


Pharmaceutical services in primary healthcare and the Farmácia Popular Program: the perspective of public administrators from subnational spheres of the Brazilian National Health System


Assistência farmacêutica na atenção básica e Programa Farmácia Popular: a visão de gestores de esferas subnacionais do Sistema Único de Saúde

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Abstract

This study aimed to identify the perception of public administrators from pharmaceutical services in subnational spheres, and of technical administrators from collegiate instances of the Brazilian National Health System on the impacts of the Farmácia Popular do Brasil Program (PFPB - Brazilian Popular Pharmacy Program), an exclusively federal initiative, in the administration of pharmaceutical services in primary health care (AFAB), of the responsibility of the three government levels and operationalized by the municipalities. Municipal, state and technical administrators from the National Council of Municipal Health Secretaries and from the National Council of Health Secretaries were interviewed. Content analysis considered the categories: (1) challenges and advances of AFAB and PFPB and (2) connections between AFAB and PFPB. There were different visions on the relations between them, either competing or complementing. The contrast between the growing investments in the PFPB and their stagnation in the AFAB, the overlapping of lists of medications, patient migration and the role of the PFPB as an access alternative, among others, were highlighted. The centralized implementation of the PFPB seems to have happened with poor articulation with subnational spheres of management, generating

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distinct and conflicting interpretations about the program's role and objectives for the municipalities, considering the decentralization guidelines of pharmaceutical services.

Keywords: Pharmaceutical Services; Primary Health Care; Health Management, Health Policy; Federalism.

Resumo

O trabalho teve como objetivo identificar a percepção de gestores públicos da assistência farmacêutica em esferas subnacionais e de gerentes técnicos de instâncias colegiadas do Sistema Único de Saúde sobre os reflexos do Programa Farmácia Popular do Brasil (PFPPB), iniciativa exclusivamente federal, na gestão da assistência farmacêutica na atenção básica (Afab), de responsabilidade tripartite e operacionalizada pelos municípios. Entrevistaram-se gestores municipais, estaduais e gerentes técnicos do Conselho Nacional de Secretarias Municipais de Saúde e do Conselho Nacional de Secretários de Saúde. A análise do conteúdo considerou as categorias (1) desafios e avanços da Afab e do PFPPB e (2) conexões entre a Afab e o PFPPB. Houve visões divergentes sobre as relações entre Afab e PFPPB, se concorrentes ou complementares. Ressaltou-se o contraste entre os crescentes investimentos no PFPPB e sua estagnação na Afab, a sobreposição dos elencos, a migração de usuários e o papel do PFPPB como alternativa de acesso, entre outros. A implementação centralizada do PFPPB parece ter se dado com baixa articulação com as esferas subnacionais de gestão, gerando distintas e contraditórias interpretações sobre seu papel e objetivos para os municípios, considerando-se as diretrizes de descentralização da assistência farmacêutica.

Palavras-chave: Assistência Farmacêutica; Atenção Primária à Saúde; Gestão em Saúde; Política de Saúde; Federalismo.

Introduction

Since the launch of the National Medicines Policy in 1998, institutional and normative changes began, aiming to harmonize pharmaceutical services (AF) and policies to the principles and guidelines of the Brazilian National Health System (SUS) - among them, decentralization. The new marks delegated most of the responsibility of providing medicines to outpatient treatment to the municipalities, which are responsible for listing, planning, making the procurement and distributing it in the context of primary health care (AB). The funding of pharmaceutical services in primary health care (AFAB), in its turn, started being carried out in three parts, between the federal government, the states and municipalities (Kornis; Braga; Zaire, 2008).

However, several problems of public provision remain, making AFAB's qualification an open agenda (Vieira, 2008). Some of the issues described in literature are: low availability of medicines, inadequate physical structure for storage and assistance, lack of qualified human resources, obstacles in procurement and logistical processes, insufficiency or delay of financial allocations and issues with suppliers, among others (Opas, 2005; Vieira, 2008).

