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National Primary Health Care Policy: where are we headed to?

Ligia Giovanella (https://orcid.org/0000-0002-6522-545X) [1]
Cassiano Mendes Franco (http://orcid.org/0000-0003-1430-6951) [2]
Patty Fidelis de Almeida (https://orcid.org/0000-0003-1676-3574) [3]

Abstract *This paper analyzes recent policies in the field of Primary Health Care (PHC) and their possible implications for the care model in the Unified Health System (SUS). Initially, some of the concepts that influenced the models of care in the Brazilian public system are revived, and we argue that the Family Health Strategy (ESF) bases for reorienting care practices in primary care are consistent with the principles of the SUS. Below, we analyze the central elements of new federal policies for PHC. We show that changes in the PHC care model threaten the teams' multidisciplinarity, prioritize acute illness care, focus in individual care, weaken the community territorial approach and establish coverage by registration, which evidence redirection of the health policy, harming the principles of universality, integrality, and equity in the SUS.*

Key Words *Primary health care, Health policy, Healthcare models*

[1] Escola Nacional de Saúde Pública Sérgio Arouca, Fundação Oswaldo Cruz. R. Leopoldo Bulhões 1480, Manguinhos. Rio de Janeiro RJ Brasil. ligiagiovanella@gmail.com
[2] Faculdade de Medicina, Universidade Federal do Rio de Janeiro. Rio de Janeiro RJ Brasil.
[3] Instituto de Saúde da Comunidade, Universidade Federal Fluminense. Niterói RJ Brasil.

Introduction

As we celebrate the 40th anniversary of the Alma-Ata Declaration on primary health care (PHC) that has for decades inspired social movements, activists, professionals, and governments defending the universal right to health worldwide, Brazilians are faced with setbacks, threats and testing new challenges. The erosion of social rights and shrinking civil and political rights promoted by the Bolsonaro government hurts democracy, worsens the social determinants of the disease, and, in the health sector, threatens universality, integrality and equity in the Unified Health System (SUS).

This paper analyzes recent policies in the field of PHC and discusses its implications for the care model. Initially, it revives the meanings of the care models that inform the implementation of the SUS. It is stated that the Family Health Strategy (ESF) provides a basis for reorienting care practices in primary care consistent with the principles of the Brazilian public system. Below, we analyze the central elements of federal policies for PHC. It is argued that the directionality of public policies, especially from 2017 onwards, signals changes and threats to the ESF care model and the principles of universality, integrality and equity in SUS.

The ESF and the change in the health care model

Care models are characterized as the "logic or rationality that guides a given technological combination in health practices" or "ways of organizing the action and having the scientific and technical means to intervene on both individual and collective health problems and needs"[1](p.463). It involves the way how resources (human and material), technologies (material and non-material), the service network, practices, and relationships between professionals and the population are provided in the political, managerial, and organizational realms[1,2].

The creation of the SUS implied changes in the healthcare model in the various realms, especially in politics and management. However, a new PHC model was not established in its creation, albeit influenced by proposals with different rationalities and experiences located in the previous decades[1]. The health care model of the social security medicine was rejected, characterized by restricted and stratified access to health, the dichotomy between care and prevention, and the biomedical and hospital-centric conception of care. The 8th National Health Conference advocated the prerogative of universality, integrality and equity, but also PHC and health promotion. However, it is from the 1990s onwards that a model for reorienting care practice in PHC, the Family Health Program (PSF) would hold what Viana and Dal Poz[3] called "programmatic void" since the establishment of the SUS – although initially PSF aimed at population groups without access and with a selective scope of actions[2,4].

Paim[1] subordinates the initiative of the PSF and its predecessor, the Community Health Workers Program (PACS), in its early days, to what he called "hygienist" model, characterized by vertical and hierarchical programs aimed at controlling certain diseases. Nevertheless, the author understands that the PSF has been progressively redefined as a strategy for changing hegemonic healthcare models[1]. The Family Health Strategy (ESF) is characterized as an alternative model that seeks to combine the practice of individual care with the population approach from the perspective of health surveillance, integrating epidemiological and health surveillance, territorialization/districtization, clinical care, and intersectoral policies, programmatic actions, and reorganization of service to self-referred demand with user-centered care, consolidating SUS principles such as universality, integrality and equity[2,4].

In 2002, the launch and distribution of Barbara Starfield's book[5] "Primary Care: Balancing Health Needs, Services, and Technology" to all health teams in the country at the Sergio Arouca National School of Public Health/Fiocruz spread a specific concept and organization of PHC based on essential attributes (first contact, comprehensiveness/integrality, longitudinality, and coordination) and derivatives (family and community orientation, and cultural competence), which were later incorporated into the National Primary Care Policy in 2006[4,6]. Besides directing policies and practices, PHC attributes[5] incorporate principles present in the performance and training in Family and Community Medicine (FCM). Beginning in the 2000s, central positions in the conduct of primary care policy at the Ministry of Health, in municipalities and states with national projection, were held by managers with training in FCM, as well as policies for training and provision were implemented, encouraging the specialty training.

