

## Notes on persistent challenges for basic health care in Brazil

Apontamentos sobre os desafios (ainda) atuais da atenção básica à saúde

Apuntes sobre los desafíos (todavía) actuales de la atención básica en la salud

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### Abstract

*In recent decades, Brazil has witnessed a proposal to create an extensive basic health care network as the main portal of entry to a universal public health system. Based on the recognition of consistent strides in that direction, the article addresses four issues on some important challenges for the consolidation of the basic health care proposal: (1) the use of the term “basic health care” as opposed to the usual, hegemonic concept of “primary health care”; (2) the disconnect or mismatch between the policy’s wording and its real-life implementation, underscoring the need for a review of the Brazilian National Basic Health Care Policy (PNAB), which centralizes and standardizes rules and routines for the entire country while overlooking Brazil’s continental dimensions, heterogeneity, and wide local diversity; (3) the isolation of basic health care and its peripheral position in the health system, pointing to the need for more complex arrangements in the coordination of care, not left merely under the organization and responsibility of basic health care; and (4) the lack of health policymakers, administrators, and professionals who are prepared and aligned with a project aimed at transforming the country’s prevailing health care model.*

*Primary Health Care; Family Health Strategy; Health Systems; Policy Making*

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## Introduction

In the restructuring, strengthening, and rationalization of public health systems, an essential role has been played by primary health care or basic health care, the latter name being used for a wide network of basic services in the Brazilian Unified National Health System (SUS) <sup>1,2,3,4</sup>. According to numerous responsibilities discussed in the most important documents produced by the World Health Organization (WHO), Pan American Health Organization (PAHO), and various governments, basic health care is the principal strategy for producing the health care system's transformation and regulation, seeking universal coverage and social protection in health, providing answers to people's needs and expectations in relation to a wide range of risks and diseases, promoting healthy behaviors and lifestyles, and mitigating social and environmental harms to health <sup>3,5,6,7,8</sup>.

This task is expected to be met by health teams deployed in basic health units (UBS in portuguese) assigned to well-defined territories with enrolled users, with the mission of facilitating access and making appropriate use of technologies and medicines to provide the necessary individual and collective health care. An organized and coordinated basic health care provides a broad response at all levels of care, besides taking responsibility for linking institutionalized participation by civil society in the political dialogue and accountability mechanisms. This issue has been the subject of exhaustive research, analyses, and reviews <sup>9,10,11,12,13,14</sup>.

The current essay addresses the following preliminary questions: (a) What remains to be said about basic health care in Brazil's health policy formulation, particularly a certain ideal functioning as the dreamed-of portal of entry to the SUS?; (b) What still needs to be addressed for this ambitious project to implement a broad network of primary care services, and which, if successful, will shift health care's center of gravity from hospitals and specialized services to a network of basic health units with capillary distribution in demarcated territories where people study and work, with multidisciplinary teams "trained" for comprehensive and humanized care (for individuals, families, and communities), capable of promoting life and "*impacting people's health status and autonomy and the communities' health determinants and conditioning factors*" <sup>15</sup> (p. 19), ensuring the success of health education, promotion, and prevention as opposed to the current emphasis on disease and its effects and a model of care based on medical appointments and procedures?; (c) What remains to be said on this project that has been built in recent decades by actors committed to the construction of the SUS and engaged in the field of Public Health and that represents a certain objective image that we never cease to pursue? Particularly, in more or less systematized and in-depth ways, policymakers, administrators, and health professionals have come to adopt what we could call the ideals of basic health care, or at least a recognition of and conceptual acceptance of its main characteristics; (d) What is still missing for this policy to succeed, to achieve its implementation in practice?

Assuming that our task here is no longer to simply reproduce the principles and guidelines of the ambitious and generous basic health care proposal in Brazil, we seek to explore some factors that have hindered in one way or another the consolidation of a health policy proposal which apparently suffer no outright opposition, at least in terms of its formulation and premises. Beyond the hegemonic discourse on the proposal for basic care in the public health care system, more and more health plan operators have explicitly adopted its principles and recommendations (user enrollment, multidisciplinary health teams, protocols, and emphasis on primary care, the family physician as the gatekeeper to access to medical specialties and specialized procedures, health education, health promotion, prevention, etc.) in testing new health care models that prove to be more economically feasible, and (why not?) in better care for beneficiaries of health plans <sup>16</sup>.

