DOI: 10.1590/1413-81232018249.18612019

Creation of the Primary Health Care Secretariat and its implications for SUS

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Abstract *On May 20, 2019, one day after the world's celebration of the Family Physician's Day, the Ministry of Health published Decree N. 9,795 of May 17, 2019, which changed the organization chart of this federal body. For the first time in the country's history, a specific Secretariat responsible for Primary Health Care and the Family Health Strategy (ESF) was created. The ESF celebrated its 25th anniversary in 2019. The new Primary Health Care Secretariat (SAPS) has three departments: the already existing Department of Strategic Programmatic Actions (DAPES), a Department of Family Health (DESF) and a new Department of Health Promotion (DPS). The Secretariat has, among its competencies, commitments that seek to meet structural challenges, even in the face of a budget constraint scenario that has been observed since 2014. Among the commitments are: (i) increasing the population's access to family health units , (ii) definition of a new funding model based on health and efficiency results, (iii) definition of a new model for the provision and training of physicians for remote areas, (iv) strengthening of clinic and teamwork, v) expansion of the computerization of units and electronic medical records.*

Key words *Primary health care, Family health strategy, Organizational innovation, Ministry of Health, Brazil*

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Introduction

Since 1994, federal support for the funding of Family Health Teams has been permanent year after year, which allowed the countryto reach a total of 42,064 teams implemented in 5,506 municipalities and the Federal District in April 2019, after 25 years

Throughout this period, the Ministry of Health has consolidated dozens of Ordinances and structured the National Policy for Primary Care (PNAB) in March 2006[1], subsequently revising it twice, in 2011 and 2017. The PNAB redefined a set of actions at the individual and collective levels, covering health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation and health maintenance.

To address the challenges brought onby primary health care, the number 1 priority of the Ministry of Health (MH), on May 20, 2019, one day after the worldwide celebration of the"Family Physician's Day", this federal agency published Decree N. 9,795 of May 17, 2019[2], which changed the then-existing organizational chart of this federal agency.

For the first time in the country's history, a Secretariat in chargeof Primary Health Care and the Family Health Strategy was created, which also turned 25 in 2019. The structure of the new Primary Health Care Secretariat (SAPS) includes three departments: the already existing Department of Strategic Programmatic Actions (DAPES), a Family Health Department (DSF), and a new Health Promotion Department (DPS) (Figure 1).

Thus, Primary Health Care, by acquiring the institutional status of Secretariat in the ministerial structure, gained strength by receiving a greater role in the decision chain of the Ministry of Health, as well as greater significance in the internal discussions on budget allocation from the amount of resources of the Ministry of Health, adding potential for the reproducibility of the structure between the state and municipal entities.

As of 2019, new challenges regarding the budget constraints observed in the Ministry of Health since 2014 raised some issues that started to be considered by federal managers, related to: (i) increasing the population's access to family health units (ii) definition of a new funding model for primary health care, based on health outcomes and efficiency,(iii) definition of a new model for the provision and training of doctors for the most remote areas of the country, including the definition of a medical career in Primary Health Care (PHC); (iv) strengthening of the clinic and teamwork in Family Health Strategy, (v) expansion of computerization of family health units (FHUs) (family health centers and units) for electronic individual records in health files and extensive use of data from these records for management improvement.

Increase of the population's access to family health units

The MH Ordinance N. 930 of May 15, 2019[3], which provides for extended operating hours in family health units, will allow the increase of the population's access to primary health care services by increasing federal funding for municipalities that adhere to this Program.Moreover, it will support local managers wishing to transform mixed units, emergency care and hospitals with very few beds into family health units (during the day shift). Thus, the Ministry of Health will start to provide new resources to those FHUs that operate for 60h or 75h a week, and offer a mandatory set of actions and procedures, in addition to agreeing to a set of electronic data, both administrative and clinical, of the followed patients, aiming to carry out regular monitoring associated with the financial transfers.Therefore, the proposal aims to increase access in a more timely and convenient manner for the citizens, by providing care in the same environment where they are routinelytreated, even when outside business hours, while ensuring twice the funding for managers to achieve the expected health outcomes, such as ensuring the provision of essential full-time actions and services, bringingthe Brazilianhealth system closer to the best ones in the world.

