Perceptions and uses of public and private healthcare in a Brazilian favela

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Abstract

Since 1988, Brazil has reorganized and expanded its public healthcare system, defining access to healthcare as a right of every citizen. In parallel, the private healthcare sector grew rapidly to become one of the largest in the world. We explore the use of public and private health care by a low-income population living a favela, Rio das Pedras, in Rio de Janeiro. At the time of data collection, only part of the community was covered by the primary health care program. We conducted semi-structured interviews with 14 adults, both with and without access to the public primary care program. Regardless of program coverage, participants noted barriers and negative experiences while accessing public healthcare. The perceived inability of health professionals to deal compassionately with a low-income population was prominent in their narratives, and in the expressed motivation for pursuing private sector healthcare alternatives. We explore the tension arising from the more recent rights-based healthcare provision and historic social control and assistentialist framing of state intervention in Brazilian favelas.

Keywords: Brazil; public healthcare; private healthcare; access to care; qualitative interviews

Introduction

Since 1988, Brazil has reorganized and expanded its public healthcare system, defining access to healthcare as "a right of every citizen and the duty of the State", with a series of reforms that led to the Unified National Health System (SUS). One component of SUS is the Family Health Program (Programa Saúde da Família), created in 1994. Anchored in primary care Clinics as a spatially targeted strategy and point of entry into the healthcare system, the Family Health Program was designed to reorient "ways of thinking about and practicing healthcare, transforming the traditional Brazilian health model, doctor-centered, drug-centered, curative and individualist, with the hospital as the main *locus* for responding to each and every health problem, into a health model that is collective, multi- and interprofessional, centered on the family and in the community" (G. D. da Costa, Cotta, Ferreira, Reis, & Franceschini, 2009). The strategy has geographically defined areas of coverage for each Clinic and for each of the multidisciplinary teams within it. Trained community health workers, called health agents, are key to pursuing the creation of ties with the community. By 2013, the proportion of Brazilian households registered in the program was 53.4% (Malta et al., 2016).

In parallel to public healthcare expansion, the private sector has grown dramatically since the 1950's, becoming one of the largest of its kind in the world (Agencia Nacional de Saúde Suplementar, 2016) Brazil, thus, can be described as having a two-tier healthcare system, where a public health care system provides universal access to all citizens, while a parallel system exists where individuals can purchase health services. It is worth noting that health care professionals are allowed to, and often do work in both systems. This recent expansion has been partially based on the creation of new "products" that target populations with a moderate to low income, such as low-cost private clinics for certain specialties and exams, as well as private insurance coverage. Thus, access to healthcare by low income populations has increased in Brazil over the last decade not only through expansion of SUS but also through private service delivery. Currently, both public and private organizations are involved in healthcare management. Moreover, the project of healthcare system reform since 1988 has occurred in the broad context of neo-liberal State reform, with a

range of social and political consequences. Challenges encountered by the democratizing project of SUS can be understood in light of contradictions with the broader neo-liberal ideology that limits State responsibility for and involvement in the assurance of citizenship rights (Silva & França Junior, 2015).

Previous studies have focused on satisfaction and dissatisfaction of users within the public healthcare system (Harzheim et al., 2006; Macinko, Harris, & Rocha, 2017), but the perceptions and opinions of non-users have been less studied. An exclusive focus on public healthcare users might incompletely depict the diversity of perceptions of this system, and dynamics in use over time. A study in the region of Madhya Pradesh, in India, has explored how healthcare professionals in the public system view their counterparts in private healthcare and vice versa, discussing the mistrust that permeates such perceptions (De Costa, Johansson, & Diwan, 2008). Meanwhile, studies in Mexico (Colmenares-Roa et al., 2016) and Brazil (Sanabria, 2010) explored the differences in doctor-patient relationship in public and private healthcare.

However, despite the coexistence and interconnections between public and private healthcare, broad perceptions of these juxtaposed healthcare systems have been insufficiently explored. This is particularly interesting since one consequence of simultaneous public and private healthcare system expansion is the combined use of these services. Focusing on residents' perspectives within a specific community has the potential to incorporate a more diverse range of views of the healthcare system than would be encountered among frequent users of a particular healthcare facility. It also allows for an analysis of residents' perspectives on the comparative value and roles of both public and private healthcare. It is, moreover, coherent with the strategy of implementation of primary care in SUS, for which population coverage is spatially defined.

Favelas and the State: a complex relationship

In Brazil, *favelas* are often referred to in terms of physical or social deprivation, thus defined through a 'deficit perspective', in terms of what they 'lack', as is also the case in informal or slum communities around the world (Lacerda, 2015). However, alternative definitions can emphasize that

"there is evidence of so much energy, imagination and determination that the slums could be taken as a paradigm of bottom-up human development" (Msafiri, 2017).

The lack of consensus on a definition of *favela* exists also among government institutions (Queiroz Filho, 2015). According to the Brazilian Institute of Geography and Statistics (IBGE), a favela or "subnormal agglomeration" is defined as an illegal occupation of at least 51 housing units (Snyder, Jaimes, Riley, Faerstein, & Corburn, 2014). However, the definition presented by the country's Ministry of Cities encompasses a more broad definition of Brazilian favelas, anchored in two aspects: a) it is a mostly residential area, inhabited by low income families; and b) it is characterized by the existence of precarious conditions of living, including a number of inadequacies such as irregular ownership of the land, absence of infrastructure, location in areas poorly served by State services, often also observing a high populational density and located in areas unfit for construction due to environmental risks (Queiroz Filho, 2015).

The study of favelas in the Brazilian social sciences has focused largely on the "marginality" of these territories and the "absence" of the State. Poverty and the lack of public services such as sanitation, access to healthcare, education and urban infrastructure have played a central role, implying a binary contrast between the *favelas* and formal areas.

