

“Previne Brasil”: bases of the Primary Health Care Reform

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In November 2019, the Ministry of Health launched a new financing policy for Primary Health Care (PHC), called “Previne Brasil”, to strengthen the essential attributes and derivatives of PHC proposed by Starfield¹. Previne Brasil seeks synchrony between reviving the historically established principles of PHC and the organizational modernization imposed on us by the 21st century and social and cultural changes. With this movement, we intend to address the unsolved challenges of PHC in the SUS, and innovate in the organization of services, maintaining, with solidity, the principles that govern our Unified Health System (SUS) and PHC.

The text presented by Massuda mistakenly suggests that Previne Brasil², “(i) seems to have a restrictive objective”, “(ii) would limit universality”, “(iii) increase distortions in financing”, “(iv) inducing the focus of PHC actions in the SUS”, “(v) reverses the reduction of health inequalities”. Now, the set of strategies planned and made official throughout 2019 – among which Previne Brasil is the most important – is moving in a diametrically opposite direction. We propose the radicalization of PHC attributes, radical as in root, foundation and origin, radical as in structural reform. Thus, we present below the five central points that mark this new direction for the strengthening of PHC.

The first point refers to the objective of expanding resources to increase the number of Family Health (eSF) teams and the types of teams financed. For the first time, primary care teams (eAP) started to receive federal resources, unlike the former EAB, which existed on paper, but which in practice did not have federal resources for their implementation. However, the municipality can only accredit eAPs with the maintenance of ESF coverage. That is, it is impossible to have a setback in Family Health coverage. Moreover, there are incentives and systematically proposed actions that can only be applied to Family Health teams, such as the incentive for residency in Family and Community Medicine, Family and Community Nursing, and Family and Community Dentistry. Another specific action for the ESF is the program for providing and training specialists in Family and Community Medicine, *Médicos pelo Brasil* (Doctors for Brazil). We have a total of 43,458 Family Health teams financed in December 2019, and

43,448 in January 2020. And another 1,192 eAP that started to be paid in 2020. The first financial year based on registration in 2020 will finance around 45,700 Family Health teams, an increase of 6% compared to December 2019. Therefore, there is no restriction in the implementation of the number of teams; on the contrary, in federal planning, the goal is to reach 50,000 teams by 2022, that is, to maintain and accelerate the expansion of eSF in Brazil³.

The second point is associated with the issue of universality. In no universal PHC-based health system, capitation – proposed as part of current federal funding – has limited universality. Just look at the reality of Portugal, which also uses weighted capitation as part of its financing, and is close to reaching 100% of the population covered by family doctors^{4,5}. On the contrary, weighted capitation expands the health system’s accountability for people, allowing better knowledge and longitudinal monitoring of people when financing the care offered to people effectively assigned to the teams, and transparently favors the planning and allocation of resources for the PHC teams. Through the e-Gestor⁶ System, the registration information of each municipality and each team is available, with the individual identification of all registered people, as well as the health indicators that will serve to guide the payment-for-performance. These data are available and transparent at the national, regional, and state levels for all citizens. Massuda says that weighted capitation puts universality at risk. We have a question here: did the Fixed PAB, established at the end of 1996, ensure universality and made us achieve 100% PHC coverage? What we propose is the return to the origin of PHC, the inherent principle of Primary Care and Family and Community Medicine: people-centered, real responsibility for individuals and communities, in their context and their uniqueness.

The third point, “increase the distortion of financing”, precisely the mixed model – with capitation, payment-for-performance, and specific incentives – balances financing, reduces distortions, and produces equity. The fact is that 4,472 municipalities will have a potential of R\$ 3.2 billion in additional resources in 2020 compared to 2019, while 1,098 municipalities will receive, for

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12 months in 2020, the highest financial year value observed in 2019, also increasing their transfers. In other words, R\$ 50.50 will be transferred annually for each individual registered in the teams⁷, divided into 12 monthly payments.