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Influence of Family and Community Medicine on PHC care models

Brazilian FCM dates back to the 1970s, when Community Medicine programs were created, mostly organized by the Preventive Medicine departments, as teaching-care integration initiatives[7]. Although it represented a reaction to the specialization of medical practice and demand for broader social reforms, the programs were also funded by international agencies such as the Kellogg and Ford Foundations with focused concepts of health and elements of liberal medical practice, which resulted in criticisms by the Collective Health movement[7,8]. Donangelo[9] argued that the Community Medicine proposal did not change the way of conceiving the practice. While focused on communities – closed in the class structure – it continued to perform in another scenario the same medicine, without criticism about its social action.

The formation of the specialty of FCM in Brazil, contributed to the discourse on PHC practices. The first residencies date from 1976, under the name of General and Community Medicine, which was the name of the specialty until 2001, when it switched to FCM, which reflected the construction of an identity that distanced it from Community Medicine and Preventive Medicine[7,8].

The distancing from Preventive and Community Medicine also marked a distinction from FCM concerning public health doctors and Collective Health. In parallel to the opening of a broad field of practices from the consolidation of the ESF, the specialty sought to assert itself as an autonomous field, connected to the ideas, practices, and knowledge of countries with more consolidated experiences of first-level primary care such as Canada, England and Spain[7,8,10].

Such tensions were expressed within the FCM, in defense of the specialty in the context of the Health Reform and the SUS versus strengthening the autonomous specialty in the liberal perspective of the profession. The Brazilian Society of General Community Medicine, created in 1981, a precursor to the Brazilian Society of Family and Community Medicine (SBMFC), participated in the movement for the creation of SUS. Nevertheless, in 2015, SBMFC representatives proposed to resettle "the foundations for a new public health", from universal access to health with public funding and private provision, contracting of medical offices, reversion of the right to health for the right to cost-effective health services, patient registration and remuneration by mix of salary, capitation, and performance[11], clearly adapting to the liberal practice and the private supplementary health market[12]. In the current scenario, such recommendations have echoed in the direction of primary care policies, especially since the review of the PNAB in 2017[13], with possible implications for the health-care model's components, outlined from the ESF.

Setbacks of the ESF care model in primary care policies

Multiprofessional team

PNAB 2017[13] allowed the establishment of Family Health teams with only one health worker (ACS) and Primary Care teams (eAP) without health workers. The possible absence of ACS affects one of the pillars of the care model that characterizes the ESF in its community and health promotion components, guided by the conception of the social determination of the health-disease process and the expanded clinic[14]. New teams with a minimum professional workload of ten weekly hours restore medical employment in primary care as a "filler job" in force in the pre and early SUS period. It also tends to strengthen a professional performance, especially of the doctor, geared to curative care and control of individual risks[14]. The new financing policy of APS[15] regulates eAPs that may receive financial incentives equivalent to those of ESF teams.

The multi-professional component is also weakened by the extinction of accreditation and federal funding to the Family Health Support Teams (NASF)[15], under the justification for greater autonomy of the municipal manager for the composition of these teams. Incorporated into the PNAB in 2011[16], the NASFs were conceived from the perspective of interprofessionality, continuing education, communication, joint planning, shared decisions, knowledge and responsibility, for higher resolution of care; actions that are likely to be discontinued due to the real possibility of dismissing these professionals.

With these initiatives, the ESF's idea of multi-professionality and interdisciplinarity is no longer encouraged and tends to disappear in the medium term, replaced by teams whose composition includes only one medical professional and one nurse.

Priority to individual care and self-referred demand

The *Saúde na Hora*[17] program, the first launched by the Ministry of Health under the Bolsonaro government, explains the priority given to individual care and meeting self-referred demand. In this proposal, Primary Care Health Centers (UBS) with at least three teams will provide care for 60 weekly hours, with flexibility and reduction of the workload of professionals. The incentives for *Saúde na Hora* point to the transformation of UBS, in medium-sized and large cities, into emergency care units[18].

The caring for acute illness in PHC must undoubtedly be ensured. However, this initiative tends to transform the ESF into a minor injury unit care, changing its work process and organization of actions[18]. Openness to hiring on-duty personnel may compromise PHC attributes such as longitudinality and coordination of care. Without designing an articulation with the emergency care network, the isolated proposal directs attention to acute demands and disease management, with the monitoring of severe cases waiting for transfer. We should also alert the possibility of team concentration in the central areas of the municipalities, losing the capillarity of the ESF in the communities.

Medical work management for PHC

The *Médicos pelo Brasil* Program (PMB)[19], touted as an innovation, continues the *Mais Médicos Program* (PMM), in its axis of providing professionals in remote and less-favored areas. However, it abandons the component of intervention in medical graduation and expanded residency positions in FCM – the gold standard for acting under the PHC care model – and the axis aimed at improving the infrastructure of UBS. In this sense, it has a more restricted scope than its predecessor[20].

