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New funding for a new Brazilian primary health care

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Abstract---Primary Care has been one of the bases of Brazilian medical care for offering Brazilian citizens more access to complex levels of care in order to prevent and treat various diseases. From there, it seeks to promote more well-being for everyone, without distinction. For the above, the general objective is to carry out a systematic review regarding the new financing policy for Primary Health Care (PHC). The new model began in 2019 with the launch of a new policy aimed at PHC in the Unified Health System (SUS), entitled Previnhe Brasil. This policy introduced significant changes in relation

to the financing of PHC to municipalities. The research method adopted to achieve the proposed objective was the systematic review, as it is a type of review that combines the results of multiple primary studies (with the same design) related to a specific problem. It is an important part of the process of creating and organizing a body of literature, and should have the same levels of clarity, rigor and replication as primary research. It was concluded that the new PHC financing policy in Brazil signals the important strengthening of attributes, in addition to making the SUS principles more effective in terms of universality and equity.

Keywords---primary health care, unified health system, health equity.

Introduction

In Brazil, the health system is characterized as institutionally pluralistic, financing and the mode of health care, having as main access by the Brazilian population, the Unified Health System (SUS). With the promulgation of the Federal Constitution of 1988, the right to health began to be guaranteed to all Brazilians¹. Access to medicines is an essential component of social inclusion and, consequently, of the search for equity and strengthening of the Unified Health System (SUS). This means that policies are needed to ensure these constitutional rights¹.

Public health has its action focused on public and social interests, centered based on the perspective of the State considering its forms of social and political organization of citizens¹. In this context, it is understood that public health is the act of applying medical knowledge in order to structure health systems and services¹. In addition, it is a sector that has its conditioning and determining actions in the health/disease binomial, aiming to control the emergence of diseases in populations through the execution of surveillance practices and government interventions^{1,2}.

The definition of public health integrates the search for the complete physical, psychological and social well-being of the entire population. But, on the other hand, the institutions that continue to be currently the competence of the public authorities is the SUS, which aims to establish a public and egalitarian health system^{1,2}. The SUS was created with the capacity to deal with all health actions, whether in primary care or health promotion of all Brazilian citizens, as well as in curative actions essential to rehabilitation².

The implementation of the SUS has established as a great challenge for health professionals, managers and society as a whole. The decentralization of health decision-making processes has allowed a better visualization of the problems to be faced, as well as the possibilities and limits of interventions. The search for an innovative care model gains practical meaning in the effort to respond to concrete needs^{1,3}.

The process of decentralization of the management of the health system faces probabilities and challenges that must be taken in solidarity, and each manager must have decisive actions in overcoming the challenges and consolidating this system that, committed to the specific needs of each Brazilian locality, should always seek the construction of a more democratic society³.

One of the ways to build a more democratic society, in the health dimension, is through the SUS, because it is one of the greatest examples of policy promoting social inclusion in the country and in the world. The assumptions and principles of the SUS define the universal access of citizens, the integrality of health care and social control. Since it was created through CRFB/88 it has been a system that has been promoting significant expansion in the volume of services and actions offered to the population with the expansion of its coverage throughout Brazil⁴.

It was due to the expansion of the SUS that the need to expand services arose, in addition to making them more problem-effective, efficient, qualifying actions for an improvement in the health profile³. According to these authors, the concern with quality in SUS services was present in Primary Health Care, which was given primary care, terminology used in the country to define the preferred gateway to access to the public health system ^{1,2,3}.

It was only in the CRFB (1988) that the SUS becomes a legal basis and, from then on, health in Brazil becomes a duty of the State and a right of all Brazilian citizens. The principles of the SUS establish the basis for the comprehensive approach to health in the country, however, it has focused on the organization of disease care services². This procedure can lead to the financial unfeasibility of the system by the incorporation and use of technologies that are not guided by epidemiological criteria, being more sensitive to market injunctions⁵.

The increased flow of resources to health services, as they are constituted, has little impact on the health status of the population since the resources provided to satisfy the incorporation and expansion of technologies independent of epidemiological and evaluative notes⁵. The SUS should represent for Brazil a policy that gives the entirety to professional practices in health, guided by a legal and normative greatness that determines the philosophical and operational bases. In this sense, the SUS should then facilitate and enable the universal access of citizens to health actions and services, however, it faces difficulties related to insufficient financial resources in the face of the demands presented and the lack of organization of states and municipalities for the implementation of regionally hierarchical actions ^{2,3,5}.

In view of the context presented, it is noted that public health in Brazil is of great relevance in the promotion and recovery of community health, as well as in epidemiological profilaxia, hospitals, basic sanitation, health posts, among others. However, the capacity of the SUS to provide decent care to the Brazilian population is quite precarious and, in Brazil, it is necessary that the health of most Brazilians scares from the performance of supplementary health, where it is funded by the users of the portfolios themselves and that, in this context, they deserve a quality service, even for the high amount that Brazilians pay for^{this 4}.