Previously, through the Fixed PAB, a maximum of R\$ 28.00 per person per year was transferred. This amount of R\$ 50.50 can also reach R\$ 131.30 per year, according to the individuals' vulnerability characteristics and the municipality in which they live. With the definition of this value in January 2020⁷, we increased the earning potential of the municipalities in 2020 by almost R\$ 3.5 billion, if they register and take responsibility for the entire population parameter per team, especially with more considerable effort and dedication in identifying the most vulnerable people, such as children under five, older adults over 65 or beneficiaries of social programs (*Bolsa Família* – Family Grant, *BPC* – Continuous Cash Benefit, and Social Security benefit up to two minimum wages).

Massuda's fourth point of criticism, "focus", is, on the contrary, the path to equity in the individual and contextual sense (municipality). Transferring more resources to teams and municipalities that are responsible for age extremes that require more significant health care, transferring more resources to socioeconomically vulnerable populations, and more impoverished and more remote municipalities contributes to equity, maintaining the principle of universality. We will only reduce inequalities if we prioritize the search for equity. Equity, precisely, is offering more resources to those who need them the most. Who would oppose a Reform that multiplies up to 2.6 times the cost of Primary Care for those people and municipalities that need it most?

The fifth point of criticism, "reversing the reduction of health inequalities", is not what is expected, given the expanded access, with the increase of registered people and under effective care based on five individual vulnerability criteria, as well as the municipal-based vulnerability criterion. Inequalities can only be reduced with real health gains for all if there is an effort to that end. As of 2019, the Ministry of Health began to manage the lists of duplicate entries and database linkages per individual, something unprecedented in the history of PHC in Brazil, and very common in the routine of countries with strong PHC. In August 2018, the register had 81 million people linked to the eSF. Approximately 50 million citizens potentially covered by the Family Health Strategy (ESF) were outside that register. Of these, about

30 million were in situations of extreme social and economic vulnerability. After the announcement of *Previne Brasil*, at the end of 2019, people's registration had already risen by 26%, jumping to 103 million Brazilians. In this way, registration and weighted capitation will be the main responsible for boosting Brazilians' equal access to PHC.

Moreover, Starfield already stated that strengthening PHC is about increasing equity. Several other systemic strategies for strengthening PHC are underway at the Ministry of Health. The first was the creation of the Primary Health Care Secretariat (SAPS), showing a clear political priority for PHC. Then, the removal of obstacles to first contact access was addressed with the "*Saúde na Hora*" (Timely Health) Program⁸, expanding access and service hours. This has already reached 1,455 health units, providing access to PHC for people who previously only managed care in UPAs and hospital emergencies due to the incompatibility of their routine with the schedules of family health units. Greater computerization of PHC and resources for the integration of clinical data were provided by the *ConectaSUS* Programs (with funding for computerization) and *InformatizaAPS*^{9,10} to support the coordination of care. The clinical fragility and the need to expand the professional scope will be strengthened with the publication, in 2019, of the Primary Health Care Services Portfolio¹¹, and then with the lines of care and Nursing clinical protocols. Furthermore, the Ministry of Health offers a new financial incentive for the other standard in the training of specialists in Family and Community Medicine, Family and Community Nursing, and Family and Community Dentistry in PHC¹². This incentive is intended for Family Health teams' vacancies occupied by medical residents, nurses, or dentists affiliated with Medical and Multiprofessional Residency Programs approved by the Ministry of Education. Finally, the Doctors for Brazil Program (MPB)¹³ is one of the main strategies to address the shortage of qualified medical professionals and deficient support to remote areas, respecting the professionals' right to free will.

The financing model in force until 2019

The financing model in force until 2019, after the expected expansion of the ESF until the middle of the last decade, contributed to preventing the increase in the number of people under the active responsibility of the teams. This model was exhausted and had limitations in terms of its ability to induce primary responses to the challenges of

the health system and PHC, such as making access effective and producing better health outcomes. It consisted of several components created at different times and with little integration in care.

The first consisted in part of a fixed portion, calculated from the population size of the municipality, the so-called “Fixed PAB”. This resource, around R\$ 4 billion per year, was transferred without any auditable requirement for consideration by the municipality since there was no record of the person-to-person linkage, nor was there a criterion of homogeneity in the inspection of its application in primary care by the control agencies, and, much less, the need to expand PHC services.