However, before sharing some thoughts on what we call the difficult genesis of basic health care as the backbone for an ideal, public, high-quality, universal health system, we need to acknowledge the extraordinary expansion of the basic health care project in Brazil in recent years. Beginning with the adoption of Family Health by the Ministry of Health, created as a Program in 1994, through agreements signed by Brazilian National Health Foundation (FUNASA) with small municipalities (counties) in Northeast and Southeast Brazil, since 2003, under the name Family Health Strategy (FHS), as a structural element of the SUS, the country experienced considerable extension of the coverage for broad segments of the population, reinforced especially by the "More Doctors for Brazil" Program beginning in 2013 <sup>17,18</sup>. Coverage by family health teams increased in 10 years, from December 2007

to December 2016, from 46.2% of the population to 63.7%, that is, an increase of 72.5%, totaling 40,098 teams across the country. More than 123.5 million Brazilians can now rely on the FHS, an internationally unprecedented extension of supply<sup>19</sup>.

Although it is too early to fully assess the impacts of such expansion, a few well-conducted studies (e.g., by researchers from the Institute of Public Health at Bahia Federal University) have already shown that the higher the family health coverage rate in a given group of municipalities, the greater the reduction in the post-neonatal infant mortality rate and the larger the reduction in deaths from diarrheic diseases and respiratory tract infections<sup>20,21</sup>, besides improved reporting of vital statistics and a decrease in avoidable hospitalizations (15% reduction since 1999) as the FHS is expanded<sup>22</sup>. A comparison of the basic health care coverage and hospitalization rates in large Brazilian cities, based on data from Brazilian Health Informatics Department (DATASUS), showed an inverse association between the two rates, i.e. the higher the FHS coverage, the fewer the hospital admissions from basic health care-sensitive causes, also demonstrating the positive effects of the FHS on the population's health<sup>23</sup>. Such findings corroborate other countries' experiences and are reason enough to defend the extension of basic care<sup>24,25,26</sup>.

Such progress is all the more relevant in light of the chronic underfinancing of the SUS, especially comparing Brazil's per capital health expenditures (pegged to the dollar) with spending in high-income countries, particularly those with universal health systems centered on basic health care<sup>27</sup>.

Despite the irrefutable growth in investments in the expansion of an extensive basic health care network, a recent study by Puccini<sup>28</sup> on trends in overall health expenditures in Greater Metropolitan São Paulo in 2002-2015 points to data that deserve analysis. From 2002 to 2015, health expenditures from the cities' own budget grew between 19.9% and 26.4% in the State of São Paulo, proportionally more than state budget expenditures or federal transfers. The study also showed that according to data from the National Health Fund, when one adds the budget amounts for the fixed minimum for basic health care, the fixed minimum for Health Surveillance, and the Basic Component of Pharmaceutical Care, the amounts of which are determined according to the number of inhabitants/year, in Greater Metropolitan São Paulo they accounted for only 15.52% of the direct transfers received by the municipalities in 2015, while the other transfers were conditioned on adherence to various Brazilian Ministry of Health programs or incentives.

This situation suffered a severe setback under the New Fiscal Regime proposed by President Michel Temer's current Administration and approved by the National Congress, which established a cap on primary expenditures (while setting no limit on financial expenses such as interest payments), resulting in estimated losses exceeding BRL 743 billion (approximately US\$ 230 billion) in financing for the SUS in 20 years (2017 to 2036) during which the adjustment model for federal public spending in health will be in force, solely according to adjustment for inflation by Brazil's Consumer Price Index (IPCA in Portuguese)<sup>29,30</sup>.

The previous discussion raises the second question: beyond the shortage of physicians (a dilemma partially resolved by the "More Doctors for Brazil" Program) and the chronic underfinancing of the health sectors, what obstacles to the consolidation of a basic health care network have either been overlooked or insufficiently addressed in the Brazilian National Basic Health Care Policy (PNAB), or when they have been identified, are difficult to tackle in the short and medium term?

As fuel for the debate, we will now present four notes on what we consider key challenges for progress with basic health care in Brazil.