However, this way of analyzing the *favelas* assigns an appearance of homogeneity to complex and varied urban areas (Valladares, 2005), and reinforces the duality city/*favela,* perpetuating a discourse that deals with concepts such as "inclusion/exclusion" or "broken city" (Telles, 2006) and understands the *favela* from a perspective of Otherness. This perspective of Otherness is instrumental to construct a divided city as reality, and becomes an obstacle in understanding the heterogeneity of the *favelas* and the dynamics that connect them to their broader context in the city or urban areas globally.

This perspective is criticized by those who instead draw attention to the importance of the bonds between the *favela* and its surroundings. As Machado da Silva (2011) describe, "The *favela* is not an isolated community: its own existence depends much more on the structural conditions of the global society than of the internal mechanisms developed to maintain it". Instead of an absence of

the State, emphasis can be given to the historical negotiation and renegotiation of the boundaries of State action, which are entangled with the genesis and consolidation of *favelas* (M. Cavalcanti, 2013). Their existence, then, is not independent from, but embedded within the historical processes that configure the Brazilian State over the last century.

Historically, the *favelas* have been addressed by the State through two main outlooks. The first understands these neighborhoods as a "problem" for the city, to be solved through police control and slum clearance. This has been the main perspective shaping policies targeted at *favelas* through the 1930's and during the first decades of the military dictatorship (1964-1984). A second type of policy has focused on assistentialism, providing limited services such as electricity or the asphalting of streets, while aiming to curtail the power of social movements organized by *favela* dwellers. This has been prominent during the populist dictatorship of Getulio Vargas, at times through a partnership between the state and institutions such as the Catholic Leão XIII foundation (Mariana Cavalcanti, 2007; Zaluar & Alvito, 2006).

Policies following redemocratization focused on urbanizing the *favelas* by mobilizing discourse associated with citizenship rights, although in practice this discourse was sometimes accompanied by the reproduction of ongoing practices of social control (M. Cavalcanti, 2013) or sentiments of assistentialism. This movement happened in parallel with the re-emergence of the discussion surrounding the concept of citizenship in sociology and other social sciences, during the 1990's, when its understanding as primarily a legal status is complexified to encompass the discussion about what activities citizenship does or should entail (Kymlicka & Norman, 1994). The concept of citizenship, thus, denotes not only the membership to a nation-state, but also the set of associated rights and duties, and the effective exercise of rights, obligations and political participation (Soysal, 2011). As a consequence, the idea of citizenship-based rights has been introduced, but exists alongside and often in tension with previous perspectives.

Even though at times one of the logics has seemed to predominate, throughout history both social control and assistentialist perspectives have coexisted. It can be argued that they have become even more intensely interrelated in Rio de Janeiro since 2008, when the city deployed "Pacifying

Police Units" (UPP) and the associated project "UPP Social", a policy that integrates proximity policing with social actions and infrastructure interventions, mainly the regularization of public electricity and sanitation services, as well as private services such as cable television, banking and financial services. The policy of military occupation of *favela* territories through the UPP with the declared purpose of withdrawing power from armed drug dealers remains the strongest manifestation of this strategy, implemented exclusively in *favelas* dominated by drug cartels (Fleury, 2012).

Neo-developmentalist national policies

With rise of the Worker's Party (PT) in federal government in 2003, the framework for public policies has changed yet again, marked by the neo-developmentalist project of consolidating an internal Brazilian consumer market as a strategy for decreasing social inequality by expanding access to commercial goods, while maintaining general continuity with neo-liberal macroeconomic policies. To lower-income households, this political project has been tangibly realized through targeted cash transfer programs (Medeiros, Britto, & Soares, 2007) and access to credit markets, and in a broader sense, by expansion of regularized employment and a substantial increase in the minimum wage.

Thirteen years of center-left federal government in Brazil, headed by the PT, has profoundly changed the composition of Brazilian society, leading to the emergence of a new, heterogeneous working class (Chauí, 2013). The governmental plan developed by the PT promoted economic growth and income redistribution while avoiding direct confrontation with major economic powers, with attention to both external and internal markets. This strategy significantly improved living conditions for many Brazilians by increasing their purchasing power. However, it explicitly links citizenship and consumption, under the neo-liberal premise that the market would be more "effective" than government in reliably meeting needs of the population (Sader, 2002).

In the neo-liberal ideology that sustains the association between citizenship and consumption, the role of the State is narrower than the role anticipated when the Brazilian public healthcare system was originated. Theoretically, the neo-liberal State ensures the existence of freely

functioning markets and free trade, promotes individual property rights and the rule of law, and uses its power to enable or create market systems where they don't exist (Harvey, 2011, p 64-65). In practice, the global advance of neo-liberalization has led to the often contradictory redefinition of the role of the State. One of such contradictions is that, "on the one hand the neoliberal state is expected to take a back seat and simply set the stage for market functions, but on the other it is supposed to be activist in creating a good business climate and to behave as a competitive entity in global politics" (Harvey, 2011, p 79).

While center-left administrations headed by the PT (2003-2016) have partially aligned with neo-liberalism, tensions between SUS' universalizing project and neo-liberalism were at play since the creation of SUS, which was coincident with broad neo-liberal reform of the Brazilian State (J. S. Paim, 2013; Silva & França Junior, 2015). While advancements were made in establishing the national healthcare system during the 1990's, implementation collided with the general economic policy orientation, leading to substantial underfunding of public healthcare and, indirectly, to the accelerated expansion of the private healthcare sector (A. M. Costa, Noronha, & Noronha, 2015).