Another relevant form of obtaining medicines for outpatient treatment in Brazil is through out-of-pocket expenditure in community pharmacies and drugstores, a sector in expansion and driven by a market-oriented logic, remaining in many cases as the main source of access to medicines in Brazil (Pinto; Costa; Osorio-de-Castro, 2011; Silva; Caetano, 2016).

In 2004, *Programa Farmácia Popular do Brasil* (PFPPB - Brazilian Popular Pharmacy Program) was started, implemented and managed exclusively by the federal government, in order to increase the access to medications through its availability at a low price, targeting mainly the low-income population that has private health insurances (Pinto; Costa; Osorio-de-Castro, 2011). The PFPPB assists patients from public or private institutions in public or private facilities, and most of its medicines are listed in *Relação Nacional de Medicamentos Essenciais* (Rename - Brazilian National Relation of Essential

Medicines), coinciding with those offered in public facilities (Silva; Caetano, 2016).

During the evolution of the PFPB, its branch *Aqui Tem Farmácia Popular* (ATFP - There is a Popular Pharmacy Here) - that is, medicines funded with copayment by the patient and the government in private pharmacies - has prevailed in a number of facilities and volume of directed resources when compared to the branch in public facilities. The partnership with drugstores has also been the main way of operation of the *Saúde Não Tem Preço* (SNTP - Health Has No Price) action - i.e. medications free of charge for high blood pressure, asthma and diabetes. The PFPB's own network became residual over time (Mattos, 2015; Silva; Caetano, 2016).

Frenkel (2008) states that the creation of the PFPB represents a change of emphasis in state action, aiming at increasing access to medicines, regardless of the used tools. It represented, therefore, a change in the focus given so far -qualification of public services and exclusive use of this route to promote access. The program was among the four main priorities of the federal agenda in health during the 2000s (Machado; Baptista; Nogueira, 2011). Recent data on the growth of funding and amount of facilities in the program confirm this trend and show the effort of the federal government to implement the policy. From 2010 to 2015, the number of pharmacies registered in the program increased two and a half times, from 14,003 to 34,625.¹

On the other hand, the funding of AFAB remains without adjustment of the federal financial counterpart since 2009, stagnated in R\$ 5.10 (*per capita* value). In absolute terms, the resources allocated by the Ministry of Health (MS) were from more than R\$ 970 million in 2010 to almost R\$ 932 million in 2015¹, in current values, that is, a reduction of 5%. In the same period, the state and municipal counterparts went from R\$ 1.86 to R\$ 2.36.

Considering the fast expansion of PFPB and the difficulties in AFAB, it is expected that, locally, the dynamics of access has changed, bringing impacts and issues for public management in the subnational spheres. On the one hand, they are responsible for

organizing and ensuring the provision of medicines within the AB. On the other hand, we can see the advance of a federal policy that takes place in private facilities that are not directly linked to the public health system. All these questions bring direct implications to the municipal administration.

Thus, the objective of this study is to identify the perception of public administrators from the pharmaceutical assistance in subnational spheres, and of technical administrators from collegiate instances of SUS on the reflections of the PFPB in AFAB and the practical implications of the coexistence between them to the municipal administration.

Method

This is a qualitative study based on semi-structured interviews. We sought, as profile of the respondents, technical administrators from collegiate instances of the SUS and public administrators, preferably municipal health secretaries, representatives from municipalities with different population sizes and regions of the country. The inclusion criteria sought to value strategic decision-making and implementation positions in the SUS public management at the municipal level. The MS administrator was not interviewed since we intended to capture the vision of subnational spheres on the politics of the federal entity.

Thus, the first two interviews were conducted with technical administrators responsible for the Pharmaceutical Services area in Conselho Nacional de Secretarias Municipais de Saúde (Conasems - National Council of Municipal Health Secretaries) and in the Conselho Nacional de Secretários de Saúde (Conass - National Council of Health Secretaries). From them, an indication of municipal health secretaries and other public administrators was obtained. Among the interviewed secretaries, all occupied, in addition to their main function, some position in the Conasems, ranging from the presidency to specialized regional secretaries of the institution.