### **First note: basic health care or primary health care?**

To prepare our discussion, the use of the term "basic health care" is a Brazilian characteristic, as opposed to the hegemonic and consecrated use of "primary health care" both in the international literature and in documents from international agencies<sup>31</sup>. Mello et al.<sup>32</sup>, in a review article on the difference between these concepts, state in their conclusions:

*"The terms basic care, primary care, and primary health care have been used synonymously in Brazil, often overlooking their conceptual and ideological contexts, the references for which vary, from openly functionalist*

and rationalist approaches to more progressive ones, particularly using the concepts of 'basic care' and 'primary health care' in opposition to 'primary care'" <sup>32</sup> (p. 211).

The term basic health care is used preferentially in the Brazilian Ministry of Health's documents, even though the *Ministry of Health Ruling n. 2.488/2011* that established the PNAB considered basic health care the equivalent of primary health care. In our opinion, basic health care can be considered a kind of ideological differentiation from the inherent reductionism in the idea of "primary care". Such differentiation is not fortuitous, but the result of a political process with roots in the very history of the Brazilian Health Movement, in the development of the Collective Health field, and reinforced by the determined and supra-partisan position of such key organizations as the National Council of Health Secretariats (CONASS), the National Council of Municipal Health Secretariats (CONASEMS), and the National Health Council, all of which aim for the utopia of a public and universal health system.

Brazil's health policy project was born in the country's democratic Left and was always part of the struggle for re-democratization in the face of the military regime. A central strategy was to build basic health care with case-resolution capacity, covering the entire national territory, and with the possibility of questioning and overcoming the hegemonic medical model. This strategy was largely inspired by the experiences of countries that developed welfare states following World War II as well as the former members of the so-called Real Socialist bloc.

The strong idea in this set of ideals, set out in Brazil's *1988 Federal Constitution* (now under attack), was health as the right of all citizens and the duty of the state, a fundamental strategy for expanded citizenship and an important component of a civilizing project for Brazilian society, capable of reducing the inequalities that have assailed the country for centuries. We thus contend that basic health care, as built in our country, is not merely a replication of international experiences and policies since at least the *Conference Alma-Ata*. The proposal is not simply technical, rather, it was and is both a technical and political project that mobilized (and still mobilizes) health workers, activists, policymakers, council members, and many other social actors in Brazil.

Now more than ever, the defense and strengthening of basic health care is a rallying cry at a time in Brazil's history when the SUS is suffering the worst attack since it was created in 1988. We reiterate that the defense of basic health care must not lose sight of comprehensive care, necessarily connected to networks of services with different technological levels. The proposal is counter to a definition of health systems based on purportedly universal coverage, but which in fact is fragmented and restrictive, centered on a kind of "primary care" that operates a basic basket of services that fits the budget of poor countries, leaving the rest to the market, as recommended explicitly by agencies like the World Bank and International Monetary Fund (IMF).

Any analysis of basic health care in Brazil must assume that it is not possible to speak of a single kind of basic care in the country, with its huge territory and economic, social, and cultural heterogeneity, but rather of multiple and differentiated basic networks cohabiting in the SUS, the result of striking regional differences and municipalities with highly diverse characteristics in terms of population size, the structure of their local and regional health systems, and the private sector's greater or lesser presence, particularly that of health plans. This clearly suggests the inadequacy of any attempt at centralization and homogenization of basic health care policy formulation, management, and assessment.

This essay is based on authors that include policymakers, researchers, health professionals, and consultants with advanced and consolidated experiences in basic health care in medium-sized and large municipalities from South and Southeast Brazil, particularly in the State of São Paulo <sup>33,34,35,36,37</sup>, and could thus lead to information bias in the commentary, which refers largely to contexts that may not reflect the "deep Brazil", that of small towns and isolated communities, where the arrival of a Family Health team, community health workers, or physicians via the More Doctors program means a veritable revolution <sup>38,39,40,41,42,43</sup>.

The SUS is also an experimental school or laboratory, and no study or evaluation can give visibility to everything that has been done and tested across Brazil. Suffice it to visit the posters reporting on "successful experiences" at the congresses held by CONASEMS and the Councils of Municipal Health Secretariats (COSEMS) from the country's 26 states, or by the Brazilian Public Health Association (Abrasco) and its sister organizations at the state levels, in national and regional meetings on basic care, and in publications in *Public Health*, just to provide an overall idea of the size of such research output.