The growth of private healthcare plans in Brazil thus has origins prior to the neo-developmentalist period that starts with Lula's government, during which growth was further accelerated through economic policies while also expanding the public healthcare agenda (A. M. Costa et al., 2015). Some of the strategies adopted both by Lula and Dilma Rousseff's governments, such as increased fiscal incentives, stimulated the growing market for private healthcare plans, and, within the logic of expanding the Brazilian consumer market to include part of the "new working class" (Chauí, 2013), amplified the consumer market for private healthcare, often taking the form of low-cost, low-quality plans with predatory practices.

The present study

Our study focuses in Rio das Pedras, a *favela* located in Rio de Janeiro. This community has grown rapidly over recent decades, and is today one of the largest *favelas* in Brazil. Many residents are migrants from the Northeast region of the country who relocated in search of economic opportunities. The community has more than 60,000 inhabitants, and during the study period (2015)

it had one local public Clinic (Clinica de Saúde da Família) that covered approximately 40% of households.

The "Rio das Pedras Community Diagnosis" project, conducted in the context of a partnership between Columbia University and Oswaldo Cruz Foundation, gathered information about living conditions and health in this community, aiming to complement the limited available data. The project focused household sampling within two neighborhoods of Rio das Pedras, Areal and Areinha, and included several data collection phases: a questionnaire, analysis of the quality of water, analysis of oral microbiome, geographic positioning system logging of mobility, systematic observation of streets, and semi-structured interviews. The present qualitative analysis uses data from semi-structured interviews and explores the experience of seeking healthcare, both in the public and in the private system. We developed this research to understand how healthcare access is experienced by Rio das Pedras residents, including barriers encountered when seeking healthcare and strategies to optimize healthcare access, either in the public system or with private providers.

Methods

We used a qualitative approach based on 14 semi-structured interviews conducted with residents of Rio das Pedras, with a perspective based in focused ethnography, as our research is problem-focused and context-specific, describing residents' experiences with healthcare in the Rio das Pedras community, within their particular cultural context (Higginbottom, Pillay, & Boadu, 2013). Our study used an interview guide to apply a similar set of questions to all participants in line with our objectives. Interview questions were developed around six topics: 1) personal history; 2) perceptions of the community; 3) local travel patterns and difficulties faced; 4) housing instability; 5) access to health care; and 6) perceptions of public healthcare. Barriers and facilitators to healthcare access were further explored through probes, but the interview guide did not specifically include questions about the use of private healthcare.

Participants were aged 20 to 52 years, and representation was sought for each of the following groups: women aged <= 30 years, men aged <= 30 years, women > 30 years old, men > 30 years old. The group was thus heterogeneous with respect to gender and age, as well as race, occupation

and family structure. However, as residents of Rio das Pedras, all experienced similar living conditions and nearby healthcare infrastructure. Hence it was estimated that saturation would be reached with approximately 12 interviews (Guest, 2006).

Recruitment took place within the context of the larger community diagnosis project. Spatial sampling of households for the main study, and random selection of one adult per household, resulted in 104 participating adults. Residents invited for the semi-structure interview were selected from this group based on their willingness to be re-contacted. Potential interview participants were contacted initially by telephone and later using a door-to-door approach. When questioned about the motives for declining to participate in the semi-structured interview (n=4), participants mentioned lack of interest, not having the available time, and feeling that information provided in previous research phases should be sufficient. All interviews were conducted at the participants' residences.

Data saturation was evaluated during as the fieldwork evolved according to the six main topics in the interview guide, and re-evaluated during data analysis.

All interviews were digitally recorded, and transcribed independently using the software Express Scribe 5.56.

Analysis

All transcribed interviews, as well as field notes, were analyzed using QSR NVivo software, version 7.0.281.0. Transcripts were coded using a strategy that integrated Descriptive, In Vivo and Versus coding, as described by Saldaña (2013).

Descriptive and In Vivo coding were initially used. Descriptive coding refers to the creation of codes that described particular situations or topics, such as "Quality of service," "Barriers," "Hospitals," "Strategies of access" and so on. In Vivo coding consists of creating codes that derived from participant's own expressions and includes either the expression itself or others that are very similar in meaning. Codes used in our dataset through this strategy include expressions that could be roughly translated as "you are humiliated" and "make a commotion". In these cases, InVivo coding was used because the correspondent expressions in Brazilian Portuguese - "Você é humilhado" and "Fazer um barraco" - were recurrent in our interviews (respectively, referenced 21

times in 6 interviews and referenced 15 times in 7 interviews) and carry a strong cultural meaning. Specifically, "Fazer um barraco" refers to building typical improvised and informal construction, with a secondary meaning of the act of causing a public commotion, fighting in public and embarrassing oneself in the process. It implies, then, an association between poverty and a public behavior that is understood as inappropriate. This code was applied whenever this expression, or its variations, with all the social meaning that it carries, was used by interviewees.

In a second phase, this strategy was expanded to include "Versus" coding, which applies where explicit conflicts, oppositions or contrasts were narrated. Examples of such codes in our dataset include "Doctor vs. Patient", "Citizen vs. Consumer", "Public vs. Private". This strategy is proposed for use in "qualitative datasets that suggest strong conflicts or competing goals" (Saldaña, 2013), in order to explicitly identify oposing terms that emerge from the participants' narratives. Such codes were applied when participants compared and contrasted categories in a way that portrays them as opposites or in conflict, thus the code "Doctor vs. Patient" is not applied to a mere description of doctors (the Descriptive code "Doctors" being used instead) but to situations where a conflict or contrast between doctor and patient is described.

The coding process developed iteratively, with ongoing attention to the categories created and their inter-relation. Similar codes were later grouped into broad categories to characterize and explore the relationships between such categories. We present results according to the main categories identified in the analysis.