The omission to other ESF training plans, from undergraduate to postgraduate level, shows that the reorientation towards medical practice in PHC will not be encouraged[18,21]. Maintaining the current FCM Medical Residency programs will be even more difficult given the training proposal provided for in the PMB restricted to a specialization course whose tutoring can be exercised by clinicians, and not family and community physicians[18]. It equates this specialization with FCM medical residency title, shortening the time required (four years) to qualify for the specialty title test by half.

The PMB provides for the hiring of doctors registered in the country and, after a two-year fellowship along the lines of the PMM, a Consolidated Labor Laws (CLT) contract brokered by a private non-profit entity, euphemistically called PHC Development Agency (ADAPS)[19]. ADAPS promotes a shift of public management from PHC to the private sector[18,21] in alignment with the proposals for universal health coverage. PHC in the SUS is recognized, even by the World Bank, as the most efficient area of the entire Brazilian health sector[22], because most of the primary care services are state-owned, offered by the direct public administration.

If implemented, the set of propositions within the PMB[19] may represent a return to the social security health care model, a path to the privatization of PHC, space hitherto less marketed in the SUS[23].

The scope of actions/ comprehensiveness

The scope of practices in PHC will undoubtedly be affected by threats to the teams' multi-professionality, priority to acute illness care, and weakening of the community territorial approach. The PHC-derived attributes are structuring of a comprehensive PHC model and guide how health care should be developed[18]. In the Bolsonaro government's policy, these attributes have been disregarded in the various initiatives and programs.

In 2019, the Ministry of Health released a proposal for a "Portfolio of Primary Health Care Services"[24], which, due to its centrality in individual medical care, suffered intense criticism from researchers and professional associations, including the National Health Council[25]. After public consultation, the final version corrected some of the initial distortions, citing all the PHC attributes and listing surveillance, health promotion, and prevention actions, combined with a wide range of individual clinical care. Nevertheless, the care model expressed in the portfolio is of the first level with an emphasis on timely individual care, denoting a restricted conception of PHC, to the detriment of a comprehensive approach and the integration of PHC into the health service network[26]. This imbalance can be illustrated by the almost absence of mention in the portfolio of ACS actions and the regionalized network. The

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final version mentions the ACS only once, when stating the need for the active search for puerperae, and the integration to the network is only cited when mentioning referral and counter-referral mechanisms[24].

It should also be noted that, associated with other initiatives, the portfolio also serves to recruit private services, an instrument that can be used to price the scope of PHC practices.

Effects on SUS universality and equity

The new PHC financing model, by replacing the fixed Primary Care Baseline (PAB), and the variable one to encourage ESF and NASF teams with a weighted capitation payment, calculated by the number of people registered with the teams, can have drastic effects on the ESF care model.

The fixed PAB allows the implementation of actions provided for in the Municipal Health Plans and more suited to local realities, without the common restriction of federal transfers. In the model hitherto in force, the teams' actions target the entire population of the territory, and in hundreds of municipalities, they represent the only health services available to the population.

Even if the guidelines of the current PHC policies signal the priority for individual care, the new financing modalities could mean significant losses for many overburdened municipalities. Estimates of the Councils of Municipal Health Secretariats of São Paulo and Rio de Janeiro (Cosems SP[27] and Cosems RJ[28]) for calculating transfers based on weighted capitation signal huge losses. In the 12 municipalities of the *Baixada Fluminense*, for example, it would be necessary to register more than 2 million people by May 2020, with a monthly loss of six million *reais*, which will undoubtedly result in a lack of care to the population[28]. On the other hand, Cosems SP[27] estimates a loss of 47% of federal resources for PHC in São Paulo municipalities in 2021. Despite ministerial projections of some increase in funding for PHC in 2020, what occurs is a reallocation of resources, with evident losses for part of the municipalities, especially those classified as urban.

Another component of the new financing is the performance that will progressively have a higher weight, according to preliminary simulations of the Ministry of Health. Even without representing additional resources, as was the case of the National Program for the Improvement of Access and Quality of Primary Care, the new performance proposal will also have great emphasis on redirecting practices.

Besides the possible loss of financial resources, the political option seems to be targeting and selectivity. The new financing undermines SUS constitutional responsibility for health security and risk prevention, given that care will be restricted to the "registered" public, compromising collective health promotion actions. Considering only the registered population, in practice, means breaking with the universality and equity of the SUS.

Final considerations

Combining good clinical practice, commitment to disease prevention and health promotion, broad access to services, interdisciplinary, multiprofessional care, linkage to territories, community participation and focus on social determinants are challenges that have always been present in the implementation of a new care model in the SUS, from the perspective of health as a universal right.

Breaking with the universality of the SUS, as intended and implemented by the current government based on a supposedly pro-equity discourse, is a fallacy. It is a process of "neoselectivity" characterized by the provision of publicly funded health actions only to impoverished population strata, by private or public providers, without the perspective of health networks and regions, in line with restrictive fiscal adjustment policies and reduced state intervention. The set of social policy reforms, including those in the health sector, undertaken voraciously and hastily by the Bolsonaro government accentuates and crystallizes inequities, and strengthens commercialization also in the provision of PHC services.

Collaborations

L Giovanella, CM Franco and PF Almeida participated in the conception, analysis and writing of the article.

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