Our first observation is thus that the difference in the use of the terms PHC and BHC is more than a semantic issue. Rather, it reflects the dispute between different projects vying for the SUS. We thus acknowledge the resulting limitations of the authors' respective vantage points, highlighting the advantages and disadvantages of a contextualized reading.

### **Second note: the mismatch between the policy's formulation and its actual implementation, or when the centralization and complexity of the policy's formulation become a problem**

A striking characteristic of the development of the basic health care project in recent years was its growing complexity and the generous and ambitious guidelines of the PNAB and the Brazilian National Policy for Humanization of the SUS (PNH) <sup>44</sup>, the key aspiration of which, in our view, is for basic health care to function as the center for communication and regulation of the country's health care networks. This means distancing itself from everything reminiscent of primary health care and its targeting of poor and vulnerable groups, while adding more and more attributions and attributes, with increasing details in the ideal functioning of basic health care.

This complexification has produced an unexpected paradoxical effect, sometimes unnoticed and not always discussed publicly: a distancing or decoupling from the policy as an ideal formulation in comparison to the real world of the teams and the production of care, in the daily and direct contact with users and their needs.

At first glance this complexification of the basic health care policy formulation might be seen as positive, except that it runs into at least two factors that undermine its power.

The first is that the basic health care policy appears to overlook the diversity of Brazil's 5,570 municipalities (counties). Some 73% of these have fewer than 20,000 inhabitants, some with huge gaps in health care infrastructure, with all different types of resource constraints, including the size and diversity of their local management teams. These local teams also lack the necessary backing from the State Health Secretariats, consumed by the management of specialized hospital and outpatient services and incapable of assuming the coordination of regional health systems or providing technical support to the municipalities, particularly the smaller ones. At most, they have the support of the COSEMS, who are unable to effectively and regularly respond to the needs and difficulties of the small municipalities. This appears to be a relevant point in the debate on the difficulties in effectively implementing a basic health care network <sup>45,46</sup>.

Another complicating factor, related to the first, is that the Brazilian Ministry of Health operates according to a logic of normalization, standardization, and homogenization that it is apparently unable to overcome. This logic has been justified by such ideas as "there is only one SUS," or "without guidelines, the municipalities would end up reproducing the hegemonic medical model and only offer medical appointments," among other "arguments". We believe that this fact could be called the Brazilian Ministry of Health's failure to produce "a unique management project", capable of dialoguing with local and regional specificities.

The fact that is through its staff, the Brazilian Ministry of Health acknowledges diversity in its discourse, but operates in fact with the homogenizing logic, making use mainly of financing rules with strong inductive power, aimed at inducing local health practices all across Brazil, or from "Oiapoque to Chui" as Brazilians say, from São Paulo, with its 12 million inhabitants, to the small riverine communities in the Amazon.

Reproducing or updating the old public health maxim of "normative centralization and executive decentralization", the underlying fear in this centralizing logic appears to be the following: what would happen if the Ministry of Health or the tripartite central management bodies failed to back the field of a "should be" as homogeneous as possible for the entire country as a guarantee for building a truly national SUS? What would happen if every municipality acted on its own, with minimal central guidance?

Implicitly (and sometimes explicitly) there appears to be an assumption that it would be virtually inevitable for municipal (local) administrators to become "hostage" both to highly specific local interests and to workers' self-government and their vested interests, or even to the triumph of the biomedical model and the interests of the medical-industrial complex.

We think that this concept of over-centralization of policymaking could be challenged by a counter-question: what actually happens in Brazil's immense, complex, heterogeneous network of basic care in terms of fulfilling the PNAB and hundreds of other Brazilian Ministry of Health policies (and those of the State Health Secretariats, which follow the same logic), such as the PNH and the Health Care Networks, to cite just two examples?

What happens in the health teams' daily practice of the progressive and generous conceptualization of such as arrangements as reception (acolhimento), referral/counter-referral, and expanded person-centered clinical practice, challenging the teams to conceive health as a step-by-difficult-step journey on the path of life?

Can assessment tools with top-down logic capture the infinite movements of creation, transcreation, and translation, but also of denial, pettiness, and impoverishment of the Policy (with a capital P)?