The second component of the financing model in effect until then was the so-called “Variable PAB”, a potpourri of financial incentives transferred as per the accreditation and minimum activity of the most diverse types of ESF teams, *Consultório na Rua* (“Street Clinic”), prison teams, and others. To receive the “Variable PAB”, the municipality had to accredit the team with the SAPS, keep a complete registration of this team in the SCNES, and report some activity of the team, even if it was only one procedure per month, without any requirement related to the number of people under the responsibility of the team. In the late 1990s and early 2000s, this model fulfilled a crucial initial role of decentralizing outpatient health actions and services to municipalities that previously lacked installed capacity, as Costa & Pinto¹⁴ analyzed in detail. However, over the last two decades (1998-2018), the variable PAB started to concentrate most of the federal resources allocated in the PHC, despite showing limitations, such as the excessive focus on installed capacity, in conditioning the transfer to not very flexible federal rules, and the profusion of programs, which totaled 20 different types in 2019.

The third component was related to the incentive given to municipalities for the implantation and maintenance of Community Health Work in the eSF, which totals more than R\$ 4 billion annually, and is linked to the legal duties of managers in ensuring payment of the baseline, but without any link and proportionality to the performance achieved by the strategy.

The fourth and last component was the Access and Quality Improvement Program (PMAQ), which innovated positively in 2011 by explicitly addressing the need to expand access and improve the quality of care in the ESF and bring the culture of assessment in PHC. Despite this significant advance, the PMAQ’s method had several limitations. One of its components is based on face-to-

face collections of low periodicity (2 to 3 years), without a pre-established transparent schedule, using several questionnaires without any national statistical and scientific validation, which generated more than 1,000 variables that comprised the final evaluation of each ESF team. Now, all of us researchers know that when you want to measure everything, you do not measure anything at all! Almost R\$ 2 billion were transferred through the PMAQ evaluation only to the teams that joined, since it was an optional evaluation that reached about 36 thousand ESF teams, about 80% of the total of the existing teams in 2019, which means that there was no evaluation of the care provided to the Brazilian population for 20% of the ESF teams.

About health systems financing models and payment for health services

Contrary to what Massuda says, the Ministry of Health is not directing PHC and public health programs to be “focused on specific diseases”. By including three macro indicators in the PHC assessment as part of the overall assessment – Net Promoter Score (NPS)¹⁵, PDQR9¹⁶, and the Primary Care Assessment Tool (PCATool)¹⁷, we created an assessment strategy that measures the PHC principles and attributes. The NPS measures affiliation, loyalty, and trust, that is, the strength of the interpersonal relationship (longitudinality) between people and PHC teams, the original and irreplaceable principle of PHC. PDRQ9 measures the quality and trust of the relationship between people and the Family and Community doctor (longitudinality). The PCATool-Brasil measures the presence and extent of the four essential attributes (first contact access, longitudinality, coordination, and integrality) and two derived attributes (family and community orientation). Besides incorporating instruments validated in Brazil and abroad, widely used in scientific production in PHC, it allows for temporal and geographic-based comparisons, both within the country and internationally. This strategy brings broad transparency to the results achieved or not by each Ministry of Health management, and enables an unambiguous rule to measure the success of public policies. It is not only an ongoing innovation but also a revival of IBGE as a great external evaluator of Health and PHC in Brazil, starting with the National Health Survey (PNS-2019) that included in its “Medical Care” Module the issues of the reduced adult version of PCATool-Brasil¹⁸.

We agree with Massuda when he states that “the different remuneration models have advan-

tages and disadvantages”. This sentence summarizes the expression and the need to combine integrated, mixed, and balanced models^{19,20} when building a federal financing policy for PHC and a SUS monitoring and evaluation policy. For example, when the author mentions the coverage rates of Family Health teams between 1998 and 2018, he forgets to mention that coverage – historically speaking – has always considered an average of 3,000 to 4,000 people covered by an ESF team. Now, the work of cleaning the databases and linkages carried out throughout 2019 showed that millions of registrations were in fact “duplicate records”; that is, the numerator was estimated arbitrarily to calculate the coverage rate. And this was legitimate since the actual numerator was not known with the exclusion of duplicate records and management of inconsistencies that became possible with the registration of the individual in the calculation of this indicator from the new federal PHC financing policy and the monitoring proposed by the National Team Identifier (INE) code for each eSF from 2020.