Coding was performed by the same researcher responsible for the interviews and fieldwork, and was not subject to inter-rater reliability procedures since this is an interpretive qualitative inquiry (Morse, 2012). Saturation of the data during the coding phase was evaluated based on the creation of codes in the initial phase, and the frequency of their subsequent use. Data saturation is often mentioned in the literature but procedures for operationalizing its evaluation are rarely described (Guest, 2006). In order to ensure saturation was achieved we used an approach similar to Guest's (2006), documenting the progression of theme identification and the frequency of code application. We identified that most (19 out of 21) of the codes used had emerged during the coding

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of the first 6 interviews, and the frequency of utilization of these codes is similar in the subsequent 8 interviews. During the coding process of these following interviews, the need to create new codes was rare (2 out of 21) and did not add significantly to the coding structure already developed, but added nuance to our understanding of the narratives about public healthcare.

Ethics

All protocols for this study were submitted to and approved by the ethics committees of Oswaldo Cruz Foundation and Columbia University Medical Center. All participants provided written informed consent.

Findings

Experiences with public healthcare services

All of the interviewees mentioned some kind of barrier to accessing healthcare (Travassos & Martins, 2004), including barriers encountered by both oneself and others. Many of the problems described refer to structural aspects of the healthcare system in their community or in the city as a whole, such as scarcity of personnel and equipment, or long waiting periods. For some participants, the first place they turned for treatment (either the local clinic, emergency units or hospitals) were insufficiently staffed or equipped, resulting in a pilgrimage around the city to find which of the available facilities was ready to provide care. The extremely long time lags, often several months, between exams, results, and specialist follow-up were a consistent complaint during the interviews. These lags were seen as particularly problematic in time-sensitive situations. As one woman tells about her pregnancy,

> *"you could never get an ultrasound, (...) SUS often doesn't provide all types of exams (...) because you have to schedule an appointment two or three months in the future and if you have a bacterial infection or anything, you don't know, so you might even lose your baby or die, without knowing the results [of the exam]".*

In two cases, however, the specialist treatment that participants sought was available in the public system, and yet unobtainable to them: geographic distance between the residence and the site where care could be provided made it impossible for the patients to access it. These participants'

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narratives express how in a context of overlapping injury and poverty, geographical distances can perpetuate a condition that in the eyes of the healthcare system had already been addressed.

Interactions with health professionals

Of the fourteen residents interviewed, all but one described experiences of conflict when dealing with doctors and other professionals of the public healthcare system. It is worth mentioning that the only resident who did not mention such experiences of conflict had limited contact with the healthcare system, since he claimed to have perfect health and that his wife was in charge of the health needs of their children and elderly family members. Generally, experiences that fell short of residents' expectations were similarly described across the interviews. As much as participants were reluctant to generalize their comments to all doctors – attributing them to the individuals they interacted with and not to the medical profession itself – their narratives jointly depict doctors as impolite, inattentive, unsympathetic and indifferent to their needs. According to one of the residents:

> *"(...) There is no conversation, but a doctor has to interact, he has to feel. (...) You're talking and he just says 'ok, ok, ok', you see? And then you say: 'Listen to me. You're not listening to me, you're only writing'".*

The lack of conversation in the doctor-patient interaction was mentioned by several residents, for whom doctors were seen as only willing to prescribe medicines, without explaining their diagnostic process or conducting a thorough investigation of the patient's condition. For some, this was intimidating and inhibited people from extensively reporting their symptoms or asking questions about their health. It also added to the anxiety associated with illness, either their own or their children's.

These attitudes were often explained as doctors' inability to deal with the population from *favelas*, both when they refer to professionals at the local Clinic and at other public healthcare facilities across the city, such as hospitals. Interactions with doctors, as well as with other healthcare professionals, were marked by a feeling of mistreatment, sometimes depicted as dehumanizing to the patient:

P1. "We need more doctors, more professionals that are able to work with a community, because community suggests what? Poor people. [...] So more doctors who are able to work with this people."

P2. "Sometimes you arrive at one of these hospitals, and the employees look at you like... They look at you with a gaze of repulsion."

P3. "They should ask what the person is feeling, it is just that, to talk. Because some doctors are so rude, they hardly look at you. They just prescribe medicine as if you were a horse or something."

Another way in which interviewees referred to the dehumanization of patients was by stating that doctors were unable to "deal with human beings", a recurrent statement in our interviews. In fact, the perception that doctors and other health professionals can not relate to "human beings" and "people from the *favelas*" alternate in the narratives, appearing in parallel. This would seem to suggest a perceived dehumanization of people from the *favelas* as a group in their experiences with public healthcare.

Perceptions of Barriers

Perceived barriers and concerns following clinical encounters result in a range of feelings that culminate in a sense of powerlessness for the patient. For some residents, the moment of realization that they will require healthcare for some reason – becoming ill, discovering a pregnancy – was accompanied by fear, either of being denied access to care and having further complications, or of being exposed to mistreatment. As residents search for emergency care in more than one facility and struggle to obtain assistance, some refer to a growing despair:

"Because you can't get treatment, you arrive there with your son, you arrive in despair. Your son is sick, in your arms, he needs help, help, but there are no doctors."