1 BRASIL. Ministério da Saúde. SAGE: Sala de Apoio à Gestão Estratégica. Available at: <<http://sage.saude.gov.br/#>>. Access on: Aug 1, 2016.

In total, 12 public administrators were interviewed: technical administrators from Conass and Conasems, eight municipal health secretaries, one municipal AF administrator and one state AF administrator.

The questionnaire was tested previously, and contained four blocks of questions, namely: (1) general situation of the AFAB in the municipalities, with main problems, advances and challenges; (2) MS's responsibilities in guiding and organizing the health policies; (3) evaluation of PFPB's impacts in municipalities and the role the program occupies within the AF policy; and (4) possible relations between policies in different aspects.

Twelve interviews were performed by the main author between May and August 2014. Among the ten face-to-face interviews, one was performed on the road with this specific purpose (key informant), while the others occurred during the 30th National Congress of Health Departments. All interviews were recorded and transcribed.

Regarding the profile of the nine people linked to municipal administration, three were from the Southeast Region, two from the South, two from the Northeast, one from the Central-West and one from the North Region, representing seven different states. Regarding the population size, there were three administrators of each populational size group - small (up to 50 thousand inhabitants), medium (from 50 to 250 thousand inhabitants) and large (over 250 thousand inhabitants).

Regardless the authorization to disclose their names, we have decided to omit them. Aiming to indicate the position of the interviewees, citation marks designates the administrative position occupied and municipality population size (when applicable). Thus, administrators from collegiate bodies of SUS were classified as G-ICSUS (1 and 2), the state administrator as GE, the municipal ones as GM-P (1 to 3) in the case of small municipalities, GM-M (1 to 3) in case of medium-sized municipalities, and GM-G (1 to 3) for large-sized ones.

The content analysis (Bardin, 2011) of the speeches was synthesized in the following categories: challenges and advances of the AFAB and PFPB, and connections between them. Data treatment stages consisted in: transcription of the interviews, preliminary reading,

in-depth reading, organization in thematic blocks, synthesis and selection, and interpretation. Two major thematic blocks were identified, from which the results' presentation was structured.

All respondents expressed their consent with the use of the interviews by signing the Informed Consent Form. The project was approved by the Ethics Committee of the National School of Public Health Sérgio Arouca (process no. 626,060).

Results

Problems, progress and challenges in the provision of outpatient medicines funded by SUS

Among AFAB's problems, there was unanimous reference to insufficient funding. The lack of value adjustment of the federal counterpart in the basic component of AF funding, the gap between the resources and the increased local demand driven by the expansion of the AB and AF policies, the rise of medicines prices, and the expansion of the list of drugs were selected. It has been repeatedly argued that the municipal level is overloaded and forced to allocate higher amounts than its counterpart to avoid shortages. *I think the speed [of the expansion] of primary health care services hasn't been accompanied by the AFAB funding. And then it creates a huge deficit for the municipality (GM-P1).*

It was mentioned as aggravating factors: delay by the state level on transferring its counterparts and by the latter and federal level on delivering medicines on their responsibility, as well as the judicialization of the municipality for supplying medicines.

We want the MS to comply with its obligations. We have two months with delayed fund transfers. [...] We endured almost all of 2013 without receiving contraceptives. (GM-P2)

You have a generic medicine that is the same thing. But the doctor says that it's no good, the patient does not want it and the judge tells you to give that other product. (GM-P3)

Other citations points out the difficulties involved in medicines procurement, highlighting issues with

suppliers - such as the lack of companies interested in public procurement processes, the failure of the domestic market to meet the full demand, the delays in delivery and the non-compliance of contracts.