Even the Brazilian National Program to Improve Access and Quality in Basic Care (PMAQ-AB)<sup>47</sup>, which could be considered the most complete and ambitious assessment tool for the PNAB, ends up suffering from the same excessive complexity of the policy that it intends to assess, thus resulting in its difficult operationalization and sustainability, among other problems.

Meanwhile, the complexification bias in the political project for basic health care could be seen as positive by providing technical and political support for policymakers and workers committed to the defense of the SUS and to improving care. Thus, the official policy's complexity and generosity in some way back the experiences of cities that worked the PNAB proposals to the limit, signaling how far the necessary changes can go, challenging the limits and problems in all their complexity.

Likewise, while the strides made in larger and more highly developed cities cannot be extrapolated to Brazil as a whole, there are many small communities where "what works like the SUS" is exactly basic health care, and it would be no overstatement to say that the policy's guidelines would act as a kind of signal for more caring practices, making the basic health care network a territory for the defense of citizens' rights.

We wish to summarize this note with several questions: would it be possible to simplify the PNAB guidelines without losing the intended quality? What would it mean to review the municipal financing policy, expanding the share of federal/state transfers based on demographic criteria (and local/regional needs) and no longer on program-centered packages?

### **Third note: the difficulty in overcoming the isolation of basic health care and its peripheral position in the national health system**

Much progress has been made in formulating a more central position for basic health care in the SUS, always from the perspective of health care's continuity and comprehensiveness. Basic health care as the backbone for care and the center of communication with the health system is the clearest expression of such a proposal.

The manner in which the Brazilian Ministry of Health has dealt with the proposal to build health care networks in recent years has never failed to use basic health care as the beginning and end of the process. Just as the discussion of policy proposals for specialized care, including the "More Specialties" proposals, which was eventually abandoned, all took basic health care as their point of departure.

The ambitious project for building a basic health care network with capillarity and quality would only be complete if it actually achieved a "tie-in" with the health system as a whole. We agree with Mello et al.<sup>32</sup> (p. 201) when they say:

*"The consequences of Brazil's harsh social inequality logically extend to the health system, such that basic care in the SUS is prioritized for the economically underprivileged classes. This in itself is not a problem. On the contrary, it is precisely an option related to the system's equity in the search to offer access to the vast majority of the population. However, it becomes conceptually relevant when basic care is viewed by some as 'medicine for the poor', or when the other technological levels [of care] are not organized according to the same equitable principles. In this case, the policies tend to focus mainly on the system's 'coverage', that is, they remained targeted, especially on extending access to that poor population, but without involving the proper technological consideration, thus reinforcing the class nature associated with the conceptualization of primary health care".*

Magalhães Junior & Pinto <sup>48</sup>, with data from the first wave of the PMAQ-AB (completed in 2012), show that basic health care has still not succeeded in acting as the coordinator of care:

*“The PMAQ also asked health professionals in basic care how often they contacted colleagues in specialized care to exchange information related to patient care. Only 15% said they ‘always’ contacted the specialists. Another 52% said ‘sometimes’, while no fewer than 33% said ‘never’. When the same basic health care professionals were asked the other way around, that is, how often the specialists initiated the communication with them, the figures were even worse: ‘always’ dropped to only 6%, ‘sometimes’ reached 42%, and ‘never’ was more than half, at 52%”* <sup>48</sup> (p. 22).

What types of arrangements would be possible and necessary for a more systemic coordination of care, combining the strengthening of local micro-regulatory processes in each basic health unit with the work of central levels of regulation and control? In other words, what is the best path from the current situation, with extremely low coordinating capacity, to better preparation for this indispensable role of basic health care as the center of communication and coordination?

In other words, what strategies can promote the transition from the current situation, with a largely marginal position for basic care, functionally disconnected from the equipment with higher technological density in the SUS, to its projected capacity to promote more comprehensive and longitudinal care, thus finally fulfilling its great promise in the Health Reform project?

It does no good to keep repeating the mantra that “basic health care should be the coordinator of care” if no objective strategies are created to overcome the fact that today basic health care lacks the material and symbolic conditions to act as the center of communication between the various points in the complex networks of care <sup>37</sup>.

A recent study at Federal University of São Paulo (Unifesp) highlighted what was called users’ “maps of care”, that is, the set of points in the public and private health systems, whether services and/or professionals, that people turn to when they need care. In short, the study showed how people creatively assemble, by trial and error, their own “mini-health systems” in the formal health systems’ interstices, whether public or private, and that are not merely miniature reproductions of the SUS’s functional logic <sup>49</sup>.