This contributed to the use of the unique number of identification of people best known by Brazilians, which is the number of the Individual Taxpayer Registration Number (CPF) strengthened by the Federal Government²¹, which as of February 2020 became mandatory for the univocal identification of people in Brazil in the registration form for primary care teams in the citizen’s electronic medical record (version 3.2.21), the SUS-APS²². Even if you use another electronic medical record system or record on paper sheets (CDS), the mechanism for transporting information and the data model are the same.

Another example, in contrast to the author’s text, refers to the reduction of health inequalities, since, contrary to what Massuda presented, with *Previne Brasil*, an increase in resources and financing of more than 2 thousand teams in 2019, when compared to the year 2018. Moreover, *Previne Brasil* responsibly set a transition rule for financing models, avoiding the loss of resources by the municipalities²³.

On the support received by the new Brazilian PHC financing policy

Contrary to what the author states, the new financing policy was not only supported by the Brazilian Society of Family and Community Medicine (SBMFC). The National Council of State Health Secretaries (CONASS), the National Council of Municipal Health Secretaries (CONASEMS)

and the National Confederation of Municipalities (CNM) published several technical notes, and not only supported but actively participated and impacted²⁴⁻²⁶ the face-to-face meetings that the Ministry of Health held during the 2nd semester of 2019, in all 26 federated units and the Federal District, with the presence of more than 10,000 technicians and managers from these departments. Furthermore, we held an International Seminar with the participation of experts from Harvard and York Universities, who contributed and supported in the development of the new financing model. And also at the 9th Meeting of the Tripartite Interagency Committee (CIT), the level of agreement between federal, state and municipal managers, on October 31, 2019, the new mixed financing model was unanimously approved, and CONASEMS developed a tool entitled “Management Support Panel”²⁷ to provide greater transparency to municipalities and the Brazilian population in monitoring the new model. In other words, when considering that SUS is not managed solely by the Ministry of Health, but democratically, by representatives of the three spheres of power – federal, by the Ministry of Health; state, by CONASS; and municipal, by CONASEMS – we can affirm that *Previne Brasil* is a new proposal for the PHC built, debated and approved by the SUS management as a whole.

Expected challenges

The challenges that lie ahead are undeniable. However, it is believed that *Previne Brasil* will induce states and municipalities to follow the same mixed financing model, also reviving the role of state supporter for municipalities with less institutional capacity for the implementation of primary health care services. After all, the role of the federated units with the ESF teams has been reduced over the decades. With the new financing policy, some states may create similar induction mechanisms to complement the new federal per capita, potentiate the payment-for-performance component and further encourage computerization, expanding access and training human resources through medical and multi-professional residency.

As for the role of the Federal Government, a robust, and transparent monitoring based on reliable indicators will be essential to reduce risk selection, as the author remembers. On the other hand, in the current SUS, as in the PAB era, access barriers were not lacking, and therefore, it will not be only the appropriate register that will expand them; on

the contrary, it will map them so that managers can address them. In fact, with the planned goal of 50,000 teams by 2022, the Ministry of Health directs the continued expansion of Family Health teams to the entire Brazilian population, to correct the gap in official statistics, which, as mentioned, had duplicity: people said to be “covered by eSF teams”, but who in reality did not have PHC teams and services to care for them. The search for the registration of another 50 million people is a course correction, as well as expanding access and making the statistical calculation feasible for real population coverage.

As for the “effective registration”, in the information and computer age, the time has come to face this great challenge in the country and with new federal resources to support this registration (which has always been the responsibility of local managers)²⁸. In this sense, the resources transferred to the municipalities consider a higher value for the poorest and most remote municipalities, based on the IBGE²⁹ typology that will be used in the 2020 Demographic Census. They will also be weighed, considering the most vulnerable population – children and older adults. The details of the adjustment factors for onlendings of federal financing amounts are detailed in another text in the press that makes up this thematic number³⁰.

