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National Primary Care Policy 2017: analysis of teams composition and national coverage of Family Health

Clarice Brito e Souza Gomes (https://orcid.org/0000-0001-7707-9050) [1]
Adriana Coser Gutiérrez (https://orcid.org/0000-0002-7305-5841) [1]
Daniel Soranz (https://orcid.org/0000-0002-7224-5854) [1]

Abstract *The Family Health Strategy is the main form of organization of the Brazilian health system. However, the third edition of the National Primary Health Care Policy (PNAB) recognized other types of teams financially. A time series study was conducted from 2007 to 2019 using data from the National Register of Health Facilities (CNES) of jobs, teams and national coverage of Family Health to analyze the effects of the 2017 National Primary Health Care Policy (PNAB) on team composition. We observed the concentration of doctors in the Southeast and Northeast and variation of this professional category before the events of the "Mais Médicos" (More Doctors) Program. The number of nurses increased 5% and Community Health Workers (ACS) dropped 0.3% in the country. Despite the authorization and funding for the implementation of "Primary Care" teams (eAB), they correspond to less than 1% of the total teams. It is noteworthy that the municipal managers' preferred mode is the traditional Family Health Teams, equivalent to 75% of the total and growing. While the questionings and expectations generated by the 2017 PNAB in the context of Primary Health Care, we can conclude that, regarding the teams and their compositions, no significant change was identified two years into its coming into force.*

Key words *National primary health care policy, Primary health care, Family health strategy*

[1] Escola Nacional de Saúde Pública, Fiocruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. britoclarice@yahoo.com.br

Introduction

The Family Health Program (PSF) was implemented in 1994 and improved in subsequent years as the Family Health Strategy (ESF), and is the main mechanism used to induce the expansion of Primary Health Care (PHC) coverage in Brazil[1-3]. Until 2006, PHC was regulated by several ordinances and rules published by the Ministry of Health (MS) to support the process of decentralizing the system through financial incentives to Brazilian municipalities and states.

Among these regulations, the Basic Operational Standard (NOB/SUS/96)[4] published in 1996 by the Ministry of Health stands out. It is a decisive initiative for the implantation of the PSF teams, which completely changed the financing rationale and allowed the greatest change in the care model seen so far[5]. Thus, with the implementation of the Level of Primary Care (fixed PAB and of incentives), the PSF started to have its own budget to enable its expansion in the country[6].

In 2006, the federal government published the first National Primary Health Care Policy (PNAB) to establish organizational guidelines, taking into account the principles proposed by the Pacts for Life, Advocating for the SUS and Management and the national expansion of the ESF, ratifying this model as a priority in conducting PHC[7].

Built from a solid scientific basis, the 2006 PNAB started an important discussion of the institutional organicity of the system in healthcare networks, by providing guiding recommendations for health services, for the work process, the composition of the teams, the attributions of the professional categories, and the financing of the system, among others[8].

Moreover, its text incorporated and disseminated in the country the PHC attributes defined by Starfield[9], such as: first contact; longitudinality; integrality; coordination; community orientation; centrality in the family and cultural competence.

Since its implementation, many studies have shown in many ways the benefits of Family Health to the Brazilian population[10-23], corroborating the international literature, which already pointed this path to the main universal health systems in 1920.

As an inherent part of the process of formulating public policies and based on the need to adapt to new services, coupled with the demand of the National Council of Municipal Health Secretaries[24], the PNAB underwent two revisions, in 2011 and 2017. We can observe that its three editions took place in different governments, characterized by different socioeconomic contexts, besides the several programs that spanned their validity period, and were incorporated into subsequent editions (Figure 1).

While it reaffirmed the guidelines of the previous edition, the 2011 edition eased the workload of the medical category, with the possibility of working for 20 or 30 hours a week to fill the shortage of these professionals in the teams[25].

The ESF for the riverside and fluvial population, the *Consultório na Rua* (Street Office) team, the Family Health Support Center (NASF), the School Health Program (PSE) and the *Academia da Saúde* (Health Gym) were recognized as important inclusions of this process of policy review to expand access and promote resolution of health care[26-30].

Some proposals after the second edition of the PNAB are worth remembering, such as the PHC Assessment Instrument (PCATool), the Access and Quality Improvement Program (PMAQ-AB), the *Requalifica UBS*, the Primary Care Professional Valuation Program (PROVAB) and the *Mais Médicos* (More Doctors) Program (PMM), to evaluate service, qualify the physical structure and the work process through educational offers, providing and fixing professionals, coupled with the institutional support of the Ministry of Health to the group of states and municipalities[30-33]. We understand that the sum of these initiatives represents what is called 'catalysts in the implementation of PNAB'.

