

Previne Brasil Program: the apex of threats to Primary Health Care?

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Abstract *Since 2017, the Brazilian health system is facing a wave of counter-reforms in policies that have expanded coverage and access and intended to change the care model. Primary Health Care (PHC) has been substantially modified by synergistic and complementary federal official acts. The creation of federal autonomous social service for the provision of doctors; public consultation to institute basket of consumption in healthcare; the flexibility of the weekly workload of doctors and nurses, who may integrate more than one team; the non-setting of a minimum number of community health workers per team form the context in which the Previne Brasil Program was launched to be in force by 2020. The government's argument is to increase: flexibility and local autonomy to organize services, greater efficiency and valorization. of performance. Criticism from sanitarians, some state councils of municipal authorities and the National Health Council points to the privatizing, marketing, selective and focused character of the proposal that is moving towards universal health coverage. This paper analyzes the Previne Brazil Program which, among other things, alters funding and suggests increasing resources for PHC in a context of freezing social spending. Contradictions and alternatives are identified to minimize potential damage to existing policies.*

Key words *Healthcare financing, Financial resources in health, Primary Health Care*

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Introduction

After the juridical-mediatic-parliamentary¹ coup that ousted Dilma Rousseff in 2016, there has been a clear shift in the ideological guideline for the conduct of social policies in subsequent governments, with new measures implemented in the Temer government and intensified after Bolsonaro's election.

Although the adoption of the fiscal adjustment model took place during Dilma Rousseff administration, in an attempt to overcome the political and economic crisis, actions such as the approval of Constitutional Amendment (EC) 95, which freezes the ceiling on social spending, and Labor and Social Security reforms, have been implemented after the coup.

In 2017 and 2019, with a focus on Primary Health Care (PHC), ministerial ordinances, public consultation and complementary and synergistic Provisional Presidential Decrees (MP) were issued, dehydrating SUS principles and undermining the processes of planning, funding and provision of actions and services.

The National Primary Care Policy² starts remunerating Primary Care Teams (eAB) composed of medical doctors, nurses, nursing assistants or technicians; provides for the presence of dentists, oral health assistants and technicians, community health agents (ACS) and endemic control agents (ACE); and sets the minimum workload per professional category in the eAB at 10 (ten) hours and a maximum of three professionals per category with 40 hours/week. For the Family Health Teams (eSF), it will no longer establish a minimum of four ACS per team, who will be able to measure vital signs and blood sugar level and do wound dressings. The new standard³ has established as a minimum component of the eAB, now called the Primary Care Team (eAP), the medical doctor and the nurse, with 20 or 30 hours a week, in addition to allowing their participation in more than one eSB, eAP or eSF, without risk of suspension of transfers, and making the workload of the oral health teams (eSB) more flexible, along the same lines.

The transfer of federal funds in the costing and investment blocks⁴, despite the accountability being organized in the six old blocks, weakens the protection of PHC funding against the pressure of the costs of hospital and specialized care, and of diagnosis and therapy procedures, with a strong private component⁵.

The Portfolio of Services for Primary Health Care in Brazil⁶ aims to “establish an ‘optimal

scenario for the implementation and provision of clinical services at health units” and “strengthening the PHC clinic with a scientific basis for decision-making”. It provides for: a) list of Health Care services (Adult/Elderly Person; Child, Procedures at PHC and Oral Health); b) remuneration by capitation upon “a list of patients” and “payment per person accompanied”; c) minimum basket of services; d) detailing the organization of the “*Saúde na Hora*” Program, in which the Basic Health Care Units (UBS) work 60 to 75 hours a week; e) secundarization of health promotion goals at PHC, exemplified by “the nurse, who has historically been focused on performing activities that are repetitive and quite ineffective, focused on health promotion and prevention, to the detriment of curative and/or care activities”⁶.

The *Médicos pelo Brasil Program*⁷ establishes the Agency for the Development of Primary Health Care (Adaps), a federal autonomous social service to provide doctors to PHC in hard-to-populate or highly vulnerable locations. During training, the professional will work for two years on a scholarship, with no employment relationship. The Advisory Council of Adaps will have representatives from the Ministry of Health, the Councils of Health Secretaries and the private sector, with the National Health Council, users and workers being, therefore, absent.