There is not enough in the market to supply the demand. The laboratories frequently say they don't have the conditions, the productive and technological structure to meet such a demand. (GE)

Companies don't want to sell to the public so they don't go through the public procurement process, which fail, or nobody comes; those who enter don't meet the requirements, don't deliver, don't quote; and the market is short on medicines for everyone. (G-ICSUS2)

“Bureaucracy” was related to the difficulty in complying with legislation related to public procurement, resulting in slowness of the processes, among other issues. Corruption was also a relevant issue, although less mentioned. Regarding logistics, in addition to the delays in delivery of medicines, problems were highlighted in organization, distribution infrastructure, inappropriate requests by units and the non-compliance of service by third party companies.

Sometimes it even causes shortages. It's the whole procurement process, of prices benchmarking. (GM-M2)

It's an area that is still linked to cartels, [...] it's linked to the practice of 10% of commission, it's linked to the lack of public procurement process within the Secretariats. (GM-M1)

So if an unit [...] didn't make the correct request, and then it's lacking. (GM-M3)

Human resources problems included insufficient professionals, low qualification and poor training, both in management as in care. Turnover, difficulty in hiring, and low wages were mentioned less frequently. *There were no qualified people to perform AF in all units. We have a very capillary network to have people in all these places (GM-G1).*

Regarding structure, the lack of conditions for storage, assistance and informatization were also highlighted. Less frequently, the overall low understanding of SUS administrators on the importance of structure was mentioned. On the other hand, some advances in these aspects were acknowledged. *Today, I don't have an effective control of dispensation, I don't have anything computerized, I don't even have internet in the units (GM-M3).*

The interviewed considered that the MS has been supporting the municipalities to face the organizational and structural problems on AFAB management, especially from referred positive initiatives, such as the Programa de Qualificação da Assistência Farmacêutica no SUS (Qualifar-SUS - SUS Pharmaceutical Services Qualification Program in SUS) and the Hórus system. These would have approached the MS to the municipalities and would represent an advance in the AF understanding beyond the logistical aspect.

Today you have the Hórus system, you get in a minute all the situation of the municipality. So, this is an advance. (GM-P2)

It moved from an understanding that was merely in terms of distribution, to take a first step in a more integrated discussion with municipalities. (G-ICSUS2)

However, there were questionings about the insufficiency of resources for greater effectiveness and extent of these actions and difficulties on its implementation.

From the state and municipal levels points of view, the solutions implemented or suggested by administrators to structure and organize the AFAB are diverse, being prior or simultaneous to federal initiatives. They quoted: greater internal organization, cooperation between municipalities and the more prominent action of the states. *The State invested a lot, centralized pharmacies structure, created digital registration system. There are resources to contract pharmacists (GM-P3).*

Specifically regarding the procurement of medicines, the intermunicipal consortium and state centralized purchases were considered relevant

experiences since they allowed obtaining lower prices, greater attendance from companies to public procurement process and greater supply stability. [The consortium] *is the most well succeeded experience of medicines procurement, of planning, of regular delivery. Because you enlarge the scale, optimizing resources and ensuring distribution* (GM-G2).

The situation that most interviewees thought to affect AFAB patients is the shortages on the supply, hindering access. *Part of the population often have difficulty in accessing medications in SUS pharmacies* (G-ICSUS1).

As irregular supply is a reality in AFAB, and the main positive point mentioned about the PFPB was that it works as access alternative in case of shortages. *To the city manager, it's the best thing in the world. If you don't have it in the services, at least you have a place to send your patients to* (GM-P2).

From an administrative perspective, it was questioned the low interaction between the federal and municipal levels within the PFPB, as well as the lack of accountability on results and of a clearly defined role of the program for the municipalities.

What results? We know the results we have. Now, what are the results of the Popular Pharmacy? (GM-P3)

It[MS] isn't discussing it with the local administrator, they always think that we're criticizing Popular Pharmacy. (GM-G3)

Regarding pharmaceutical care in AFAB, some municipalities with structured services made progress. However, the focus in logistical and managerial actions and the lack of specific efforts in this area are still limiting pharmaceutical care qualification. *The weakness is the low quality of care. Actions are still directed to logistical aspects, [...] but there's still a lot to do in pharmaceutical care, in follow-ups* (GE).