Defining a new funding model for primary health care

Twenty years after the creation of the fixed and variable PAB by the Ministry of Health, it is necessary to rethink the funding of primary health care. This model was important to stimulate increased coverage of the Brazilian PHC, but it has reached its limit. To date, the MS only funds the existence of PHC teams, with no reflections on their accountability or resolutivity. The main limitations of the Fixed PAB refer to the logic of *per capita* payment with no link to clinical responsibility, passed on according to the population estimated by IBGE and updated by the General Accounting Officefor purposes of transfer of the Municipal Participation Fund.

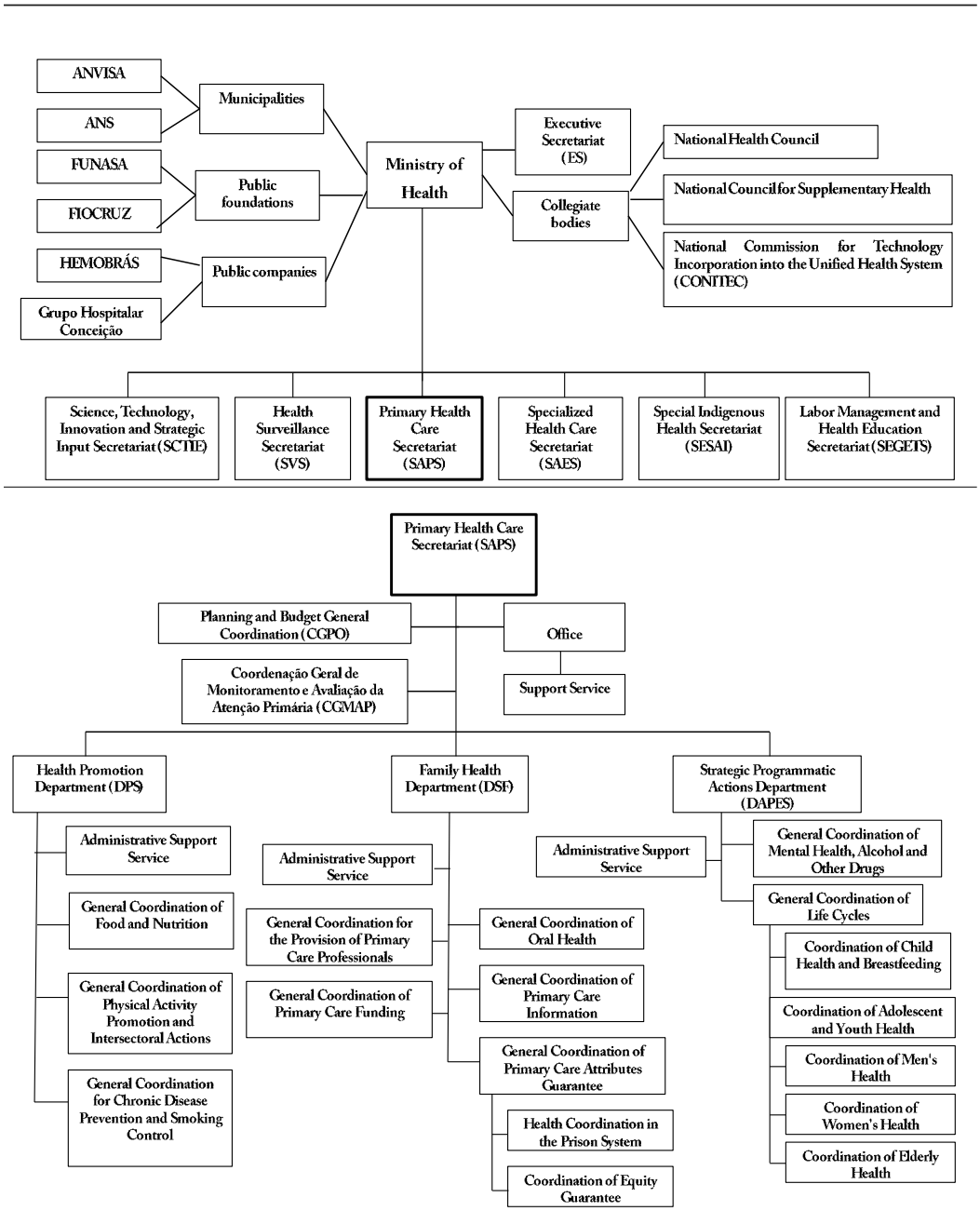

Figure 1. Ministry of Health Organization Chart and details of the new Primary Health Care Secretariat (SAPS) – 2019.