In other instances, frustration arises when attending previously scheduled appointments at the local Clinic. As mentioned above, it is often difficult to schedule an appointment. Even for a general practitioner at the Clinic the waiting list is long, and often appointments are scheduled several

weeks in advance. But in many narratives, when the resident arrives at the Clinic for their appointment, they discover it has been canceled because the doctor is absent:

> *"I went to my consultation five times and the doctor was never there in the day as scheduled, he had left. Then it cannot happen. I've been seen by a very impolite doctor, I don't know if he got angry at me because I asked the lady [worker at the Clinic] to be seen by someone because I was already self-medicating. (...) I arrived there and they told me that my doctor had left and wasn't going to see me. I told them: 'no, this is not possible, I will demand my rights. You scheduled the appointment, and I'm here'. They told me my doctor had left, and I answered that this was disrespectful".*

Thus, it was sometimes mentioned that depending on the local Clinic – or even on public healthcare in general – for access to medical care puts residents in a situation of vulnerability and causes suffering. Many residents mention the experience of being sick as one of great frailty, which exacerbates the doctor's power because of his access to knowledge and resources that can provide relief, and his perceived unilateral capacity to choose to provide care or not:

> *P1. "You see a lot of cases where the person arrives already feeling very ill, and she has to sit there, there were people falling around, people laying on the ground there, feeling that pain, oh my God!... I always end up feeling sorry for them [the other patients], I see them waiting there, for the doctor to call them, and the doctor only sees them when he wants. I think that is wrong."*

> *P2. "The doctors can watch you die. They know you are dying, and meanwhile you're asking for mercy. You're asking for an opportunity to live. And you can't have even that, you understand? You won't see a doctor [in the Clinic]. You go there to pick up your medication, and there are no medicines. For high blood pressure, the majority of the people have to buy [the medicine], and it's shameful, it is a humilliation. You look at it and there is nothing you can do. Do you know how I feel? I will tell you in all honesty. I feel useless. Because there is nothing you can do, you can't help. (...)*

And you see someone who's feeling sick, thrown on the floor. So you have to cause a

commotion to survive."

Almost half of the interviewees described situations where they felt humiliated by healthcare professionals, particularly by physicians, who are seen as having great power in this relationship. For one man who lived in an area not covered by the local Clinic, community health agent visits were seen as humiliating, as an affront that they would visit his house despite knowing that it was not covered by the facility.

"What I could, I did in private visits, I did somethings in private consultations but I

kept going to the public system, also because I was working, so I needed a doctor's

note to show to my boss. And if you spend a lot of time paying, paying [for private

care], when it's time for childbirth a lot of difficulties arise [in the public system]. If

you had money to pay for prenatal visits, then you should have money to pay for

childbirth in a private clinic, right? But we don't. So when the time comes they leave

you waiting there, they humiliate you. They humiliate you, you are humiliated."

These feelings illustrate the inequality of power that permeates the interactions of residents with the public healthcare system. Such inequality is also salient when interviewees refer to seeking care within the public system as an act of submission:

"It makes me sad. (...) There are a lot of poor people here and it crushes me. Why?

Because I think that if you submit yourself to get into that place and then you're

mistreated and not well received, for me they are in the wrong profession, you see? It

makes me very sad because, of course, if you have money, you won't seek [public

healthcare]"

While the inequality of power between patients and doctors is founded in the latter's expertise (and the patient´s lack of knowledge), it is also framed as a class issue. Part of the doctor's power, then, is seen as consequence of the fact that they have a higher economic position than their patients, and their income is secure regardless of the treatment that patients may or may not receive.

"We can't think only of ourselves, you know? We can't think: 'I'm not in this situation, so I don't care, it's not my problem'. Some people think like this: 'I work for the government, but I don't use the Unified Health System (SUS) because I'm not stupid, I pay for my healthcare plan and my children have a healthcare plan'. Yes, your children have it, but mine don't. So you will treat me badly because of this? If you're a mother, you're a father, you have to understand the needs [associated with] having children, you have to know what a mother goes through with her children."

Money plays an important role in this relationship because it is seen as the resource that determines whether one is able to choose where and who will treat them and what care they can receive. Regarding healthcare access, it establishes an inequality between those who can pay for private care and those who cannot afford it, both within and outside Rio das Pedras.

Uses of private healthcare

The option to pay for private healthcare emerges in the residents' narratives in this context, and many of our interviewees mentioned that, in different ways, they combine the uses of public and private healthcare. Insufficient funds to seek assistance, services or products in the private sector is one of the barriers that the participants mention as affecting their access to healthcare. When public healthcare experiences are disappointing, private healthcare is considered a viable alternative:

"I. So you would like to go to the Clinic, and get an appointment with an orthopedist, or you have been there already?

P. I've been there and I couldn't get it. Then I had to pay for a consultation, and the doctor asked me for that exam. (…) The area where I live had no doctor available, and I could only take one day off work to take care of this. Then I didn't try it any more [in the local Clinic]. I preferred to pay. I paid the consultation, the exam was private as well, so I could get it to the doctor."

As this participant exemplifies, using private healthcare often demands a careful consideration of how residents have to manage the economic and time resources they have available, particularly

considering that much of the employment is informal, often without an employment contract. In such cases, making multiple visits to the Clinic in order to secure health assistance has costs as well in terms of the pay that will be forfeited for each missed day of work. This results in the need to contemplate costs and benefits of different options for access to healthcare. An illustrative case was an injured person, who needed physiotherapy sessions to fully benefit from surgery and regain movement in the legs. In this case, the cost of transportation to the public facility surpassed the cost of paying for private sessions near the person's home, even though this participant could still only afford fewer sessions than recommended:

> *"[To go to Maracanã] I would have spent much more, so I had to pay in order to do the physiotherapy, so that I could start walking, and I paid a lot. (...) I think the poor, or the middle class, have a lot of difficulties in accessing healthcare. But a person that has money, soon handles it. Just as my situation: if I had money I would be walking perfectly, but since I don't have it, this goes on, slowly, until you manage to get better."*