Regarding PFPB, the lack of access to dispensing data in commercial pharmacies, the low concern with pharmaceutical services, the involvement of the private sector in the policy and its insufficient counterpart for the resources paid were mentioned.

The greatest disadvantage is that you don't know the data about patients and medicines that are dispensed. (GM-P3)

The final objective of SUS, to take good care of the patient, may never be contemplated in the Popular Pharmacy. (GE)

Despite the difficulties, several public administrators consider there were important advances in the AFAB in recent years, enabling a significant improvement of this policy within the marks of decentralization. When talking about the general evaluation of PFPB, if positive or negative, answers were diverse. They highlighted the need for debates, revisions and adjustments in PFPB to correct imbalances.

Relations between pharmaceutical services in primary healthcare and Aqui Tem Farmácia Popular

The first point mentioned was the contrast between the growing investments in PFPB on the one hand, and insufficient funding to AFAB on the other.

Today, most resources [from the] MS are spent far more with the PFPB than with primary care pharmacy. (GM-P1)

I'm funding the program more and not funding the policy. You are near [R\$] 3 billion for the PFPB and [R\$] 1.3 billion for the AFAB. That's nearly 300 items, and the PFPB does not reach 100. There's a discomfort. (G-ICSUS2)

The different costs of the programs were shown as an aggravating factor, however, without unanimous understanding. Some stated that, in AFAB, government can get the lowest prices, while others had doubts.

The government pays for that medicine on PFPB ten times more than the it pays in public service. (GM-P3)

If you add up all the costs, what you spend in the Popular Pharmacy and in public services should be more or less equivalent. (GM-G1)

When asked if there would be better results if PFPB's resources were used in AFAB, there were divergences. Some stated that it would, some pondered the logistical costs, the planning and procurement difficulties in municipalities - or considered that it was not possible to evaluate the question.

We would have a much broader coverage, we would have quality in distribution and a higher satisfaction in treatment. (GM-M1)

It's hard to know. Maybe, we might have the money, but might not make it [the medicine] available. (GM-G3)

Two possible consequences of this funding difference stood out: the symbolic delegitimation of the public sector and the admission of the AFAB weakness since shortages are common, unlike in PFPB.

Every time this medicine isn't available in the public service, they try to get it at the private pharmacy, which discredits the public management. And then it's the SUS management that is inefficient. So it's bad for the SUS. (GM-M1)

If PFPB came [...] to support, it means to say that there is a fragility of the AFAB. If this fragility didn't exist, there wouldn't be the program. (GM-P2)

Some administrators pointed that medicines sale on PFPB may be more commercially advantageous for producers and distributors. If there are restrictions on the market to meet the demand, it is possible that directing the supply to the PFPB contributes to the difficulties in municipalities procurements. However, there was disagreement on this hypothesis.

There can be interference, because the government pays a higher value there [in the PFPB]. For the distributor and manufacturer it's better, as it has a more competitive price for their profitability. (G-ICSUS2)

I don't see it [producers directing the supply to the PFPB]. I see that the small municipality has difficulty buying with competitive market prices. (GM-G2)

Overlapping part of the list of medicines of the two programs was mentioned, with differentiated perspectives. The first does not consider this an issue since segmenting the access would direct the demand among patients from public and private sectors. The second considered the overlapping contradictory, since it would be irrational that both models offer the same medicines.

Those that are patients from SUS, are treated there, they will get it in the public services. And those who are treated in the private sector should get it at the Popular Pharmacy. (GM-M3)

You're creating a competition. The municipality has to buy and provide the same medicines that are available in Popular Pharmacy. (G-ICSUS)

The third and most frequent perspective pointed out that some municipalities would no longer offer the common medicines of PFPB list to use the saved funds for purchasing other medicines.