In 2015, the review process of the new PNAB began, which, as already pointed out by Almeida et al.[34], was strongly marked by technical-political disputes between the Ministry of Health and the representative bodies of municipal and state health secretariats, and this period was characterized by the impeachment of the then President of the Republic Dilma Rousseff, in May 2016, and the consequent change in the composition of the Ministry of Health's directors, coupled with the deteriorated country's financial crisis and the significant health budget cuts, such as the Constitutional Amendment (EC) Nº 95.

However, on the one hand, the field of collective health led to uncountable manifestations on social networks to oppose to the mode and purpose for which the PNAB was being reviewed. A position contrary to the proposals was observed due to insufficient debate by analyzing part of these publications on websites, such as the Bra-

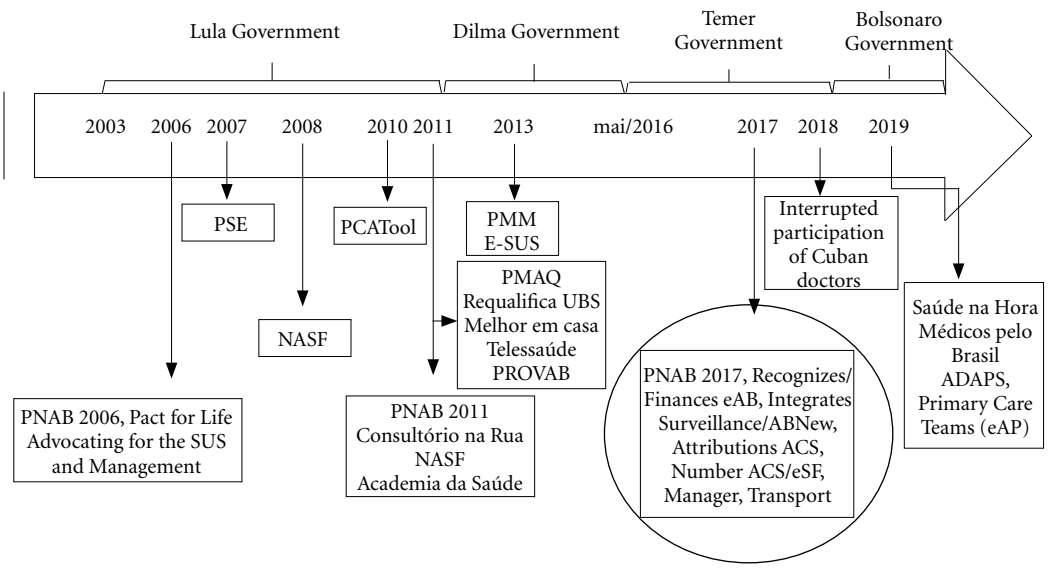

Figure 1. Timeline.

Source: Own elaboration.

zilian Association of Collective Health (Abrasco), Brazilian Center for Health Studies (Cebes), National Health Council (CNS), Confederation of Community Health Workers and Workers to Combat Endemics (Conacs), Federal Council of Nursing (Cofen) and Federal Council of Medicine (CFM). On the other hand, the National Council of Health Secretaries (Conass) and the National Council of Municipal Health Secretaries (Conasems) reaffirmed the need to reformulate the PNAB to adapt it to the health situation of regional realities[24,35-39].

The questioning to the third edition of the PNAB may have also been due to the content of its changes, which are against current guidelines, such as the recognition of the Primary Care teams (eAB) through financial incentives, the increased attributions of the Community Health Workers (ACS) and the change in their number (decrease) in the SF teams (eSF), as well as their integration with the ACE (Workers to Combat Endemics), and differentiated standards for health actions and services[40].

Subsequently, the interrupted agreement with the government of Cuba, the main partner of the PMM, generated concern in part of society regarding the continued access and the necessary increase in the coverage of PHC[41]. Faced with this scenario and after the presidential elections, the Ministry of Health issued a new call for vacancies.

Twenty-five years into the institutionalization of Family Health in Brazil, the Ministry of Health changed the organizational chart, and created the National Primary Health Care Secretariat (SAPS), the Family Health Department (DESF) and the new Health Promotion Department (DAPS)[42].

Another course change was the *Saúde na Hora Brasil* (Brazil Health on Time) Program, which provides financial incentives for the expanded opening hours of Family Health units to increase access in medium-sized and large cities[43].