Prior to the Federal Constitution of 1988, in Brazil, the financing of the health system was carried out through the social security system through fiscal resources and curative health actions. However, with the promulgation of the Federal Constitution in 1988, it became established that 30% of the resources of the Social Security Budget should be linked to the scope of health. As a way to achieve this determination, they were reaffirmed by the Organic Health Laws, their precepts for the democratic health reform of the 1980s, defining, from then on, the participation of states and municipalities in the allocation of funds, administration of resources and the transfer of funds to fund^{4,5}.

With regard to the financing of the SUS, article 35 of Law 8080/1990 is written, which set the transfer of values to States, the Federal District and municipalities, through the combination of some requirements, such as the demographic profile of the region; epidemiological of the population that will be covered; qualitative and quantitative characteristics of the health network in the region; economic, technical and financial survey of the previous period; participation in state and municipal budgets; five-year investment plan; compensation for service performed in other spheres of government⁶.

Therefore, Law No. 8,142 of December 28, 1990 was created, which established the instruments for intergovernmental transfers of financial resources destined for health in Brazil and, thus, established a legislative framework aimed at financing the SUS. Three years later, in 1993, some advances in flexibility and autonomy to municipal managers⁵ were proposed by the Basic Operational Standard (NOB). Thus, the advances that occurred as a consequence of the consolidation of the SUS, NOB 01/964 signaled the need for a reorganization of the health care model in which each federated member is given its functions in this context, as well as management mechanisms and financing flows⁶.

Based on the foregoing, it was possible to gradually decrease the remuneration in relation to the production of services and expand transfers at the global level, deep into depth. With NOB 01/964, the Primary Care Floor (PAB) was established establishing the transfer of financial resources, regularly, to Primary Care, based on a per capita value, according to the criteria proposed by Law 8.080/80. In addition, it was observed in NOB 01/964, variation in the transfer of resources via the Primary Care Floor (PAB) and, therefore, the municipalities that were part of the Family Health Program (FHP) or the Community Health Agents Program (PACS) began to receive an additional resource integrated into the PAB. When determined by the fixed and variable PAB (fixed in per capita and variable value according to the participation of specific programs), a set of services focused on PHC 6 was^{defined}.

What is noted is that the NOB published by the Ministry of Health (MS) directed the transfer of federal financial resources to the states and municipalities, giving them progressive responsibility for the management of the health system in the regional and local spheres. Thus, in view of the decentralization of the Brazilian health system, the Ministry of Health assumed a strategic role in the development of public health policies and financial incentives, with the objective of implementing health programs, especially with regard to PHC^{services 3,6}.

Based on the loco-regional results for PHC financing, the MS established in 1996, NOB-96. This NOB is aimed at making transfers to the municipalities, so that they implement programs of community health agents (PACS) and PsF. However, the PAB was the most important, established in 1998, considered the initiative with the greatest relevance to encourage the expansion of PHC throughout Brazil^{6,7}. It is possible to realize that PHC still needs to go a long way to achieve greater extension to key indicators. These indicators are comprehensiveness, first contact access, coordination, longitudinality and coordination⁷. Not only does this, in addition to the indicators, also need to reach some derivatives that are family and community orientation, as well as cultural competence⁷.

In this quest to strengthen its attributes, it is essential that PHC be guided by a national policy with political decisions on changes in federal funding. In addition, it is also important to obtain a guarantee of financing that is in fact compatible with their attributions, income distribution instruments and federal resources, as well as the respective transfers to municipal entities⁷. To this do so, an adequate structuring is done to induce the achievement of better health results. Taking this contextualization into account, the new phC financing model is created, called the Prevent Brazil Program, through Ministerial Decree No. 2,979 of 2019, which establishes the cost of PHC through weighted training, payment for performance of the ESF teams and incentives for strategic and priority actions⁸. For the above, we seek this systematic review, to do a research on the new funding model for PHC that was approved on October 31, 2019, by the Tripartite Ordinance of the Intermanagers Commission and duly promulgated on November 12 of the same year, by Ministerial Ordinance No. 2,979.

Method

Type of study

The type of study chosen for this research was the systematic review, because it is a type of review that combines the results of multiple primary studies (with the same design) related to a specific problem. It is an important part of the process of creating and organizing a body of literature, and should have the same levels of clarity, rigor and replication of primary research. Systematic review can generate statistical analyses of data from studies that are part of the review.

For the preparation of the systematic review, it was necessary to follow the following steps: formulation and objective of the review; establishment of criteria for the inclusion of studies in the review and selection of samples; data collection through the revised papers; evaluation of the results; discussion and interpretation of the data; presentation of the results in a clear and broad manner.

When searching for the articles in the databases, it was adopted for the selection and evaluation, certain criteria previously established, which were the type of study, participants, the intervention adopted and the evaluation of the results. This systematic review aims to research the new funding model for PHC. Its construction was based on a search for scientific articles, divided into constructive stages, with identification of the theme and definition of the question

to be analyzed in the research, definition of inclusion and exclusion criteria that met the predefined search criteria.

Population and sample

The study population is indexed in the following databases: VHL that composes Lilacs and Scielo and Pubmed, and the sample of the present study consisted of articles indexed in them. For the survey of the articles, an online search was carried out in these databases, through the descriptors: Primary Health Care; Health Care Financing; Unified Health System; health equity.