Paying for private healthcare is seen by participants as a guarantee that they will obtain the treatment they need, and given the barriers in the public system, access is sought through the consumption of services in the private sector. But besides avoiding the structural problems of the public system through the consumption of private services, for many of the interviewees, using private healthcare goes beyond access itself. Private healthcare becomes a strategy to avoid interaction with doctors in the public system, with whom they feel so disempowered:

> *P1."Today, I don't have a healthcare plan but I think that today [if I needed] I would pay to get treatment. Because I think that, as you have such a huge neglect [of patients in the public system], I think you're not forced to go through that. You don't have to go through that again."*
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> *P2. "In the private [healthcare system] you also have to wait, but the treatment you get is different. You wait two or three hours certainly, but when you enter, you're well received, you understand?"*

Private care becomes something that modifies the relationship between doctors and patients, attenuating the imbalance that is so strongly felt as negative within the public system. By paying, some participants feel they deserve the doctor's attention and politeness.

However, a similar argument is at times used by participants to explain their expectation of better service and treatment within the public healthcare system. In those cases, participants emphasize that the funding for the public system comes from the taxes payed by the population:

> *P1. "And the ones who pay for that service, the ones who are paying them are the people. In the kilo of rice that we buy for 5 reais. In the oil that we buy for 4 reais. In a piece of meat that we buy for 20 reais. The ones who pay for the public service are the people."*

> *P2. "I thought this was very inconsiderate. Something like: 'I [referring to the doctor] will see the people I want, and the ones I don't want to see now I won't see. And I will do it in the way I want.' (...) I'm in the State, I'm paying all my bills on time and yet I have to go through this."*

While our interviewees combine the uses of public and private healthcare as a strategy to overcome some of the barriers mentioned earlier, this combination is framed within a conflict between what the public health system is expected to deliver and the resident's experiences when seeking care in public facilities, and this is not an easy conflict to manage. It weaves together the structural problems of SUS and the difficult relationship with its healthcare professionals. A woman's narrative of her uses of public and private healthcare during pregnancy are illustrative of this tension:

> *"So sometimes you go to the Clinic and you can't get an appointment, so you do everything [all pre-natal care] in the private sector. But when the time comes to have your baby, you have no way to pay because child-birth is much more expensive. Then you go to a public facility. But when they look at your pre-natal book and there are no annotations [from doctors in the public system], they already look upset. (...) Then you can't complain of delays, you can't complain of anything. (...) They say, 'do*

you think you're in private healthcare? This is a public hospital, you will have to wait'. You're moaning with pain but you have to wait and they make no effort to speed up your turn. This leads even people with the worst economic conditions to do everything they can to pay for private care."

Uses of private healthcare included buying a healthcare plan for some periods or having access through employment benefits, interspersing periods where access to healthcare was covered by insurance, periods where private consultations and exams were payed out of pocket, and periods where access was exclusively through the public services, resulting in unstable trajectories with these services. In some cases, while a healthcare plan was not accessible to all members of the family, paying for a private healthcare plan for one family member was used as a strategy to confront specific situations, such as a chronic disease. This was mentioned by a young man, whose mother suffered from diabetes and was covered by a healthcare plan.

"I. And how did you make this decision of having [your mother] covered by a healthcare plan?

P. Well, I remember that when I was a child, we used to go to a hospital in Praça Seca [to treat her diabetes], I don't know where it is. And I remember what it was like, she would take me, she left here maybe at seven in the morning, and we would arrive at two in the afternoon. I believe that because of this delay in the way things work and also because, I don't remember well, but the house was rented so the rent money was used entirely on her healthcare, you know? I believe the economic conditions got better and as it got better we looked for an insurance to improve her healthcare."

Discussion

In this study, we explored the perspectives on and experiences with public and private healthcare in a Brazilian *favela*, using semi-structured interviews with 14 residents of Rio das Pedras (Rio de Janeiro). We note many barriers faced by residents in accessing healthcare. Although structural problems and resource constraints (personnel or equipment shortages, or long

waiting times) are important challenges, they do not encompass the full scope of concerns expressed by participants when discussing healthcare. By using qualitative interviews, our study was able to identify barriers to accessing acceptable healthcare that go beyond the lack of infrastructure, physical availability and programatic inclusion of populations and consider the relationships with healthcare professionals, resident's expectations and how access to public healthcare is experienced by them. The conflictive, distant and impersonal relationship with doctors and other health professionals gains prominence in participant's narratives about their interactions with the public healthcare system. To the best of our knowledge, this is the first study to explore these topics and how they affect the use of healthcare services among residents from a Brazilian *favela.*

The figure of the doctor emerges as pivotal in the conflictive relationship between residents and the public healthcare system. Traditionally, healthcare in Brazil has been dominated by the medical model, based on, among other things, the understanding of health and disease as commodities, the medicalization of problems, and an emphasis in curative medicine (J. Paim, Travassos, Almeida, Bahia, & Macinko, 2011), in which the doctor is central and the hospital is a privileged space (G. D. da Costa et al., 2009). While the medical model in Brazilian healthcare coexists with the sanitarist model, its political and cultural influence with health professionals and the general population positions the medical model as hegemonic (J. Paim et al., 2011), which in turn accentuates the doctor's authority in the healthcare system.