Also in 2019, the Provisional measure that establishes the *Médicos pelo Brasil* (Doctors across Brazil) Program within the scope of PHC in the Unified Health System (SUS) was published, and authorizes the Federal Executive Branch to establish an autonomous social service, called the Agency for the Development of Primary Health Care (ADAPS)[44,45].

Finally, in September 2019, the Ministry of Health published the ordinance that extinguished the eAB and created the Primary Care teams (eAP), which should be composed at least by doctors, preferably Family and Community Medicine (FCM) specialists, and nurses, preferably Family Health specialists, besides prohibiting the replacement of eSFs by eAPs, under penalty of suspension of the transfer of financial incentives[46].

Although the recent proposals come with the promise of expanding access to Family Health units, as well as changing the financing model, provision and training of doctors for remote areas, team work strengthening, as well as a new portfolio of services, Abrasco[47] points to the possible alteration of some pillars that had been favoring institutional stability and the achievement of good health results in the country.

However, in view of the successive changes mentioned, the new government's only argument left is to discuss the effects of the 2017 PNAB, and whether or not to review it. The question remains: in fact, has the desire of some secretaries to create other types of teams been applied? And, how much did this option change the composition of the teams?

This paper aims to show the practical effects of the 2017 PNAB on the composition of the teams (eSF, eAB and EACS) and the impact on their professional staff.

Methods

This is a nationwide time series study (2007 to 2019), using data from the National Register of Health Facilities (CNES) of the following variables: Human Resources (doctors, nurses and ACS), Care Network (eSF, EACS eAB) and Family Health national coverage.

In the analysis of CNES/MS, which provides information on "jobs" based on the Brazilian Classification of Occupations (CBO), December was used as the month of reference in the 2007-2018 period and, in 2019, August, last available reference until the closing of this paper.

Data were tabulated using Microsoft Office Excel software. The calculation of the coverage of registered users considered the average of 3,450 users per implanted eSF, the same reference used by the Ministry of Health, and the estimated population in the annual projections of the IBGE as the calculation basis for this study. The registration data from the Primary Care Information System (SIAB) and the Primary Care Health Information System (SISAB) were used to calculate the registered coverage.

During the survey of the types of teams at CNES, we found that several classifications and codifications subdivide them. As inclusion criteria, we selected teams that could undergo probable modifications due to the changes in the 2017 PNAB and the teams of *Consultório na Rua* (eCR), Nasf-AB, transitory, fluvial (eSFF) and riverside (eSFR) eSFs, as well as Primary Care teams from the prison system (eABP).

Thus, we aimed to relate the changes that occurred in the last edition of the policy to the behavior of PHC in the country, regarding the composition of the teams, in the care practice at the national level.

Regarding the Health Information System, it is recognized that, while the CNES is the main source of official data to extract the information that the study proposes, there may be inconsistencies regarding the feeding and updating of information on the platform.

Results

Next, the results are presented in order to provide an overview that considers the main variables that characterize the composition of the PHC teams, correlating them to the Timeline (Figure 1) shown in the Introduction.

In Table 1, when analyzing the data, one can highlight the interregional disparity in the distribution of 'Family Doctors' and 'Family and Community Doctors', in view of their greater concentration in the Southeast and Northeast regions of the country.

In 2007, the base year, 16,739 medical records were found in Brazil's total, a number that remained until 2012. In 2013, an increase of 4,000 is probably attributed to changes in the 2011 PNAB, which eased the workload of this professional category to face its eSF shortage.

In 2014, a new, significant increase for the period of almost 7,000 is observed, due to the *Mais Médicos* Program (PMM), established in October 2013, increasing the number of 'Family and Community' medical records to 27,484 in the SUS. Surprisingly, yearly increases of around 1,000 doctors were recorded in the following years, reaching 30,181 in 2017, the highest number recorded in history. In 2018, the cutback of 3,000 contracting relationships in the Family Health Strategy is noticeable with the interrup-

Table 1. Distribution of Doctors by Region (2007-2019) as per CBO 2002 – Brazil.