A better and more attuned understanding of people’s maps of care by the basic health care teams could help acknowledge and value these micro-movements of tying basic health care into the system, ultimately resulting in multiple networks of care that are invisible to policymakers.

In our opinion, some initiatives could increase the regulatory and functional capacity of basic health care as the center of communication and coordination of care in the health system. The first such initiative would be to strengthen local micro-regulatory mechanisms, giving the teams more autonomy and case-resolving capacity <sup>34,50</sup>. Another initiative would be to create local and regional regulatory levels with representatives of basic health care and specialized public services, users’ representatives, and when appropriate, private providers. Such regulatory levels would act regularly as technical chambers, an innovate health management instrument. Ideally, the initiative would adopt elements of continuing education to train members of this regulatory level, always based on “case studies” of users’ difficulties in obtaining comprehensive care. The third and last initiative would be to incorporate into the teams’ work routine an ear for and recognition of users’ maps of care, as discussed previously, to seek to improve formal governmental regulation, based on the recognition of the real flows used and produced by health workers and users.

#### **Fourth note: the challenge of producing a new kind of health worker**

Almost every discussion on the difficulties in implementing high-quality basic health care with case-resolving capacity concludes that there is a shortage of workers with the necessary “profile” and professional qualifications to implement the health policy as it was conceived.

Physicians appear to constantly update the biomedical model, but we could also cite the municipal coordinators and local administrators that rarely succeeded in mediating (that is, “translating”) the grand Policy with a capital p to the teams’ daily realities. Nurses also frequently have difficulty in reinventing their practices in basic health care, and dentists tend to insist on individual curative practices in their offices, as do psychologists, etc.

The SUS's twofold challenge has always been to build the policy while simultaneously building the actors for the policy, as if there were always a shortage of actors for the policy, at least as it is conceived in all its complexity. And we never cease to idealize a "moral worker", the one who would be like a blank sheet on which it would be possible to print the policy guidelines<sup>51</sup>. The proposed solution is almost always training, training, and more training, or the dreamed-of curricular reform and training of the health professional of the system's dreams, a daunting task despite the investments and strides made in recent years.

But what is to be done in the meantime? We believe that in recent years the Brazilian Ministry of Health has pointed to some interesting paths for intervention, such as continuing education in health services, more participatory management models (anchored in the idea of shared management), and the highly innovative idea of the "supporters", who have both therapeutic and pedagogical responsibilities with the teams. These aspects of the policy deserve a more in-depth analysis.

The main difficulty in such proposals (effective practices in shared management, continuing education, and support) is precisely the lack of professionals prepared to implement them. In other words, the SUS needs to produce actors (or trainers) to produce the actors that will produce the new policy!

Such a process takes time and requires extensive investment. These wagers, with a clearly emancipatory inspiration and counter-hegemonic to traditional management practices, are unfortunately far from being consolidated as a real management alternative. Meanwhile, the more functionalist and functionalizing proposals are constantly defending their own management concepts in the SUS, in this public policymaking arena involving permanent struggle between competing meanings.

## Final remarks

The completion of our essay coincided with the publication of Brazil's new PNAB<sup>52</sup> in September 2017, which consolidates some of the provisions established since 2011, incorporates references used by the Brazilian Ministry of Health, and makes other significant changes. However, it maintains the extensive, homogenizing, and prescriptive characteristics of health services and care, although under the aegis of recommendations.

There is also an evident emphasis on two dimensions that are not duly covered in the PNAB 2011: the organization of the basic care component in the Health Care Network and the relationship between basic care and health surveillance, expressed in the conceptual redefinition contained in the ruling. However, such themes are subsumed or limited to the prescription of measures for the organization of basic care, in a relationship outside the production of a living network and of traditional epidemiological surveillance.