The medical profession is characterized by a substantive autonomy, both within technical practice and economic dimensions, with strong capacity to self-regulate its large body of specialized knowledge, labor market, and work conditions (Machado, 1997). Doctors in Brazil have long held a position of prestige, and throughout the 20th century the profession became increasingly elite, with a growing proportion of doctors coming from wealthy backgrounds (Machado, 1997). Recent data shows that the economic returns of a medical degree are substantial in Brazil. Approximately 80% of the country's doctors receive an annual income above $47,052[1] (Scheffer, 2015). This value is

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[1] All values converted from Brazilian Real (BRL) to international dollar ($) using the Purchasing Power Parity for private consumption (PPP) conversion factor for 2015 (World Bank 2015), and multiplied by 12 to convert from monthly to annual figures.

considerably above the $4,632 of the Brazilian minimum income (Palácio do Planalto, 2014) and the $9,864 average annual household income reported by participants in the Rio das Pedras community diagnosis study.[2]

It is noteworthy that socioeconomic differences between doctors and residents emerging in the narratives of Rio das Pedras' residents are also part of a broader context of social inequality in Brazilian society. Beyond economic conditions, they also reflect cultural differences that might result in challenges in the communication between highly educated professionals and populations whose life experience is often marked by the uncertainty of their living and work conditions (Valla, 1999). The radically different life experiences of these groups affect how they construct and appropriate discourses, including their views of health and the body. This is exemplified by a study in a low income neighbourhood in Belém do Pará, which explores the use of the term "nerves" by a patient to refer to a difuse feeling of distress, a term that, while broadly used by patients in the Brazilian public healthcare system, is often overlooked by doctors (Traverso-Yépez & de Medeiros, 2005)

The narratives of Rio das Pedras' residents indicate that the multiple dimensions of status of the medical profession play a strong role in the identification of doctors as figures of authority. The status of their profession, their knowledge and ability to give response to people's afflictions, and their socioeconomic conditions, have emerged in the narratives of participants as elements that define the unequal balance of power between doctors and patients and sustain doctors' authority. Moreover, their portrait in resident's narratives is in line with the doctor's centrality in the Brazilian healthcare system, a historical legacy of the hegemonic medical model which is not questioned by our interviewees.

The conflicts between doctor and patient mentioned are neither attributed to the doctor's monopoly on medical knowledge nor to the obvious inequality between doctors' and patients' socioeconomic conditions. Instead, frustrations are ascribed to doctors' impoliteness and perceived

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[2] Data obtained from the questionaire applied to residents by the "Rio das Pedras Community Diagnosis" study. Among 104 participants, 68 agreed to share the family´s total income, whereas 29 declined, 3 did not know, and 9 were not rated.

inability to deal with low-income population. Perhaps doctor's attitudes towards patients, however, are rooted in those dimensions of medical autonomy and socioeconomic inequality, particularly since they are incorporated into the professional identity. Moreover, the space in which the doctor-patient interaction occurs might play a role in defining health professionals' attitudes towards patients. As doctors often work in both public and private system, their transit between the two spaces has been described to involve a shift between the highly standardized treatment offered to patients in the public healthcare system and the individualized, personalized medical attention offered in private clinics (Sanabria, 2010).

As it is described by the Brazilian constitution, the Unified National Health System (SUS) is a right of every citizen and a duty of the State. This implies a certain conception of the State, as an entity strongly committed to social security, citizenship rights and social policies, with the healthcare system as part of a democratizing process (A. M. Costa, 2013). However, as noted in the narratives of Rio das Pedras' residents, there are inconsistencies between SUS' project aspirations and formal definition of healthcare as a citizenship right, and the current reality which includes practices of several actors – managers, doctors, nurses, users – often guided by a conception of public healthcare as an assistance given to the poor, a gesture of benevolence or favor. Such a perspective manifests in some of the expressions of the participants – for instance when mentioning that doctors should show "mercy" or "pity" for the inhabitants of the *favelas* – even though it is in contradiction with the universalist nature of SUS. Different perspectives of the role of the State appear to compete in participants' experiences with and descriptions of public healthcare.

In their narratives, the State is perceived not only as the provider of citizenship rights, but also as an assistentialist entity. This is coherent with the history of State policies both in the *favelas* (Valladares, 2005), and in healthcare. The structure that predates SUS, created in the 1930's, was overseen by the Institutes of Retirement and Pensions, for those engaged in the formal labor market, and the Brazilian Legion of Assistance, for those excluded from it (J. S. Paim, 2013), hence relying heavily on State assistentialism. In spite of the replacement of this system by SUS following the redemocratization process, in the narratives of the participants in our study, the conceptual

association between public healthcare and assistentialism persists and acquires a central role in the interpretations of their experiences in SUS. Furthermore, this influences decisions when seeking healthcare, and using the public system is often framed as resorting to charity.

Resident's relationship to the public healthcare system, then, can be interpreted as mirroring the overlapping and contradictory roles of the State as a provider of rights, an assistentialist entity, or a paternalist authority. These are contradictions that exist also in the organization of the public healthcare system, where policies with a universalist profile coexist with programs such as the Family Health Strategy that, by targeting specifically the poor (J. S. Paim, 2013), show continuity with the logic of an assistentialist State. It is essential to emphasize that residents' discontent is often solved by resorting to private healthcare providers; as consumers in the health market, they mention that the treatment received is more in line with their expectations of an appropriate patient-doctor relationship.

The growth and consolidation of an internal consumer market in Brazil, whose cornerstone is increasing the purchasing power of the lower-income population, is often mentioned by former president Lula da Silva as one of the greatest achievements of his administration: "This was the biggest legacy of these ten years: we discovered ourselves. We are no longer treated as second-class citizens. We have the right to travel by plane, of entering a shopping mall and buying the things that everybody always wanted to buy. And we recovered the pleasure, the fondness of being Brazilian, the fondness of loving our country" (Lula da Silva, Sader, & Gentili, 2013).