					PNAB		PMM			Interrupted participation of Cuban doctors			
Region	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
North	1,325	1,238	1,253	1,300	1,220	1,191	1,733	2,473	2,570	2,655	2,677	2,324	2,408
Northeast	6,449	6,096	6,017	6,100	5,778	5,851	7,703	9,328	9,609	9,552	9,855	8,458	8,865
Southeast	5,604	5,533	5,645	5,895	5,882	6,193	7,105	9,589	10,004	10,471	10,871	10,035	9,646
South	2,304	2,120	2,157	2,227	2,255	2,312	2,897	4,258	4,403	4,400	4,655	4,227	4,286
Midwest	1,057	1,023	1,031	1,118	1,075	1,228	1,337	1,836	1,896	1,941	2,123	2,073	2,087
Total	16,739	16,010	16,103	16,640	16,210	16,775	20,775	27,484	28,482	29,019	30,181	27,117	27,292

Source: Ministry of Health – CNES.
Note (1): month of reference December (2007-2018) and August (2019). Note (2): Doctors (Family Doctor, Family and Community Doctor).

tion of Cuba's participation in the PMM. Almost a year after the departure of the main partner of the PMM, that is, in August 2019, this number is practically the same as observed in 2014.

Still regarding team composition, Table 2 shows the development of registered ACS in Brazil and the highest concentration of this workforce in the Northeast, followed by the Southeast. In 2007, the ACS were among the main professional work categories in the SUS, totaling 240,220 people. In 2012, they had already grown around 17%, reaching 280,000, a number that practically remained until August 2019. As for the 2017 PNAB, there were significant changes related to these professionals, who had their participation suppressed for at least 1 ACS/eSF.

However, data for the 2017-2019 period show a reduction of 780 community workers in Brazil's total. The analysis by region shows a 3% decrease of ACS in the South, 0.4% in the Northeast, and 1% in the Midwest. The Southeast and North regions showed a 0.8% growth.

Table 2 shows the trend of three professional categories that make up the eSF workforce. A discrepancy is observed mainly between doctors/nurses per team. Comparing August 2019 with December 2017 evidenced a 5% increase in the number of nurses, a 10% decline in the number of doctors, and 0.3% drop in the number of ACS for Brazil's total. Moreover, the Primary Care teams correspond to 1%, when compared to the total number of teams, and no evolution of the EAB was observed after the 2017 PNAB.

In absolute numbers, an increase of the teams (eSF, EACS, eAB) is observed in the country over the period studied. However, in 2017-2019 period, eSF grew by 2.9%, EACS by 14.2%, and eAB decreased by 1.7%.

This increase is also reflected in the elevation of the estimated coverage of Family Health by 1.2%, but attenuated by population growth estimates. The fact that only 42.6% of the population is registered in the Primary Care information systems in the same period is a marking contradiction despite the estimated coverage of 69.9% in August 2019. Moreover, worth mentioning is the interrupted historical series due to the shift from the SIAB (Primary Care Information System) to the SISAB (Primary Care Health Information System).

Discussion

According to the results presented in this paper, which show the significant increase in PHC-dedicated professionals over the years, it can be said, on the one hand, that this is an important facilitator of access and use of health services. This factor corroborates the findings of Macinko and Mendonça[48], who observed that the Brazilian PHC reduced infant and adult mortality for some health conditions sensitive to primary care, improved equity of access and reduced unnecessary hospitalizations.

On the other hand, because of the diversity of the more than 5,500 Brazilian municipalities, several barriers inherent to the system, related to financing, structure, management and human resources within the scope of SUS are observed, practically freezing the expansion of coverage and the number of teams in the country in recent years[49].

Another important aspect, already mentioned in the introduction, refers to the PNAB acquiring greater organizational relevance when accompa-

Table 2. Historical series with the distribution of health professionals and teams, Brazil (2007-2019).

