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REVIEW

The benefits and challenges of the Family Health Strategy in Brazilian Primary Health care: a literature review

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Abstract *The aim of this study was to analyze what contributions the Family Health Strategy has made towards the development of primary healthcare in Brazil, and what challenges it faces. A literature review was conducted and articles were analyzed from three dimensions: political/institutional, organizational, and technical/healthcare. In the first dimension, the Family Health Strategy was found to have helped expand primary healthcare, the institutionalization of evaluations, and the promotion of equity. The main challenges identified were funding, the training, education, and management of personnel, and cross-sectoral action. In terms of organization, the benefits include a broader supply of services, access to health services through organized initiatives for specific diseases or age groups, and more comprehensive healthcare. The challenges involve access, the entry point, integration with the healthcare network, planning, and social participation. As for technical/healthcare considerations, the main benefits identified were the fostering of multidisciplinary working practices, family focus, reception, rapport, humanization, community orientation, production of care, and performance. The challenges for its improvement are associated with complex factors and require greater political/institutional effort.*

Key words *Primary Healthcare, Family Health Strategy, Public health*

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Introduction

An important milestone for the development of primary health care (PHC) around the world was the publication of the Declaration of Alma-Ata in 1978, which puts primary care at the heart of health services. The core ideas for the improvement of contemporary health systems are present in this declaration, resulting in better and fairer health outcomes, more efficiency and effectiveness, and improved user satisfaction[1].

However, it is important to highlight the different ways in which PHC is provided. In some countries, it is a focused, selective program that offers a limited range of services to poorer population groups, while in others it is the first level in a health system, providing clinical services, taking charge of coordinating and organizing health care, and serving as a policy for reorganizing the whole healthcare model[2-4].

Since the 1920s, many attempts have been made to organize PHC in Brazil. Different models were introduced in different parts of the country based on a diversity of conceptions and interests. However, the most important breakthrough was the introduction of the Family Health Program, a more comprehensive PHC proposal inspired by experiences from inside and outside the country[2,3,5].

In recognition of its capacity to shape the organization of the health system, respond effectively to the health needs of the population, and help change the prevailing healthcare mode, the Family Health Program soon started to be known as the Family Health Strategy. This strategy is based on some core healthcare principles such as people/family-centeredness, rapport with users, comprehensive and coordinated care, coordination with the health system, social participation, and cross-sectoral actions[6,7].

In the 20 years since it was first introduced, the Family Health Strategy has become the core of the political agenda for the organization of PHC activities and services in Brazil, affording multiple improvements for the health of the population[8].

Nevertheless, as it is introduced into diverse and complex contexts permeated by different political, economic, and social interests, its potential is sometimes not fully realized, which has raised questions as to its capacity to galvanize the reorganization of healthcare services and initiatives and effectively replace the country's traditional PHC model. This is why it is so important for appraisals to be made of the Family Health Strategy, detecting areas the authorities can work on to bring about future improvements.

This article aims to identify and analyze the main contributions the Family Health Strategy has made to the development of PHC in Brazil and the challenges it still faces in order to consider what aspects may affect its sustainability into the future.

Method

This study involved a literature review, based on publications from between 2002 and 2011 retrieved from the Bireme website (www.bireme.br), which provides access to the Lilacs, IBECS, Medline, Cochrane Library, and SciELO databases. The keywords searched for were "primary health care" and "family health strategy", and only articles whose main subject was the Family Health Strategy were retrieved.

Using this procedure, 197 articles were retrieved. However, the complete text of 57 of these articles was not available on the search platform, so they were excluded. A further 31 articles were repeated in the list generated by the website, and these duplicates were removed to prevent distortions in the consolidated data. Eleven of the remaining 109 articles were excluded because they consisted of reflections, essays, opinions, technical bulletins, specific protocols for clinical practice, identification of medical prescriptions, or presented aggregate results of the Family Health Strategy and traditional PHC. The remaining 98 articles constitute studies of health units, professionals, students, managers and/or users of the Family Health Strategy and literature reviews.

As the Family Health Strategy is a healthcare model – i.e. a way of organizing actions and deploying technical and scientific assets to resolve health problems and needs[9] – for its contributions to PHC in Brazil and the challenges it still faces to be identified and analyzed, a classification system was used based on three dimensions proposed by Teixeira: political/institutional, organizational, and technical/healthcare[10].