In common with these measures and with the *Previne Brazil Program*⁸, the “big bang”⁹ character of counter-reforms in relation to policies that expanded coverage and access and sought to promote a change in the care model and greater control of public spending. The political environment in the health area is tense and the dispute is fierce. On the one hand, flexibility and autonomy for local management, defended by the Ministry, National Council of Municipal Health Departments (Conasems) and medical entities; on the other hand, the criticisms of sanitarians, Councils of Municipal Health Secretaries of Rio de Janeiro and São Paulo (Cosems/RJ and Cosems/SP) and of the CNS, who point out the privatizing, marketing, selective and focused character of the proposed PHC, in the conception of universal health coverage, to the detriment of a universal health system aspired to by the SUS^{5,10-13}.

This article analyzes the *Previne Brasil Program*⁸, based on the submissions made by Primary Health Care Secretariat (SAPS) of the Ministry of Health, the ordinance that established it and its instructional manuals, in addition to identifying contradictions and alternatives to minimize potential damage to policies in force.

Arguments for implementing the *Previne Brasil Program*

The new proposal for funding the PHC has been disclosed at seminars held in several states, with the participation of the Secretary of Primary Health Care, Erno Harzheim, councils of state and municipal health departments, local managers and representatives of the public health movement.

In defense of the measure, Harzheim based his arguments on two criticisms of the current model: i) Alleged “inefficiency” of PHC services, considering the large number of SUS users not registered by the teams. Of the 50 million not registered, 30 million would benefit from social programs, in a situation of greater vulnerability; ii) Low valuation of the performance component of the teams, considering that federal transfers to subnational entities are mostly calculated based on population criteria.

For Harzheim, the current calculation of coverage in PHC, of 3,450 people for each eSF, would be a distortion of reality because it does not guarantee them assistance; the requirement of registration would be an incentive to real care.

The Access and Quality Improvement Program (PMAQ), which transfers financial resources upon the achievement of goals, has been criticized for its high number of indicators and low capacity to induce improvements. The model proposed now would break with this logic based on the increase, in nominal values, of approximately two billion reais to the budget for PHC in 2020, with new criteria based on three axes:

i) Replacement of Fixed and Variable Basic Care Floors (PAB) by Weighted Capitation. There are no longer regular population-based transfers and incentives for funding eAB, the Expanded Family Health Support Center (NASF) and the PMAQ. The registration of each citizen at the corresponding PHC is now considered. There is an increase in the per capita value and weighting factor for children under 5 or adults over 65, beneficiaries of social income transfer programs, population of up to two minimum wages tied to the National Institute of Social Security (INSS), higher weight for rural municipalities.

ii) PMAQ incentives will be replaced by transfers conditioned upon the performance in seven indicators to be established in 2020, related to processes and results in the Health of Pregnant Mothers, Women, Children and Chronic Diseases. By 2022, the number of indicators would

reach 21, with monitoring on Tuberculosis, Sexually Transmitted Infections and Oral Health.

iii) Transfers tied to health care actions and programs contained in the variable PAB will become part of the axis of adherence to strategic programs, such as the *Saúde na Hora Programs*; Support for the Computerization and Qualification of PHC Data - *Informatiza APS* and Training Program in Medical or Multiprofessional Residence in Dentistry and Nursing in Family Health.

Contradictions and potential harm to PHC funding

It is worth mentioning the context of the EC 95 budget constraint in relation to the promised additional contribution of 2 billion in the Annual Budget Law (LOA) for the PHC in 2020. The Institute for Applied Economic Research (IPEA)¹⁴ projected a reduction in spending on public health care actions and services (ASPS) as a percentage of the Gross Domestic Product (GDP) over the next 20 years, a projection confirmed in data presented by Ocké-Reis¹⁵.

The Federal Government's participation in SUS funding, reduced from 73% to 43% between 1991 and 2017, was followed by an increase in the allocation of funds at the state level (from 15% to 26%) and, mainly, at the municipal level (from 12% to 31%). Currently, the states have applied percentages close to the minimum parameter of 12% of state revenue (calculation basis), and there is a dispute in relation to Minas Gerais and Rio de Janeiro; municipalities have invested increasing resources, reaching an average of around 24%¹⁶ in 2017.

The capacity of municipalities to expand the application of their own funds in ASPS is also restricted when analyzed in conjunction with the constitutional powers of taxing and with the available revenue of each entity of the federation, respectively: federal government (69% and 57%); states (25% and 25%); and municipalities (6% and 18%). Following fashion (most frequent variation of a distribution), PHC funding in municipalities behaves as follows: 70% comes from the municipality and 30% from the federal sphere¹⁶.