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	(Variation % 2019-2017)
Distribution of ACS by Region - as per CBO 2002														
North	29,173	32,020	31,969	32,408	32,448	33,308	33,289	33,789	33,277	33,193	32,445	32,602	32,715	0.8
Northeast	93,785	98,481	100,650	103,880	104,642	106,306	106,726	106,878	106,276	106,202	106,353	105,974	105,926	-0.4
Southeast	67,636	71,715	73,533	77,532	81,124	85,323	85,106	87,703	87,186	87,755	87,758	88,935	88,447	0.8
South	31,438	32,779	33,434	33,779	33,807	34,949	35,095	35,922	36,247	36,264	35,289	34,798	34,169	-3.3
Midwest	18,188	18,698	18,979	20,163	20,462	20,613	20,763	20,648	20,001	20,134	20,134	20,272	19,942	-1.0
Total	240,220	253,693	258,565	267,762	272,483	280,499	280,979	284,940	282,987	283,548	281,979	282,581	281,199	-0.3
Human Resources Brazil - occupations														
Nurse	28,406	29,996	31,764	32,949	33,567	34,266	35,360	37,492	38,624	39,328	40,571	42,062	42,737	5.1
Doctor	16,739	16,010	16,103	16,640	16,210	16,775	20,775	27,484	28,482	29,019	30,181	27,117	27,292	-10.6
ACS	240,220	253,693	258,565	267,762	272,483	280,499	280,979	284,940	282,987	283,548	281,979	282,581	281,199	-0.3
Total	285,365	299,699	333,432	317,351	322,260	331,540	337,114	349,916	350,093	351,895	352,731	351,760	351,228	-0.4
Types of Health Teams - Brazil														
eSF	28,306	29,914	31,153	32,523	33,445	32,346	36,342	39,886	41,349	41,871	41,362	44,216	42,605	2.9
EACS	3,272	3,518	3,738	4,045	4,332	4,457	3,745	2,961	2,873	3,116	2,627	3,053	3,062	14.2
eAB					71	64	251	314	502	479	531	499	522	-9.0
Subtotal	31,578	33,432	34,891	36,568	37,848	36,867	40,338	43,161	44,724	45,466	44,520	47,768	46,189	3.6
Other	167	669	1,322	1,745	2,115	4,909	4,228	5,731	6,497	6,699	9,685	8,195	10,406	6.9
Total	31,745	34,101	36,213	38,313	39,963	41,776	44,566	48,892	51,221	52,165	54,205	55,963	56,695	4.4
Family Health Coverage - Brazil														**(Difference 2019-2017)**
Coverage of registered population eSF	59.7	59.5	60.5	64.8	59.6	62.2	60.1	57.5	44.7	SI	32.8	38.4	42.6	9.8
Coverage of estimated population eSF	53.1	54.4	56.1	58.8	60.0	57.5	62.4	67.9	69.8	70.1	68.7	73.2	69.9	1.2

Source: Ministry of Health - National Register of Health Facilities in Brazil – CNES. Note (1): Subtotal (eSF and eAB type I, II, III, IV with and without Oral Health; EACS with and without Oral Health).
Note (2): Others (transitory, river and riverine eSF, prison eAB, Nasf and eCR). Note (3): Month of reference December 2007-2018 and August for 2019.
Note (4): Nurse (ESF and eSF); Doctor (FCM doctor, Family doctor). Note (5): Coverage of the registered population from the register informed in SIAB and SISAB (No information for 2016).
Note (6): Estimated coverage for eSF 3,450 and Pro. IBGE 2010 Census.

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nied by programs that behave as a kind of catalyst for change. Tasca and Pego[50] recognizes that the manager's ability to use the energy provided by the programs is decisive for strengthening the health system.

Regarding the PNAB 2017, even with all the scientific evidence to the contrary and the divergent stance of the national primary care department, the correlation of forces in 2017 favored the implementation of other models other than the Family Health and the decline of ACS, as reported by Almeida et al.[34]. However, in practice, it appears that the authorization for the implementation of new eABs has not been carried out (Table 2), showing that there was no adherence on the part of most municipal health managers.

This observation is also supported by Cecílio and Reis[51], in that the recognition (financing) of the traditional model of primary care is the long-standing claim of the managers of medium-sized and large cities in the South and Southeast regions, which have low ESF coverage and resist the conversion of the traditional primary care model to ESF.

However, Table 2 shows a negligible decline in the number of ACS in the country, which, along with the evolution of the eSFs in the same period, signals a possible effect of the policy studied, which proposed the end of their mandatory coverage of 100% of the population, the suppression of 4 to 1 ACS/eSF, besides that this professional is not compulsory in the eABs.

In the last two years, the most incisive change observed that interferes with quality and access to health is related to the PMM, and not the PNAB. It is true that the difficulty in providing doctors with professional training geared to the health needs of the population, and their distribution in the national territory, has always been a challenge in the course of Brazilian PHC[52], a situation that remains to this day[53].

PAHO[3] recognizes the PMM as a successful public policy, which focused on the country's governance for health education and work, expanding access to services and the education transformation process, and has been a strategic resumption for coping with the shortcomings and unequal distribution of doctors in the Primary Care services in the SUS.

This inductive initiative, between the last two editions of the PNAB, was an exponential growth in the number of doctors in the country and expanded the Family Health coverage to resource-poor and smaller municipalities. However, according to Table 1, at the end of 2018, with the interruption of Cubans in the PMM, a 10% decrease was observed compared to 2017, with a potential threat to the composition of the teams. The number of these professionals has not been recomposed as of August 2019, despite the recent measures of the current government aimed at such an end.