The analysis of the *political/institutional dimension* covered the mechanisms by which the policies, actions, services, and especially the investments employed to improve PHC are reorganized. In the analysis of the *organizational dimension*, the relationships between different healthcare units were appraised, taking into account interactions between different levels of care. It also involved investigating the way health

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services are organized in order to provide comprehensive care.

Finally, in the *technical/healthcare* (or "operative") *dimension*, the focus was on the different kinds of relationships health care practitioners have with the health issues and determinants of health they address (i.e. health promotion, recuperation, rehabilitation, risk and disease prevention), mediated by the knowledge and technologies involved in the work process.

The elements used for analyzing each dimension, selected from the preliminary reading of the articles, are summarized in Chart 1.

We sorted the selected articles into these three dimensions, which are crucial for the development of PHC in general and the Family Health Strategy in particular. However, the results and analyses should not be interpreted as covering all the potential ways of discussing the contributions and challenges of the Family Health Strategy on PHC in Brazil.

Results

Around 71% of the 98 articles analyzed reported on research in one municipality, 18% investigated two or more municipalities from the same or different states, and 11% were classified as literature reviews. Graphic 1 shows the rising trend in publications on this subject over the period under analysis.

Approximately 45% of the articles were found to use qualitative methods, while 26% used quantitative methods, and a further 8% used mixed qualitative and quantitative approaches. Amongst the qualitative studies, there was a greater prevalence of descriptive, exploratory, and case studies, while cross-sectional studies constituted the most common form of quantitative research. Ethnographic methods were most widely used in the qualitative studies, and focal groups were the most frequently used data collection technique. The authors of around 10% of the articles labelled their work as evaluative, with analyses of the introduction of the Family Health Strategy being the most common of these.

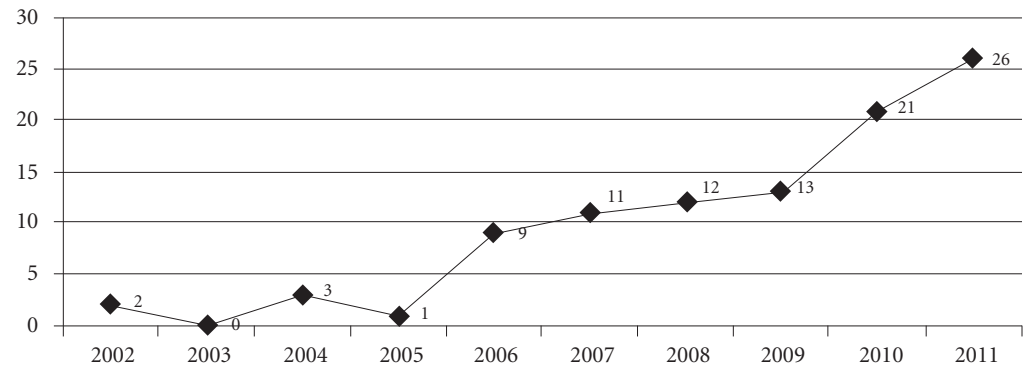
Graphic 2 shows the number of publications per state. The southeast is the region where most municipalities have been researched, followed, in descending order, by the northeast, south, north, and central west regions. Five studies covered two or more states, and four of these actually spanned different regions of the country. None of the articles selected using the inclusion and exclusion criteria investigated the Family Health Strategy in the states of Acre, Rondônia, Roraima, or MatoGrosso do Sul.

The investigation of the *political/institutional dimension* revealed that the Family Health Strategy has been instrumental in expanding PHC in the country and the introduction of evaluation as an integral part of the process. The equity of care has also improved with the Family Health Strategy compared with the traditional PHC model centered at primary basic health units (Unidades Básicas de Saúde). The main challenges are underfunding, training of professionals that is misaligned with the PHC-centered healthcare model, tenuous labor ties between professionals and institutional employers, and the development of cross-sectoral initiatives.