This model does not consider the population effectively covered by the PHC teams, nor does it consider values per more vulnerable individuals. In turn, the variable PAB is passed on according toadherence to strategies that measure more aspects of the installed capacity (such as the number of implemented family health teams and the population with potential coverage) than health outcomes.Among the factors that contribute to the maintenance of a model that gives little value

to the capitation and accountability of teams and managers is the lack of individualized information for decision-making at all three managementlevels: municipal, state and federal. To date, the so-called "population coverage of individuals with primary care" does not, in fact, consider the individual record of each person in the calculation of this indicator, thus characterizing what we might call "potential coverage", as the Ministry of Health considers an approximate calculation of one Family Health team for an average of 3,450 inhabitants.Despite countless initiatives to organize cadastral databases, people with more than one national health card can still be found, for instance. The recent publication of Decree N. 9,723, of March 11, 2019[4], which established the Social Security number (CPF, from the Portuguese *Cadastro de Pessoas Físicas*) as a sufficient and unique identification number that substitutesseveral identification documents, constitutes another advance of the current government in the attempt to reduce the duplicate and invalid records found today in most individual files of family health teams. Some countries in Europe historically carry out the so-called "duplicate list management" each year in PHC, when they clear and qualify user lists so that each healthcare team knows more precisely the number of people under their responsibility.

Considering the abovementioned facts, one of the proposed indicators for the new PHC funding will take into consideration the payment fora single individual registration of an allocatedperson and assigned to the team, without being duplicated, adding to its validation criticism, by verifying the CPF number. This registration is crucial for the adequate calculation of both primary care coverage and a range of other indicators, of which denominators are based on the variables "gender", "age group" and "social vulnerability".

Moreover, this model will allow a more stringent monitoring of the results obtained by each Family Health team against the main health problems, allowing the payment per performance of each clinical goalachieved.

One must not forget the guideline of "equity", as stated in Complementary Law N. 141/2012[5]. The new funding model will aim, on the one hand, to consider some health situations and population age groups when defining the model's capitation component, whereas, on the other, will seek to maintain financial incentives for existing specific programs and new incentives to reduce regional inequalities,meeting the apportionment criteria required by Law 141 seven years after its promulgation.

Defining a new model for the provision and training of doctors for the most remote areas of the country, including the definition of a medical career in Primary Health Care

A new federal model for the provision and training of doctors for the most remote areas of the country will be proposed as a gradual replacement for the *Mais Médicos* Program, giving free will to the professionals, decreasing physician turnover and the need for foreign professionals. This Program will be submitted to the National Congress[6] and the set of directly involved actors, in order to qualify the debate with society and managers about the tripartite responsibility regarding the guarantee of medical care in Primary Health Care, as well as the training of medical professionals with the necessary skills and competencies to work in PHC.

Associated with the medical employment model, the strategy will also comprise a training axis of family and community medicine specialists that will ensure career progression, periodic supervision in service for all medical professionals, and clinical quality and population accountability required for PHC. The creation of this strategy will include in its scope a medical provision axis based on the model of federal employment of physicians for PHC - directed only to those locations of "deep Brazil" to areas where it is more difficult to keep the professionals, according to the criteria for defining municipal vulnerability established by the country's official geography and statistics agency (IBGE urban and rural typologies[7]), as well as social vulnerability criteria of each citizen assisted by PHC (such as the recipients of social programs such as "Bolsa Familia", "Benefício de Prestação Continuada", among others).