Despite the several questionings and expectations generated by PNAB 2017 in the context of PHC, we can conclude that there was no significant change two years into its publication regarding the teams (eSF, EACS, and eAB). There was a negligible decline in the number of ACS, which is less than 1% of the total in Brazil, and fluctuation in the number of doctors in view of the latest events of the PMM.

Despite the important advances from 1994[1] to 2017, we observed few changes when analyzing the Estimated Coverage of Family Health in the 2017-2019 period, which can be attributed to the austerity economic scenario[54], and also to the lack of priority in the investments in health and PHC[55].

Finally, it is worth noting the discrepancy between the Family Health population coverage estimate and the actual population coverage duly registered in a list attributed to a professional or a team.

In 2015, the Ministry of Health interrupted the presentation of public population registration information, which evidences the discontinuity of records and the organization of the lists historically achieved by SIAB in its first manual[56].

It is also verified that the estimated coverage and the number of people registered were close in the period of validity of the SIAB with "Sheet A" records. However, the previous information was lost with the creation of another format for data collection in the Information System. This measure had an impact on the increase in the discrepancy between the two forms of calculating Family Health Coverage. That is, according to the historical series, Table 2 shows, in 2019, 42.6% of the coverage of the Brazilian population registered by the eSF, while we reached 64.8% in 2010.

Final considerations

In view of the above, we can conceive that, while the PNAB was recognized as a legal and relevant instrument in the organization of Brazilian PHC, its third edition, in isolation, barely influenced the composition of the teams and the growth of different Family Health teams in Brazil.

This finding is unusual, as it recalls the tension that occurred in the period of reformulation of this policy, when the field of public health contested the insufficiency of the debate and the proposals expressed in its text. At that time, the main institutions representing the health system alerted, through official notes, the dismantling of the SUS and the possible threats to the achievements hitherto achieved within the scope of PHC in the country.

Analyzing the 2017 PNAB from the definition of the policy provided by authors Viana and Baptista[57] as government action for a sector – which involves resources, actors, arena, ideas and negotiation – we can conclude that its implementation does not depend exclusively on the governmental proposals. In other words, considering that every policy brings about intentionalities, if "the process occurs through negotiation between the federal entities, the municipalities have the leading role of implementing the policies"[58].

We should also bear in mind that, on the one hand, the reflection of public policies sometimes takes time and, in the case of PNAB, its last edition is recent so that its real effects can be thoroughly assessed. On the other hand, when analyzing other ministerial programs, such as the PMM, for example, one perceives an immediate variation in its implementation, with a quantitative increase in the CNES in the onset year. This proves that the PMM responded to a real PHC demand.

Taking into account the above, when comparing the effects arising from the 2017 PNAB and the PMM, although both are initiatives by the Federal Executive Branch, the aforementioned public policies showed quite different behaviors in practice, which can be attributed to the care provided or not to the population's real health needs.

Thus, it is questioned whether the propositions of the 2017 PNAB were really adequate to the main public problems affecting PHC, and whether the interests that motivated its reformulation were legitimate for most municipalities, or if they only served the specific demand for health care of a particular region.

We understand that this paper corroborates Almeida's et al.[34] expectation that corporate, political and economic interests may converge towards the realization of an accessible and resolute PHC, strengthening the SUS as a whole, which depends substantially on participation and leadership of society in the fight for the right to health in Brazil.

Ideally, it is expected that social needs and evidence-based scientific research will be the main motivating instruments for public policies in our country. Thus, the actions will tend to promote advances and results that directly affect people's health, honoring the constitutional precepts of the SUS[5].

To conclude, it is worth highlighting the problem of calculating Family Health Coverage by estimate. While most countries in the world and the OECD use the number of people registered and assigned to a family doctor or an eSF (managing duplicate records), in Brazil, since 1999, we insist on calculating a "potential coverage" by multiplying the number of teams per 3,450 people and dividing by the population estimated for the mid-year by IBGE.

The current challenges lie centrally in the political will to revive the principles of Alma-Ata and the attributes of Primary Care, making the access and "Family Health" Coverage to the entire Brazilian population real.

Collaborations

CBS Gomes and D Soranz contributed to the conception, design and data analysis and interpretation, drafting and tabulation of microdata, while AC Gutiérrez participated in the drafting and critical review of the paper.

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