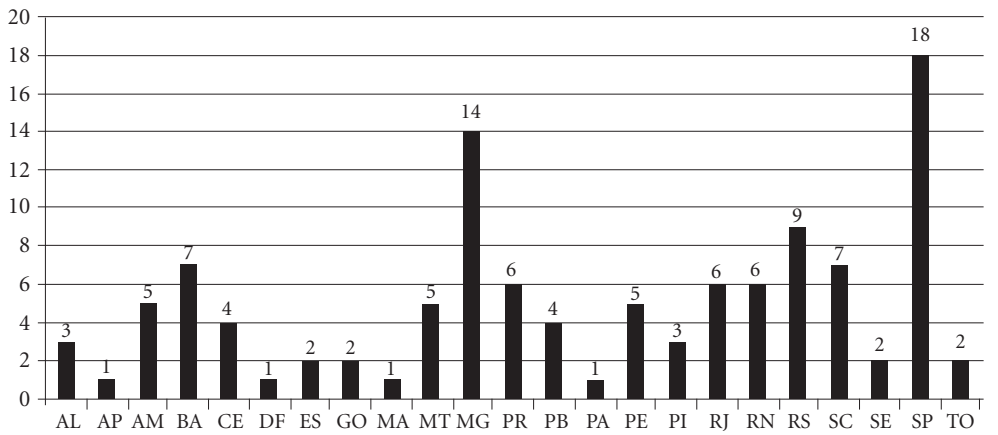
In terms of *organization*, the Family Health Strategy has helped broaden the range of ser-

Chart 1. Elements for analyzing the contributions of the Family Health Strategy to primary healthcare in Brazil and the challenges it still faces.

Dimensions	Elements		
Political/Institutional	Expansion of Family Health Strategy Equity Funding	Training/Education/Management of Personnel	Evaluation Cross-Sectoral Actions
Organizational	Access First Contact	Comprehensiveness of Care Integration with the Health System	Planning Community Participation
Technical/Healthcare	Multidisciplinary Work	Reception Rapport Family Focus	Community Orientation Care Process



Graphic 1. Number of articles published between 2002 and 2011.



Graphic 2. Number of municipalities per state targeted by Family Health Strategy research between 2002 and 2011.

vices – including dental care – available in the outskirts of cities and rural areas. It has also effectively filled healthcare gaps in small municipalities, yielding improvements over traditional PHC in terms of the comprehensiveness of care and the uptake of services via organized initiatives for specific diseases or age groups.

The challenges identified in this dimension have to do with access, making family health units the gateway to the health system, joining the Family Health Strategy up with the rest of the healthcare system, planning, and social participation.

In the *technical/healthcare dimension*, the Family Health Strategy was found to outperform traditional PHC offered at primary health units when it came to performance, multidisciplinary work, family-centeredness, reception, rapport, humanization, and community orientation.

Other benefits of the Family Health Strategy are health promotion, disease prevention, the proactive search for cases, health education, home care, more antenatal and postnatal visits, provision of guidance on exclusive breastfeeding, more cervical screening, fewer low birthweight babies, and reduced infant mortality and hospitalizations. It has also helped improve the uptake of treatments for hypertension, diabetes, leprosy, tuberculosis, and sexually transmitted diseases. Significant progress has also been found in dental care and pharmaceutical assistance.

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The challenges observed in this dimension are related to the development of complementary medicine, actions for adolescent health, mental health, people with HIV/AIDS, illicit drug users, and people with obesity. The risk of reproducing the biomedical model in healthcare processes is another hurdle that needs to be overcome in the Family Health Strategy.

Discussion

The data from this review reveal that the Family Health Strategy is the target of a growing volume of research using different methods, displaying the strategic importance of the development of this healthcare approach in Brazil. Another feature worth noting is the fact that this research covers almost every state of the country, but that most of the publications are about the southeast, especially the states of São Paulo and Minas Gerais, indicating the primacy of their research centers in analyzing the Family Health Strategy in the period under study.

As for the *political/institutional dimension*, it is worth noting that the political decision to maintain the Family Health Strategy has been sustained for over 20 years, justifying the continued expansion of primary care and the bid to make it universal. One interesting feature of Brazil's primary care service is that it includes dental care[11].

The effort to make the provision of healthcare equitable – i.e. targeting people with the greatest needs – is one of the hardest goals to achieve in Latin America[12]. However, the way the Family Health Strategy has been introduced in Brazil, with a special focus on smaller towns and cities and the outskirts of big cities, has helped provide access to health services for population groups that have historically been excluded because of the limited availability of public services in these areas[13]. Its introduction in rural areas for indigenous and river-dependent communities and care for homeless people, transvestites, and caregivers who are socially isolated because of the burden of their caring activities are other cases where neglected population groups are being reached consistently for the first time[14-17].