Strengthening of the Clinic and Teamwork in the Family Health Strategy and the Primary Health Care Service Portfolio

The strengthening of the clinic and teamwork in the Family Health Strategy involves the acknowledgement by federated entities of the importance of PHC for the organization of services. For that purpose, in addition to the physical infrastructure of Family Health Units, it is necessary to provide working conditions and a clear division, with the subsidiarity of the attributions of each of

Ciência & Saúde Coletiva, 24(9):3457-3462, 2019

the professionals based on the actions and procedures offered to the population, with no harm to the care processes shared among the professionals. In this sense, the creation of a "primary health care service portfolio" may help define the roles that each one should play, as well as direct the essential services and procedures to be performed in this care environment, reducing the wide variability of existing offers in the national PHC between the municipalities, but also between units of the same municipality. Moreover, there is the funding of the PHC professional manager to allow the teams to improve clinical management, the monitoring of priority patients and improvement of organizational arrangements, the monitoring of core indicators, and the management of team inputs. The teamwork organization will assist in the development of the primary health care attributes, especially the coordination of care.

Expansion of the computerization of Family Health Units

The expansion of computerization of the Family Health Units is the first step towards the establishment of an adequate physical and logical infrastructure for the electronic transmission of data from users treated at the units. From this perspective, one of the goals advocated by the Ministry of Health is to continue to improve the model of electronic medical records specific for PHC, which has been in development since 2012. It aims, through a community of professionals and institutions, to maintain a continuous strategy for the development and improvement of the electronic information model, and its subsidiary clinical functionalities, to allow the integration of the entire clinical trajectory of patients, improving the clinical management process, especially in priority cases. For this purpose, a specific fund-to-fund subvention for each Family Health team will allow each municipality to choose the technology solution that best fits their reality and the SAPS mandatory data model. In order to allow a cost-effective solution for the most economically and administratively vulnerable municipalities, the MS will continue to develop the current software, transforming it into an eSUS-PHC with a clear and public definition of the features to be developed, including the participation of partner municipalities in defining the priorities within the scope.

At the same time, it will allow and stimulate the development of innovations by private entities and their subsequent implementation by public entities. Improvements already planned in the data and information dissemination model will allow for better monitoring of health indicators in all government spheres, leading to an important depuration of the databases, a continuous process of data quality assessment and direct linking of users to the teams, which is crucial for the monitoring of health indicators to more closely represent the local reality.

Limits and challenges

One of the biggest challenges for primary care is the increase of the population's access to health services, as well as the implementation and funding of a PHC model that is guided by the essential attributes of PHC: first contact access, longitudinality, integrality, and care coordination. In this sense, the establishment of an indicator baseline and subsequent monitoring becomes necessary to verify which model we are starting from and how the abovementioned agendas and strategies will bring the changes.Therefore, among the new planned strategies is a partnership with IBGE along with with the National Health Survey - 2019, which will allow us to draw a baseline of PHC attributes for each federation unit, major regions and Brazil, so that, subsequently, its evolution can be compared. We are referring to the inclusion of the set of questions that comprise the instrument entitled "Primary Care Assessment Tool" (PCAT) in its shortened version for adults aged 18 years and older. This instrument has already been validated for Brazil and was a reference for the PHC evaluation process of the Ministry of Health itself until 2010[8].

Perspectives

Brazil has been going through a period of economic stagnation in recent years that bringshuge challenges to the Ministry of Health. However, before Health services can demand new resources, it is necessary to allocate the existing ones more efficiently. We advocate that Primary Health Care be the priority locus for the most efficient and effective allocation of health resources, in fact making it of the utmost importance[9] in the coordination of care for other levels of assistance, as did all countries with universal health systems in the world, which are currently able to display excellent health and quality of life indicators for their populations, with intersectoral actions and appreciating health promotion in healthy environments.

Collaborations

JG Reis, E Harzheim, MCA Nachif, JC Freitas, O D'Ávila, L Hauser, C Martins, LA Pedebos and LF Pinto participated in the writing of the manuscript. E. Harzheim made a critical revision of the manuscript. All authors approved the version to be published.

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Article submitted on 06/15/2019
Approved on 07/02/2019
Final version submitted on 07/04/2019