One of the most used statements to say that the new policy will no longer finance the Family Health Support Center (NASF) teams is unsustainable since only about 35% of professionals (among the possible multi-professional categories) are registered with NASF, as per the CNES. The others are also working in PHC, but outside this type of team, showing that there are several institutional arrangements already underway in the municipalities for the exercise of multi-professional practice in PHC, including support to Family Health. And there is a provision for monitoring the presence of these professionals who will remain working and may be hired independently by municipal managers according to the epidemiological profile of each city, as also explained in a technical note from CONASEMS³¹.

Final considerations

The new PHC financing model, Previne Brasil, has been in the process of being implemented since the beginning of 2020. The program faces the challenge of expanding access, improving quality, and bringing more equity to PHC in the country, based on the best PHC quality experiences in

the world, within universal health systems. It is a mixed financing model, which seeks to balance financial values per capita referring to the population effectively registered in the Family Health and Primary Health Care teams, with the level of care performance of these teams added to incentives for strategic actions, such as expanded working hours of service (*Saúde na Hora*), computerization (*Informatiza-APS*) and training of specialists in PHC through medical and multi-professional residency.

The proposed program’s fundamental principle is to structure a financing model that places people at the center of care, based on the composition of mechanisms that induce managers and professionals to be held accountable by the people they assist. The provision of quality care with equity is one of the pillars of Previne Brasil. It innovates by rewarding and recognizing efficiency and effectiveness, while still prioritizing access. To this end, the components include weighted capitation, payment-for-performance, and incentives for strategic actions and vulnerable populations.

In 2019, 1,098 municipalities were unable to increase their funding with the new financing due to the local PHC organization model. They represent 19% of Brazilian municipalities with a population of around 20 million people (10% of the Brazilian population). To avoid the risk of financial loss and so that no citizen is potentially harmed, in a tripartite decision, the Ministry of Health will maintain the amount received in 2019 regarding the best monthly financial competence for each municipality, generating real gain for these municipalities in 2020. With this decision, no loss in the resource will be incurred throughout 2020; on the contrary, a possible real gain of R\$ 3.5 billion reais may occur for the whole set of municipalities.

Previne Brasil is the most robust strategy of the PHC Reform in Brazil proposed by the current management of the Ministry of Health. Moreover, several other strategies, methodologically and systematically integrated, have been developed or are in the final stage of elaboration, among which are the creation of SAPS, expanded access (*Saúde na Hora*); computerization (*ConectaSUS* and *Informatiza-APS*); medical provision and large-scale training of family and community doctors (Doctors for Brazil); encouraging professional training via Medical and Multiprofessional Residence; the APS Service Portfolio (CasAPS); the production of lines of care for the entire Health Care Network, regulated by the PHC; the establishment of clinical nursing protocols; the institution of the *APS Forte* Award, and the methodological strengthening and partnerships with IBGE and the Organization

for Economic Cooperation and Development (OECD) for better monitoring and evaluation of PHC. These strategies even respond to 12 of the 20 recommendations for strengthening PHC made by Massuda in another article published in January 2020 in the Pan American Journal of Public Health³². The reversion of *Previdência Brasil* will indeed also reverse the possibility of strengthening PHC and prevent these 12 recommendations from being met.

An active Primary Care is done with stable and coherent principles and attributes, with robust financing that prioritizes equity, with transparency. The PHC Reform that we propose is consistent with the principles of PHC and the SUS, the substantial scientific evidence produced in Brazil and the world, and with the uncompromising defense of the search for equity in an unequal country. Together with all the professionals of the Family

Health and Primary Care teams, the municipal and state managers, the National Council of State Health Secretaries (CONASS) and with the National Council of Municipal Health Secretaries (CONASEMS), the bases for 2020 are set for a year with the highest qualification of Brazilian PHC and the beginning of the Primary Health Care Reform, after more than 25 years of the then “Family Health Program” and after 40 years of Alma-Ata. Finally, Brazil will build the necessary balance between clinic and collective health for the good of its citizens, rebuilding strong primary care, coordinating care, and resolving. The most significant expression of this commitment from the Federal Government is found in the 2020-2023 Multianual Plan, enacted as Law N° 13.971, of December 27, 2019, which establishes the goal of expanding the population coverage of Family Health teams, to achieve 50 thousand teams by 2022³³.

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