However, although taking the Family Health Strategy to underserved population groups is important, it has not been widespread enough to realign the healthcare model. Adequate funding is the key to its further development[18].

It should be clarified here that defining the quantity of financial resources necessary to make PHC an integrator for the whole health system with a view to ensuring universal, comprehensive care is no easy task, for it depends on the social, environmental, geographical, epidemiological, and ethnic peculiarities of each municipality and microregion[19]. This is why funding needs should be analyzed in greater depth to identify the real health needs of specific populations and thereby help ensure the expansion and sustainability of Family Health/PHC in the mid and long term. Although the Ministry of Health has expressed interest in expanding it in order to provide a more equitable distribution of resources, there is an urgent need to offset inequalities between the different levels of care so that primary care is assured the funding it needs[20].

As regards the importance of evaluation for orienting the introduction, consolidation, and reformulation of health services, the Family Health Strategy has prompted its institutionalization as an integral part of primary care, making evaluation a routine aspect of the services it provides[21]. Thanks to this, changes in catchment areas can be picked up, enabling services to be adjusted according to local needs, making the primary care more effective.

One factor that has hampered the development of the Family Health Strategy is the training of health professionals, which is still geared towards technical training based on traditional educational practices[22]. There is also still an excessive focus on diseases and specialized training because there lack disciplines on the curriculum that cover the subjective, preventive, and social dimensions of health[23].

Despite many investments in training, including residencies in family health and continuous learning opportunities, these efforts need to be stepped up if the full benefits of the Family Health Strategy and a PHC-centered health system are to be achieved.

One hurdle is the need for training to be geared towards the population's real health needs, taking on board their social, economic, and cultural complexities[24]. Likewise, training must be designed to develop professionals capable of interfacing with other fields and working effectively between the different sectors that have a bearing on the social determinants of health[22].

Training-related issues are not only a concern for today's family health professionals (doctors, nurses, dentists, health agents, and ancillary workers), but also for those that could join it in the future, because of the epidemiological and demographic transition.

The progress of the Family Health Strategy also depends on personnel management, especially hiring workers for the teams, which is often done using fixed-term contracts, eroding the employer-employee relationship[25,26]. This in turn has made it hard to keep professionals in one place, often leaving teams short-handed and hampering the overall healthcare process[26].

This phenomenon seems to be more widespread amongst Family Health professionals than those that work at traditional primary healthcare units, severely handicapping the sustainability of the Family Health Strategy model[13]. In most cases, municipal authorities admit this is a problem, but it must also be tackled urgently so as not to affect the potential of the Family Health Strategy to build a PHC where the continuity of care is paramount. The publication of rules and guidelines by federal or state authorities providing parameters and deadlines could be one way of bringing about change in local management, allied, of course, with adequate oversight by higher managerial levels.

Something else that is needed is the creation of a specific policy to improve the health of PHC workers. Education is one aspect of this, as is more effective control of the immunization of family health workers, even those who are not nominally members of the team, like administrators, janitors, etc.[27].

Another aspect of the political/institutional dimension in need of improvement is cross-sectoral action, where different sectors of public policies work hand-in-hand to address issues linked to the social determinants of health and disease[6].

It is clear that the Family Health Strategy is a new cornerstone for cross-sectoral coordination because its workers are more closely in touch with the population in their catchment areas and every aspect of their environment, enabling them to identify problems that could impinge on the people's health. Once these are identified, Family Health workers could then contribute towards designing the policies to tackle such issues.

Even so, some difficulty in coordinating the actions of different sectors has been seen, resulting in inadequate or nonexistent actions to tackle the social determinants of health[26]. Political and administrative decisions must be taken to break down the tradition of competitive, hierarchical, fragmented inter-sectorial segmentation, and to respond to social demands, because coordinated action has the power to reduce the difficulties faced by the health sector[6].

The *organizational dimension* is the one that still needs a good deal of investment. Despite the advances brought about by the expanded supply of PHC services, improved access to these services – i.e. more people seeking out and using health services – is still required. There are also problems related to the availability and location of services and the way supply is organized, such as the opening hours of clinics, the system for making appointments and getting tests, and the restrictions on organized initiatives for specific disease or age groups[28,29].

Poor decision-making in this area can directly curb access to services and result in repressed demand[29]. This is why decisions in this area have to be planned together with the target population so that local needs are met. This also ensures that health professionals and managers are held more accountable by PHC users.