SAPS predicts gains for almost all municipalities with the new model, projecting a frontier scenario of unrealistic efficiency, with registration of the entire population and full achievement of the targets for indicators that have not yet been agreed upon. Although the most vulnerable population is considered a priority, indica-

tors such as Monitoring of Bolsa Família Conditionalities are not mentioned. Furthermore, the proposal does not specify the transaction costs of the Ministry and the municipalities, failing to point out the funds required to create the Support Team for the New Funding in the Ministry of Health or the overspending of the municipal departments to expand registrations, often with teams outsourced by Social Organizations (OS).

Studies^{17,18} estimate losses of R\$400 million for municipalities in the state of Rio de Janeiro and R\$700 million for those in São Paulo, considering the current status of registration in PHC. In an optimal and unlikely scenario, with 100% registration, there would be a financial loss of around 3% in Rio de Janeiro and 25% in São Paulo on the amounts received in 2018.

It is necessary to question the registration argument in guaranteeing follow-up and care to users enrolled with UBS. The automatic parameterization of an eSF as responsible for 2,000 to 4,000 people, under the new proposal, does not mean effective access and service, nor does it mean registration in the simplified model. The measure may induce the search for registration, without significant federal financial incentive to increase the number of teams and with the real difficulty of following up on care. The analysis of the alleged inefficiency of the current registration disregards management problems in maintaining complete teams, physical structure of units and loss of records in technology transitions such as in the implementation of the Information System in Primary Health Care (Sisab) or the e-SUS Strategy.

The federal budget schedule for PHC in 2020 is contradictory to the argument of the need for greater valuation of performance. At an event in Rio de Janeiro, Harzheim compared the nominal values of the PMAQ in 2019 with the values of the “performance” axis for 2020, with a drop from R\$ 1,970.7 to R\$ 1,865.9 billion. Despite the schedule of increase in subsequent years, we reiterate that indicators and their targets have not been defined.

The lack of encouragement to maintain the Nasf and the exclusion of speech therapists, physiotherapists and nutritionists from the Multiprofessional Residency Program eliminates a positive differential in the Brazilian system and puts the principle of integrality at risk, in addition to the prediction of precarious employment relationships for two years.

The gain in flexibility and autonomy will not take place in the organization of the municipal network as there is evidence of strong action by

the central command in the guideline of weighted capitation and intensive standardization of programs such as *Saúde na Hora*, which encapsulates teams in workload distribution arrangements contrary to the bond with the families, an essential attribute of PHC.

Authors in the field of the health movement point out other criticisms: risk of “defunding”; impertinence in considering registration as the only way to enter the SUS, disregarding its universal character; likely targeting of the provision of PHC to the private sector through the combination of a basket of services and a list of registered patients; lack of social participation and representation of the CNS¹⁹; prejudice to the planning and security of funding due to the end of the fixed PAB^{10,20}. We affirm the unconstitutional or at least illegal content of the measure, by not complying with the precepts of Complementary Law 141/2012 and Law 8,142/1990, regarding the deliberative character of the CNS in the control of health care policies, including economic and financial aspects.

Final considerations

It is unlikely that a government with a technocratic profile will back down, where technical solutions obscure the problems related to fiscal adjustment and inequality of access, considering the deadline for implementing the model in 2020.

There is a need to politically and theoretically criticize the conception of that proposal in the field of health economics and collective health and to consider the positioning of entities in the health reform movement and the legislative initiatives to repeal Ordinance 2,979/2019²¹. Negotiated alternative proposals should emphasize that the registration of users – initial contact of the eSF with the enrolled population – cannot affect access to the SUS, or serve as a regular budget transfer.

The fixed PAB needs to be maintained, on a non-negotiable basis, due to the structuring nature of the pre-fixed model. In the hospital area, Ordinance 3,410/2013 indicates the global budget as an expected modality, due to the uncertainty of payment for production, even more with the outdated values of the SUS table. In countries with consistent health care systems, the modalities vary with the use of the burdens and bonuses of each one, with a significant regular portion being maintained to ensure the sustainability of the system²².

Finally, it is suggested to target the financial performance incentive to value the PBF Conditionalities Monitoring indicator, which, in addition to promoting the registration of the most vulnerable population, ensures the monitoring of nutritional aspects of pregnant women and children with weight and growth measurement, vaccination calendar and school attendance.

Collaborations

MH De Seta, CO Ocke-Reis and ALP Ramos equally contributed to the conception, analysis and writing of the article, being fully responsible for its content.

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