based on robust primary care. Brazil presents a more favorable trend, with important achievements for primary care and family practice over the last ten years. There are still challenges to be overcome so that the Unified Health System achieves satisfactory levels of access to its services, with professionals who are properly trained and valued by the public.

Keywords: Primary health care; Health systems; Family practice; Global health.

Resumo

Enquanto no Norte Global se discute uma crise na Atenção Primária à Saúde, a maioria dos países nunca chegou a constituir sistemas de saúde baseados propriamente numa atenção primária robusta. Nesse cenário, o Brasil apresenta uma tendência mais favorável, com conquistas importantes para a atenção primária e a medicina de família e comunidade nos últimos dez anos. Restam desafios a serem superados para que o Sistema Único de Saúde alcance níveis satisfatórios de acesso a seus serviços, com profissionais adequadamente formados e valorizados pela população.

Palavras-chave: Atenção primária à saúde; Sistemas de saúde; Medicina de família e comunidade; Saúde global.

Resumen

Mientras que en el Norte Global se habla de una crisis de la atención primaria, la mayoría de los países nunca han creado realmente sistemas sanitarios basados en una atención primaria robusta. Brasil, muestra una tendencia más favorable, con importantes logros para la atención primaria y la medicina familiar y comunitaria en los últimos diez años. Aún quedan retos por superar para que el Sistema Único de Salud alcance niveles satisfactorios de acceso a sus servicios, con profesionales debidamente formados y valorados por la población.

Palabras-clave: Atención primaria de salud; Sistemas de salud; Medicina familiar y comunitaria; Salud global.

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Whether in public or supplementary health care, different actors agree that health care systems, be they universal or not, must be organized based on primary health care (PHC), ideally with an emphasis on family and community medicine (FCM).[1-4] That said, the question arises: if this is so, why are PHC and FCM going through a global crisis?

Perhaps the most emblematic case is that of the United Kingdom, whose PHC served as an inspiration for so many other countries.[5,6] The number of FCM doctors is increasingly deficient, creating a burden on health care professionals, which in turn makes it difficult to retain family doctors, warns Steve Taylor in FCM on his personal profile on social media, for example. The problem is also compounded by other factors: a reduction in doctors' income; migration policies that increasingly restrict the incorporation of professionals; and even a smear campaign by some media.[6-8]

In turn, Canada still has a significant percentage of citizens without ties to an FCM doctor and faces significant difficulties in training and retaining this specialist in its health system.[9] In the United States, which needs to expand PHC and FCM considerably, the number of FCM specialists leaving was double the number joining in the same period in 2022.[10]

Without a doubt, the pandemic greatly increased the difficulties. A survey carried out in 10 high-income countries[11] found a significant increase in work demand, especially administrative work, less time dedicated to caring for the patient and greater professional dissatisfaction and burnout, generating a greater desire to permanently leave clinical practice. Furthermore, the work of the FCM doctor became more stressful in this context due to a dysfunction in the health system as a whole, hampering the coordination and resolution of care. Sometimes, this dysfunction is accompanied by a set of conservative austerity policies that substantially reduce health system financing.[11-14]

However, in this editorial, we talk about a global crisis in PHC and FCM, and so far only the richest countries in the Global North have been mentioned. The fact is that this debate draws attention because it occurs in countries that serve as a reference for PHC in countries such as Brazil. But it is also a fact that the most vulnerable regions, such as the African continent and much of Latin America and Asia, have never experienced exactly a peak in their health systems and their PHC and FCM. These are regions where there is a systematic underfunding of health measures and services, precariousness in the services provided to the public and a strong fragmentation of the health system. In Africa, for example, there is still a predominance of community-oriented PHC carried out by community health workers, often without adequate training and without a formal employment relationship, with a very small number of doctors including specialized doctors, and nurses.[15,16] Therefore, it possible to say that these regions have always experienced PHC in crisis and, in certain situations, non-existent.

One of the warnings that must be made when facing this crisis is the adoption of simplified and cheap measures that harm the scope of services offered by PHC.[9,10,1-14] It is common in the debate about the difficulty of providing a medical workforce specialized in PHC, where alternatives are resorted to, incorporating other professional categories into the services. The presence of these professionals per se is not a problem. In fact, PHC has a greater impact on the public's health by having a greater diversity of professionals who will respond in a qualified manner to different needs. The problem arises when this substitution is made to make PHC even more precarious, incorporating professionals without the desired qualifications at reduced costs. In very vulnerable locations, these alternatives may be the only short- and medium-term solution. However, it is crucial to be aware of government actions that weaken the provision of health services, often camouflaged by weakened and targeted universal coverage initiatives.