Inclusion criteria

For this study, we included publications focused on themes related to the new funding model for PHC. Following this parameter, the inclusion criteria were:

- a) publications from January 2011 to April 2022;
- b) Publications in Portuguese;
- c) publications that are available in full and free of charge;
- d) Among these publications, articles, theses, dissertations and guidelines will be researched.

Exclusion criteria

The exclusion criteria for the survey of the material that constituted the sample were:

- a) publications prior to January 2016;
- b) foreign language publications;
- c) publications which are available only in the abstract;
- d) paid publications.

Impacts that new PHC funding can cause

In 2019, health in Brazil was marked by the prioritization of PHC with the creation of a secretariat focused exclusively on the scope of the Ministry of Health. However, the change caused in the PHC funding model introduced impacts on the SUS and on the health of the population, in general. These are important impacts to be identified and, consequently, monitored due to fiscal austerity that could worsen public underfunding for health ^{8,9}.

With this, the Prevent Brazil program emerges in order to replace the requirements applied in the fixed and variable PAB in relation to the financing of costing both PHC and SUS¹⁰. The substitution was made by inserting the number of individuals registered in the ESF and APS with registration in the MS, taking into account characteristics such as socioeconomic vulnerability, geographic location, demographic profile, payment for performance, goals defined financial incentives to the priority programmes of the MS^{7,8,9}.

The Prevent Brazil program does not make use of the capitation and performance evaluation to remunerate the services provided, but rather became criteria for the calculation of intergovernmental transfers in order to assist in the financing of local health systems, considering that the SUS is a decentralized system, having as payers of the services municipalities^{6,8,9}. This use of capitation and performance evaluation as criteria for performing the calculation of intergovernmental transfers can result in not very positive aspects¹¹. If used as a payment mechanism for health services, one can consider a benefit regarding capitation, customer enrollment, accountability for a given population and strengthening of and bonding in teams¹². The data and information that are collected through the registration of people allow their use to recognize the epidemiological profile, as well as the planning of the provision of health care^{12,13}. Added to the above, the capitation can also provide the user of the health service, the free choice to link or not to the service they want and, thus, be a great factor for competition between teams. As possible effects, the selection of patients is described through the creation of difficulties for the registration of individuals who make excessive use of the health system or treatments with high costs^{3,14,15}.

As noted, replacing per capita financing with capitation as a criterion for PHC financing in the SUS has a conditioning factor for the transfer of resources to PHC. First, PHC funding will no longer be universal, as it will be limited only to the population registered in the municipalities¹². In addition, when launching the program, initially, the Ministry of Health presented the number of people registered, which allows us to show, therefore, that the federal government does not have as its goal, to carry out the financing of PHC for the entire population of the country^{10,15}.

Secondly, the financing may depend on the effectiveness of the person's registration, a situation that is likely to vary substantially in Brazil¹³. In this context, municipalities in needy areas generally have greater management difficulties as to effect the registration of people, as well as more populated areas with large clusters, leading to greater complexity in this sense¹⁴. As a consequence, it will be observed the decrease of resources for PHC in places with great need, but that could not register its entire population^{10,16}.

Thirdly, there are possible impacts of the use of capitation as a financing instrument, because it can be directed to the management of the attention of municipalities to tell registered patients against the quality and scope of services or to determine barriers to the implementation of the registration of some population groups, which require care or have health problems with expensive treatments^{9,16}. Other impacts that the new funding of PHC in the SUS can cause are restrictions on access to health programs, decreased quality of services provided in PHC and the dismembering of patients at other levels of the health system^{11,12}.

Fourth, the impact that the new PHC funding can have is the reduction of the teams' attention to health issues not contemplated in the evaluation metrics^{14,16}. With this, the performance evaluation, when established as a constituent criterion of PHC financing in the SUS, may lead municipalities to devote greater attention to the monitored indicators and, from this, modify the scope of work of PHC

teams^{12,13,15}. As noted, it is possible that there may be a compromise of the scope of the services provided in PHC due to the role of the new policy, by failing to finance teams of the Family Health Support Center (NASF), which dedicate their performance as of great importance to increase, increasingly, the problem-control competence of PHC and its participation in health networks.

Final Considerations

Based on the review, it can be seen that the criterion of capitation and performance evaluation to serve as a calculation for intergovernmental transfers is shown to be more to meet restrictive interests than, in fact, the qualification of services, limiting the universality on one side and, on the other, amplifying distortions in financing and inducing the focus on the actions of PHC in the SUS.

In another perspective, the budgetary constraint may substantially aggravate public underfunding of health and, in this case, the Prevent Brazil program can significantly help to reverse the achievements that have occurred throughout history in relation to the reduction of health inequalities, observed since the creation of the SUS and the ESF. However, it can also be understood as a proposal of the novo financing model of PHC, as an objective, strengthen the attributions of PHC and realize the principles of Universality and Equity of the SUS. To this end, it should offer municipalities and teams greater federal financial transfers, as well as an incentive to better work in favor of the health of the population, moving towards a provision of public services capable of meeting the needs of the entire Brazilian population.

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