A critical reading of the new PNAB points to three nebulous issues. The first is the regulation and valorization of the traditional basic care model through "Basic Care Teams" consisting of physicians, nurses, and nurse assistants or technicians, without the mandatory inclusion of community health workers. These teams can add to or replace the Family Health teams. Their composition can include a minimum workweek of ten hours per professional category, with a maximum of three professionals per category, adding up to at least 40 hours a week. The new rule may result in greater flexibilization of physicians' workdays, more fragmentation of the work process, and less interaction between users and the team, thus jeopardizing the coordination and continuity of care. Importantly, the recognition (i.e., financing) of the traditional basic care model reflects the old demand by administrators from medium and large municipalities in the more developed South and South of Brazil, where coverage of the FHS is low and there is resistance to conversion from the traditional basic care model to Family Health. Thus, if the expansion of funds for basic care happens, it may be concentrated in these municipalities and regions.

The second question is the end of mandatory coverage of community health workers for 100% of the population. Community health workers will only be required for vulnerable populations, based on criteria set by the municipal administrator. There will be no minimum number of community health workers per team. The territory and competencies of the community health workers and endemic disease control workers will be combined. These changes appear to involve greater autonomy and respect for local and regional diversity, while in fact they are being imposed through other kinds of



pressures: the expansion of budget spending by the municipalities without corresponding financial outlays by the state and federal levels of government based on regulation of the National Minimum Wage for community health workers and endemic disease control workers. Given Brazil's economic crisis, one can predict significant impacts on the coverage of community health workers/endemic diseases control workers under the new PNAB.

The third issue relates to the recommendation of two standards for basic care: essential and expanded care. Essential care means the "basic actions and procedures related to basic/essential conditions of access and quality in basic care". Expanded care means "strategic actions and procedures for promoting and achieving high levels of access and quality in basic care, considering local specificities, indicators, and parameters established in the health regions". What is intended with different standards of basic care? Is this linked to the movements under way, headed by the Health Minister himself, to expand the market for private clinics for the low-income population? And under the auspices of the Brazilian Ministry of Health and the Brazilian National Health Agency for Supplementary (which regulates private health insurance)<sup>53</sup>, the proposal is to create low-cost "affordable or low-income" health plans for broad segments of the population as a way to relieve the pressure on the SUS.

There are still no studies or estimates of this measure's potential impacts. Many of the users' "maps of care" clearly show that whenever Brazilians can, they try to assemble more comprehensive care by relying on a public-private mix, at least in the South and South, where private health plans are more common. Studies by Unifesp point to huge gaps in these "affordable" health plans: when the policyholders experience more serious health situations, the health plan simply abandons them to their own devices. That is, when people most need help, they end up turning to the public SUS<sup>54</sup>. Since basic health care has still not occupied its projected position as the coordinator of care, Brazilians circulate between the two subsystems (with no formal contacts to each other), where patients are increasingly left to manage their care on their own.

Meanwhile, the poorest segments of the population and the unemployed have virtually no possibility of purchasing a health plan, not even a "low-cost" plan, thus resulting in more inequity in the SUS. Therefore, the study's finding does not validate the privatizing hypothesis and cannot be used to justify the proposal for so-called affordable health plans.

Building a basic health care network is still a central element of Brazil's Health Reform project, a kind of benchmark for the necessary changes to build a universal public health care system capable of producing an alternative to the hegemonic medical model and its powerful link inside and outside the health sector, which would result in new ways of producing care and promoting life. This ambitious project would both produce a new type of health worker to operate the network and reform the functioning of the basic health care services network, aimed at a veritable revolution in the centralizing and normalizing paradigm that the Brazilian Ministry of Health has operated for decades.

That said, for basic health care to achieve a new level of functioning and inclusion in the health system requires three changes that would function synergistically: the production of a new health worker; testing of a new management paradigm in the Brazilian Ministry of Health; and a new design for the linkage between basic health care and the services network as a whole, guaranteeing a new type of leadership.

We see the ideal of a "new worker in the SUS" as even more challenging, as a change that would certainly have a greater impact on the health system's functioning. Experimentation with permanent education, adopted as a central strategy of the Brazilian Ministry of Health since the last decade, appears not to have yielded the expected results, at least on a national scale, for the reasons cited above, yet it is still a proposal we should struggle for and strengthen.

As for experimentation with a new management paradigm in the Brazilian Ministry of Health, we contend that it should be more decentralized, with assessment criteria that consider the diversity of Brazil's territory, no longer conditioning the transfer of budget funds to the adoption of "packages" of program activities, leaving it up to the local and regional levels to define their policies. The new paradigm should abandon once and for all the highly complex evaluation models that "consume energy and resources", like the PMAQ-AB, replacing them with simpler and more user-friendly evaluation tools, besides use of the results by the local teams, among other measures.