There are several [municipal] administrators today that no longer purchase those medicines that are available in Popular Pharmacy. (GM-M2)

This is happening [municipalities stop buying medicines from the PFPB]. But in a strategic way? No. It's an adequation due to insufficient funds. (G-ICSUS2)

Concerning the preference of the population for one of the two sources, most stated that the population prefers to obtain their medications directly in the AFAB. *The population that goes to the public service, if they have a guarantee that the drug is there, they do not go to PFPB* (GM-P1).

However, situations were mentioned in which specific segments may prefer the PFPB, such as retirees, health insurance clients and the high-schooling population - or even cases in which the geographical accessibility and the working hours of the participating pharmacies are better than the public services.

Regarding care, qualitative differences were highlighted between the type of assistance provided

in each of the policies, especially the vision that there is a greater concern with care, integrality and linkage in AFAB, while the PFPB focus is in providing the medicines.

We think this interferes within the strategy that we want, which is the integration of the patient with his neighborhood, and that connected to primary care facilities. (GM-M1)

They distribute the medicines. It's not even a dispensation. (GM-M2)

Discussion

This study aimed to assess from the perspective of SUS administrators the reflexes and relations arising from the coexistence of different public policies to provide outpatient medicines: AFAB and PFPB. We chose to analyze the point of view of administrators from subnational instances of SUS instead of the federal vision, since those are designers and managers of the policy.

A series of AFAB problems were signaled in most different aspects of public management, with results both in the structure and organization of the system and in the care given to patients. There was no consensus on the type of relation between PFPB and AFAB, whether of competition or cooperation. Responses showed several nuances, according to the different aspects approached and often revealing contradictory speeches.

Concerning funding, two elements stand out. First, the evolution of the resources destined by the MS to PFPB and to AFAB. When compared, the growing investments in the first and decreasing in the second were evidenced. While PFPB, with a more restrict list of medicines, had an increase of 1055% in their budget from 2010 to 2015, AFAB, with a broader list, have had its *per capita funding* frozen since 2009 (Silva; Caetano, 2016). Additionally, the lack of resources for AFAB has overloaded the municipalities because both the demand and the medicine's price have increased (Machado et al., 2014).

The second element refers to the costs of PFPB and AFAB. Two studies, which considered logistics,

structure, human resources and depreciation costs, concluded that PFPB's costs are from 150% (Carraro, 2014) to 255% (Silva; Caetano, 2016) higher than AFAB's. It is possible that, in smaller municipalities, with a small scale of procurement and/or with a less structured AF, the values spent on public purchases are equivalent or superior to the PFPB. However, no evidences were found to support this hypothesis.

Regarding medicines public procurement, aspects such as insufficient resources, corruption and lack of accountability, lack of technical bodies to deal with the norms related to the procurement processes, and low interest of suppliers are supported by the literature (Vieira, 2008). The lack of interest of manufacturers in procurement processes was partially considered by the Conass (2014) in a technical note.

No evidences were found regarding the insufficiency of the pharmaceutical productive structure to meet simultaneously the demands of municipalities and the retail market - neither regarding a production directing to ATPF's demand. On this hypothesis, possible explanations would be the greater sales return when negotiating with the retail market, given the higher prices practiced, the magnitude and stability of demand, the existence of previously established distribution channels with pharmacies, and the lower operational cost for suppliers, allowing them to escape bureaucracy and bidding requirements. These are important hypothesis that deserve to be investigated in future studies.

Another consequence arising from the underfunding and overlapping of medicines would be the interruption of the supply in AFAB of those medicines which are also included in PFPB. Thus, administrators could use the scarce resources of AFAB to purchase other medicines previously not included or to ensure the full supply of a smaller list of medicines, while the population would obtain those overlapped medications exclusively in PFPB. Despite the need for studies to evaluate this situation, these cases are worrisome since, in practice, represent the replacement of AFAB by PFPB for certain drugs.