Making Family Health the first port of call or gateway to the health service is also crucial if this is to be a comprehensive PHC model, meeting most of the health needs of the target population and providing and regulating access to other levels of care[30]. Another organizational strategy that helps make the Family Health Strategy the gateway to the health service is when new users take up the initiatives it offers for specific disease or age groups.

One factor that prevents the Family Health Strategy being the first port of call is the existence of other competing gateways in the health service, so the local family health team may end up not being the first contact people are given. This is most common in big cities, and has even resulted in waning demand at family health units[30], and a consequent sluggishness in the reorganization of PHC via the Family Health Strategy.

The absence of a statistical difference between the point of entry – Family Health vs. traditional PHC – has been identified[31]. However, this could be a reflection of the still prevailing disease-oriented culture and precipitated action by users, making them seek out whatever service is most readily available to meet their needs.

It must therefore be a priority for political and administrative decision-makers to invest in expanding the Family Health Strategy into currently unserved areas so that the supply of services can be organized in order to meet people's needs. Even if the strategy is geographically comprehensive, if family health units are not properly organized, people may still end up relying on other ports of entry. As such, we agree with Conill's appraisal that the problem of access is a determining element in the direction of the Family Health Strategy[32].

Comprehensive care, defined as the provision of services that meet the people's most common health needs and responsibility for referring patients to other primary care facilities or levels of healthcare, is one of the major boons of the Family Health Strategy over the traditional PHC model centered at primary health units[33,34]. This is because it offers a whole set of measures to promote health, prevent disease, provide diagnoses, treatment, and rehabilitation, and also has the capacity to help meet all people's health needs.

However, to ensure comprehensiveness of care, the Family Health Strategy must be the gateway to the system, and it must be fully integrated with the rest of healthcare network and be responsible for coordinating the continuity of care. Some communication problems between different health professionals have appeared, which have hampered the comprehensiveness of care. This can even be seen in the relationship between family health teams and the Family Health Support Units (*Núcleo de Apoio à Saúde da Família*), which provide an array of supporting clinical services for the family health teams[35].

Another issue in the coordination of healthcare is the shortage of specialized services, resulting in long waiting times. This seems to be linked to the fact that PHC has expanded through the Family Health Strategy without a concomitant development of specialized care to cover the population's newly identified healthcare needs[20].

Alongside the lack of policies for specialized services, there is also a dearth of monitoring of some local experiments, making it impossible to judge how long waiting times and lists are so that planning can be based on real figures[30]. There is therefore an urgent need to boost the supply of specialized services to meet current needs and keep pace with epidemiological trends as PHC spreads throughout the country.

As for the integration of the Family Health Strategy with the rest of the healthcare network, Sisson *et al* mention the importance of devising new organizational methods so that specialized services are offered even when there are shortfalls in the agreements between states and their respective municipalities[36]. The suggestion is that healthcare should be more regionalized, rather than being restricted to geographical and administrative state boundaries, as this would help the Family Health Strategy operate more effectively as a comprehensive model of primary care.

In terms of planning, it was found that the organization of the Family Health Strategy is still incipient. There is little in the way of recording useful data for analyzing health needs in catchment areas, and official information systems tend to be underused[37]. Meanwhile, there are criticisms of the planning instruments adopted because they fail to enable more detailed planning about the risks families face, such as the number of people sharing the same sleeping space or data on dental health[38].

A review should be done of the planning tools used so that better needs assessments can be done. Coherent planning is also required, because there are often so many priority issues that it becomes impossible to fulfill scheduled targets[26].

Another important thing about planning is that it should not just consider local and regional peculiarities, but must also cover issues concerning the social determinants of health and disease and cross-sectoral actions by calling on the participation of representatives from society. After all, the Family Health Strategy is rooted ideologically and conceptually in responding to local realities[14].

The participation of society in the local management of family health units is still weak, and few of the subjects of interest to the Family Health Strategy make it onto the agendas of municipal health boards[18]. This could be reverted if team members were to encourage members of the public to take part in needs assessments and planning activities, helping the Family Health Strategy to be more responsive to their needs[39]. However, such participation would have to be ongoing, because health needs change over time.

Based on this discussion, it can be concluded that planning and social participation both permeate the problems present in the organizational dimension, namely: access, first contact, comprehensiveness of care, and the integration of PHC with the rest of the healthcare network. These bottlenecks must be addressed before the Family Health Strategy can truly progress.