Much remains to be done to achieve a basic health care network to organize care and serve as the center of the system's communication. Strengthening local micro-regulatory processes is a necessary

strategy, but not sufficient in itself. One possibility would be the creation of more complex arrangements, involving different local and regional services and actors, along the lines of executive “working groups” whose strategy for management (and for training its members) would be continuing education based on specific situations/problems, which would identify people’s new paths and circuits within the health system, gradually transformed into new forms of linkage and continuity of care, where the main reference (but not the only one) would be the basic health care team.

Even assuming that other variables continue to move and influence this complex field (chronic underfinancing, a changing epidemiological profile, economic crisis and the population’s impoverishment, the emergence of “new users”, who are more alert and demanding, etc.), we contend, by way of conclusion, that these four notes should have a key place on the agenda for research, institutional intervention, and shared production of knowledge with all the actors involved in one way or another in the improvements and progress in basic health care in Brazil.

### Contributors

L. C. O. Cecilio was responsible for the essay’s conceptualization and collaborated with A. A. C. Reis in writing the article. A. A. C. Reis contributed to the critical revision of the intellectual content. L. C. O. Cecilio and A. A. C. Reis shared the approval of the final version for publication and are responsible for all aspects of the work, guaranteeing the precision and integrity of the entire text.

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## Resumo

*Consolidou-se no Brasil, nas últimas décadas, a proposta de criação de uma extensa rede de atenção básica à saúde como a principal porta de entrada para um sistema público de saúde universal. Partindo do reconhecimento dos consistentes avanços conseguidos em tal direção, o presente artigo apresenta quatro apontamentos sobre alguns desafios para a consolidação de tal projeto: (1) por que adotar “atenção básica em saúde” em contraposição ao uso hegemônico e consagrado de “atenção primária em saúde?”; (2) a disjunção ou o descompasso entre a formulação da política e sua implementação real, o que aponta para a necessária revisão do processo de formulação da Política Nacional de Atenção Básica (PNAB), centralizado e definidor de regras, rotinas e lógicas padronizadas para todo o país sem considerar suas dimensões continentais, a heterogeneidade e grande diversidade de municípios; (3) o isolamento da atenção básica à saúde e sua inserção periférica em relação ao sistema de saúde, o que aponta para a necessidade de arranjos de coordenação do cuidado mais complexos, que não fiquem sob ordenação e responsabilidade apenas da atenção básica à saúde; e (4) a insuficiência de gestores, gerentes e trabalhadores preparados e aderidos a um projeto transformador do modelo assistencial vigente no nosso país.*

*Atenção Primária à Saúde; Estratégia Saúde da família; Sistemas de Saúde; Formulação de Políticas*

## Resumen

*Se ha consolidado en Brasil, en las últimas décadas, la propuesta de creación de una extensa red de atención básica a la salud, como la principal puerta de entrada hacia un sistema público de salud universal. Partiendo del reconocimiento de los consistentes avances conseguidos en tal dirección, el presente artículo presenta cuatro apuntes sobre algunos desafíos para la consolidación de tal proyecto: (1) ¿por qué adoptar “atención básica en salud” en contraposición al uso hegemónico y consagrado de “atención primaria en salud?”; (2) la desconexión o descompás entre la formulación de la política y su implementación real, lo que apunta a la necesaria revisión del proceso de formulación de la Política Nacional de Atención Básica (PNAB), que está centralizado y define reglas, rutinas y lógicas estandarizadas para todo el país, sin considerar sus dimensiones continentales, la heterogeneidad y gran diversidad de municipios; (3) el aislamiento de la atención básica a la salud y su inclusión periférica, en relación con el sistema de salud, lo que apunta a la necesidad de marcos de coordinación sobre los cuidados a la salud más complejos, que no estén bajo la ordenación y responsabilidad solamente de la atención básica a la salud; (4) la insuficiencia de gestores, gerentes y trabajadores preparados y adheridos a un proyecto transformador del modelo asistencial vigente en nuestro país.*

*Atención Primaria de Salud; Estrategia de Salud Familiar; Sistemas de Salud; Formulação de Políticas*

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