And what about Brazil? The country has taken interesting measures in recent years to face many of the challenges presented by high-income countries that contributed to the construction of the history of the SUS. According to the Medical Demography of 2023,[17] the current rate of doctors at the national level is 2.6/1000 inhabitants, a significant increase compared to 1.63/1000 in 2010 and 0.94/1000 in 1980. However, even with this significant growth in the medical workforce in recent decades, the distribution is still very uneven territorially, with the medical specialties being in greatest demand in SUS.

As for FCM, according to the 2023 Medical Demography,[17] we currently have just over 11 thousand specialists in the country, representing around 2.3% of the medical workforce. This number is very low, especially considering that the FCM would ideally form a quality PHC that would organize SUS that today has just over 52 thousand family health teams and a potential PHC population coverage of more than 92%.[18] However, the growth data for the specialty in a decade are impressive: in 2012, Brazil had 3,253 registered FCM physicians, which represents a growth of 246%, second only to Legal Medicine (whose absolute numbers are much lower than for FCM).[17]

In a way, the PHC development vector in the country now seems to be more favorable than that observed in high-income countries. This is the result of a series of initiatives, policies and investments to strengthen PHC. Without being exhaustive, there was a strong expansion in the availability of medical residencies in FCM with funding from the federal government, including places offered by municipalities.[19,20] Provision programs, especially Mais Médicos (More Doctors), placed expansion and qualification on the political agenda of PHC and FCM,[21] and municipalities started to pay for additional scholarships for FCM residents, bringing the amounts received closer to those of permanent doctors or those included in provision programs.[22] The number of courses and other educational initiatives aimed at PHC and FCM increased;[23] the FCM degree (via medical residency or certification) had become a differentiator in the medical career for entry into competitions or opportunities for jobs and scholarships. The space of FCM and PHC in medical degrees increased after the publication of the National Curricular Guidelines.[24] FCM specialists began to occupy management, teaching and assistance spaces with greater qualification and attractiveness, and supplementary health saw an increase in the number and scale of PHC experiences with the inclusion of FCM.[4] Finally, in recent years, an environment for PHC and FCM was created which, among other effects, made the area more interesting and conducive to attracting a greater number of medical graduates and searching for professionals already allocated to PHC through degrees via SBMFC and AMB.

Evidently, there are challenges in this process. As already mentioned, the number of FCM doctors trained and in training is not enough to meet the demand. The solution put forward by the federal administration of massifying the FCM title linked to the doctor's participation in training programs[21] will quickly change this panorama, if it comes to fruition, but without a guarantee that the quality of PHC will increase in the same proportion. The current focus of municipalities on provision programs benefits the population in the sense of guaranteeing medical provision but poses the challenge of debating the professional career of the newly graduated FCM doctor. The little evidence we still have suggests that training at the medical residency level in FCM in the country is heterogeneous, both in quantitative and qualitative terms.[22] The income of FCM doctors in the public system, although not the only determinants of professional retention in SUS,[25] brings up the debate on how to contain the migration of residency-trained FCM doctors to supplementary health care. And the quality of PHC attested, for example, by the application of PCATools in the last National Health Survey, deserves greater consideration, as it does not reach the minimum standards expected for PHC adequately guided by its essential and derived attributes.[26]

In other words, Brazil, within what we are calling the global crisis of PHC and FCM, may stand out as an exception, working towards achieving satisfactory levels of access to services and professionals who are adequately trained and valued by the public. To achieve this, the aforementioned policies and PHC development vector need to not only be maintained but deepened. The massification of access to doctors in PHC is the right strategy at the national level. And it must be accompanied by greater emphasis on the quality of care provided, which will require quality training in FCM, preferably via residency, and obviously in the training of all professionals working in PHC.

CONFLICT OF INTERESTS

TDS and LFF are part of the editorial board of the Brazilian Journal of Family and Community Medicine, a publication of the Brazilian Society of Family and Community Medicine.

AUTHORS' CONTRIBUTIONS

TDS, Conceptualization, Writing – original draft, Writing – review & editing. APSCA, Conceptualization, Writing – original draft. LFF, Conceptualization. Writing – original draft.

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