In the *technical/healthcare dimension*, multidisciplinary work is important for improving the Family Health Strategy as ideas can then be discussed from different viewpoints, which boosts the quality of the care received by users[40].

An important member of this team is the community health agent, because as they work in the community and are able to optimize cross-sectoral actions, these professionals can really bring about change in the healthcare model[30].

The Family Health Strategy has been found to forge stronger ties with the community than PHC structured around traditional primary care

units. In other words, it can offer consistency of care over time, enabling relationships to be formed that foster mutual cooperation between communities and family health teams[7,31]. Its biggest plus is that it is able to focus much more directly on the target population's needs, yielding better outcomes and improved user satisfaction[41].

The aspects of family health that foster such rapport are home visits, the length of time health professionals work in a given family health team, the number of appointments attended/visits made, and the development of cross-sectoral actions[42,43]. However, bioethics studies in PHC have noted that these health workers must be aware of their daily work situations, because they may extrapolate ethical boundaries and damage the relationships forged[44].

Together with rapport, reception and humanization have also received more positive appraisals in the Family Health Strategy. However, a focus on diseases and medical appointments – detected in some settings – can weaken interpersonal relationships and affect uptake of treatment and consequently the users' quality of life[45].

Family focus is another factor where the Family Health Strategy outperforms traditional PHC[31,34]. This includes the use of family medical records and other tools that help forge closer links between health workers and families. Used together, these techniques make it easier to identify families' socioeconomic risk factors and improve the management of the services they receive[7,46].

Community orientation – recognizing that all health needs occur in a given social context, which should be taken into consideration when professionals take any actions – is another area where the performance of the Family Health Strategy has outstripped traditional PHC[31,34]. Home visits are again the mainstay of the community orientation in the Family Health Strategy, yet efforts still need to be ongoing because the modus operandi of different family health teams can vary considerably[7].

In terms of work processes, the Family Health Strategy has great potential for combatting the biomedical model that focuses on individuals, diseases, procedures, cures, and specializations[45], in that it takes on board new elements that give the work process a whole different dynamic, such as a focus on health, family-centeredness, comprehensiveness of care, social participation, multidisciplinary work, reception, rapport, humanization, and community orientation.

The Family Health Strategy has the capacity to offer a wide range of actions to cover every stage of life, different endemic and epidemic situations, the management of chronic diseases, which have proved successful by taking into account the social determinants of health and disease. It is a broad-based platform that can always be applied to any situation involving people's health. However, healthcare is a process that requires new strategies in the technical training of professionals to develop complementary medicine and mental health services, for people with HIV/AIDS, users of illicit drugs, and people with obesity.

Looking at the longitudinality of care – covering every stage of life – more resistance was detected in the development of actions for adolescent health. This is because of how hard it is to take specific actions for this age group, and results in weaker rapport with this target public[39].

Conclusions

The Family Health Strategy has helped make primary healthcare more universal by incorporating the core principles necessary for an overarching PHC approach, including, such as equity and comprehensive care. It has also contributed to the introduction of evaluation processes, which are needed to make effective ongoing improvements. As regards technical and healthcare aspects per se, it outperforms the traditional primary care model because of the multidisciplinary approach and family focus in which reception, rapport, humanization, and community orientation are key.

The difficulties the Family Health Strategy still faces are associated with complex factors, which can only be overcome by more concerted political and institutional efforts in funding, the training of professionals, the management/education of personnel, and the development of cross-sectoral actions. More consistent measures also need to be introduced to strengthen the Family Health Strategy as the chief gateway to the health system and to better organize access to the other levels of care. Parallel to this, its planning must involve social participation in order to meet the public's real needs, going beyond the still prevailing biomedical model. Another factor hampering the provision of comprehensive care is the capacity to strike a satisfactory balance between an individual approach when applicable and a community approach to tackle social determinants.

The Family Health Strategy has made considerable progress, but it still faces difficulties, es-

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pecially because of the country's administrative structure and major regional inequities, as well as the considerable growth of the private sector in recent times, hindering the organization of PHC as the lynchpin of the health system. Ultimately, its sustainability and development depend on how much the state is willing to invest in it.

Collaborations

LJ Arantes: planning; data analysis; writing, managing and proofreading the manuscript. HE Shimizu: idea: writing, managing and proofreading the manuscript. E Merchán-Hamann: proofreading the manuscript.

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