While income distribution and the expansion of Brazil's internal market have resulted in an improvement of the living standards of many Brazilians, there is another aspect of this governmental project that becomes evident in former president Lula's argument – the access to consumption goods would be the pathway to full citizenship, as opposed to being "second-class citizens"; it would nourish a feeling of self-worth, self-discovery, dignity and national pride. Explicitly bonding the ideas of citizenship and consumption, this political project is partially aligned with neo-liberal ideology, whose consequences will affect different spheres of people's lives, including health. As expressed by neo-liberal ideology, the market emerges in the narratives

of our interviewees as a pathway to obtain, as a consumer, a fulfillment of needs that are not obtained as a citizen. This is mentioned by Rio das Pedras residents' when they refer to needs related to healthcare services such as exams and consultations, obtained faster through the market, but also, and more importantly, when referring to the doctor-patient relationship. The goal of being treated by the doctor in a certain way is pursued in the private healthcare sector.

For many residents of Rio das Pedras, the recent growth of the consumer market for private healthcare results in the combined use of public and private health services, as well as in their fluctuating trajectories as users of healthcare plans. Beyond the consequences that the combination of public and private healthcare might have in the quality, continuity, and cost of the care received, the increasingly common practice of combining the uses of both systems poses a significant problem in the consolidation of SUS, since it justifies the diversion of State resources to private healthcare companies and creates optimal conditions to increase their influence in political decisions, as signaled by the rapid growth of healthcare companies' investments in election campaigns (Scheffer & Bahia, 2015). It must still be noted that the combined uses of public and private healthcare systems in Brazil is not specific to low-income populations, although use is highly patterned by social class. It has been noted, for instance, that middle-class patients with private healthcare insurance often resort to SUS for procedures of high-complexity or high cost, such as liver transplants (Bahia, Simmer, & Oliveira, 2004).

As with any study, our analysis has several limitations. Our focus on a single informal community of Rio de Janeiro, with its many particularities, limits generalizability and suggests that any broader implications should be viewed with caution. The interviews focus on healthcare prioritized the public healthcare system, particularly the one Health Clinic that, during the fieldwork, provided incomplete coverage of Rio das Pedras. There were no specific questions targeted at resident's perceptions or uses of private healthcare. However, this topic spontaneously emerged in interviews, and was probed accordingly, allowing us to explore the nexus between public and private healthcare.

Our study offers some insights into the perceptions, attitudes and feelings of users and potential users of SUS, elements that are often overlooked when analyzing the structure of a healthcare system. Beyond individual opinions, the shared perceptions of residents in Rio das Pedras are weaved together with the processes that shaped the Brazilian State and SUS itself, in a dialectical relation that provides a historic context for understanding current contradictions between the formal definition of SUS and its realization, and the political ruptures, continuities and inconsistencies of Brazilian democracy. Residents of the Rio das Pedras community, and other patient populations, are not merely passive recipients of healthcare services from other actors in the healthcare system: they are an essential in shaping the functionality of SUS, just as citizens are an essential part in shaping a country's democracy.

Beyond the Brazilian context, our findings add to the broader discussion about the public and private healthcare nexus, by exploring how uses of both systems are not only connected, but interdependent: user's perceptions of one system affect not only their willingness to use the other, but also the uses that are made of it, as exemplified by participant's narratives of seeking private healthcare in order to be treated by doctors in a certain way. Further studies can focus on the causes and implications of these perceptions, including the patterns of use and the quality of treatment received in general, as well as the needs of particular population groups such as pregnant women who may prefer to follow prenatal care in the private system while using public healthcare for childbirth. However, our findings point to the need to take participants' perceptions of public healthcare into account in policy making, as it might not be enough to provide the required services if they continue to be perceived by the population as a gesture of assistentialism, the use of which might be understood as degrading their status – in a broad sense – instead of improving it.

Furthermore, the emphasis placed by the interviewees in the patient-doctor relationship as a strong element of their perceptions of healthcare points out to latent challenges in the professional education of doctors in Brazil. It has been pointed out that doctor's education is often not in line with the guiding principles of SUS (Cotta et al., 2007), adding that further advances need to be made in order for medical professionals to be able to face the challenges of Brazil's social context,

in which poverty and inequality might act as aggravating factors in the process of illness. Our findings add to these ongoing discussions, highlighting the need for improved patient-doctor communication.

Although our study focuses on uses of public and private healthcare, the dynamics we explore may also have relevance beyond the health care sector, since the idea of consumption as a way to compensate for power imbalances can be useful in understanding social behaviors that do not seem to follow a strictly economic logic of decision making. Such is the case of residents of Rio das Pedras who are willing to, and in fact prefer, to pay for services which are available for free in the public healthcare system, often resulting in increased economic vulnerability for themselves and their families. Our findings can provide insights for the public-private healthcare nexus as well as other uses of universal public systems, such as education.

Further investigation and attention are needed to understand how evolving political tensions contribute to and construct the subjective experiences of actors that make up the healthcare system – users, potential users, doctors, nurses, managers – whose relationship to SUS is guided by those subjective perceptions, feelings and attitudes. The project of SUS, formally a tool for deepening the Brazilian democracy, is hindered by lingering remnants of political assistentialism and authoritarism, as well as with the advancement of neo-liberal politics. The Brazilian healthcare system remains quite permeable to such political influences, in part because not enough discussion has highlighted democracy and citizenship rights in the Brazilian society in general, or particularly in the constitutional right to health. Future policies and social activism initiatives in healthcare can benefit from taking into account a holistic view of the patient in light of broader discussions about democracy and citizenship, understanding that under the logic of a universal healthcare system, it is not enough for the services to be available, they must also be socially understood as citizenship rights that are worth fighting for. For it to fulfill its democratic promise, beyond the institutional changes, SUS needs users and potential users that approach and are received at the healthcare system not as charity seekers or consumers, but as citizens entitled to rights.

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