In other management related activities, such as storage, stock control and purchases planning, the speeches of administrators regarding AFAB

are supported by scientific literature (Opas, 2005; Vieira, 2008). The same happens when it comes to infrastructure issues, such as the inadequacy and insufficiency of spaces of assistance and storage, the lack of air conditioning and the low internet access (Mendes et al., 2014), although there may be local or regional successful cases. The MS initiatives to deal with these issues, notably the Hórus system (Costas; Nascimento Júnior, 2012) and the Qualifar-SUS program (Brasil, 2012), were considered important, although insufficient or little comprehensive, even if there are generally not enough funds in a scenario where supply is considered more important than care.

Reports point out that well succeeded solutions for logistical and structural aspects are related to the protagonism of the state level and to a greater intermunicipal cooperation. Concerning medicines procurement, studies showed that the consortium system actually generates savings for the participant entities and greater supply stability (Amaral; Blatt, 2011; Ferraes; Cordoni Júnior, 2007). The role of the states seems to have been decisive in some successful cases of organizing and qualifying AFAB (Faleiros; Silva, 2014; Ferraes; Cordoni Júnior, 2007).

In addition to problems on AFAB, the arguments that support the recognition of the PFPB as an access alternative by the administrators are, on the one hand, the shortage in the public services and, on the other, the ensured availability in PFPB.

Shortage in AFAB is not a new situation (Vieira, 2008). A nationwide survey applied in primary care facilities identified an availability of key-medicines of 56.1% (Mendes et al., 2014). In the same direction, a national household survey shows that the availability of medications for chronic diseases as being of 45.2%, 67.4% and 88.5%, in the SUS, PFPB and in private pharmacies, respectively (Oliveira et al., 2016). The high availability of medications has been reported in PFPB, both in its public pharmacies (Bonotto; Colet, 2013; Pinto et al., 2010) and in ATFP (Pinto et al., 2010), as well as with community pharmacies (Opas, 2005). Nevertheless, even in the case of hypertension and diabetes, in which medicines are free in SNTP, about 18% of the interviewed claimed to have obtained their medicines from it, and 60.5% of them obtained from SUS (Brasil, 2016).

On the different perspectives regarding AFAB and PFPB utilization dynamic, different studies have found out that around half the prescriptions in PFPB are originated in public services (Bonotto; Colet, 2013; Carraro, 2014; Pinto; Costa; Osorio-de-Castro, 2011). This fact reinforces the thesis of PFPB eventual use of PFPB in SUS shortage situations. Thereby, the stock-outs in AFAB and the ensured access on PFPB are characteristics that reinforce themselves and act inducing the migration from a source of access to the other, eventually or definitively. It is worth mentioning an administrator's recurrent speech: when medicines are available in AFAB, patients prefer to obtain it where they are treated - and PFPB helps municipalities as it protects the patients in case of shortage.

The administrators' speech pointed out the need to broaden the discussion around this theme in order to clarify and define the role of each policy and of each government level. The distinct interpretations regarding the PFPB's role may be related not only to its practical implications but also to its top down implementation, without dialogue with subnational spheres.

Arretche (2004) argues that the participation of states and municipalities in health policy formulation process, realized through representatives councils, has worked as counterweight to the authority concentration in federal level, removing from the MS the possibility to decide individually SUS framework and rules. However, this is not observed in the case of PFPB, a policy designed and implemented at the federal level. According to the interviewees, decisions and discussions around directions of the program have not passed through these councils and interagency commissions. In addition, PFPB does not count with representatives of subnational spheres on its centralized management model, and the federal government does not provide normative guidelines or formal instructions to the other levels on the implications of the program to the local dynamics of medicine supply.

In this case, it is entirely up to the municipalities to interpret and act on the new reality of coexistence between the policies, which goes in the opposite direction of a broader movement to strengthen inter-federative instances and make agreements on responsibilities.

In practice and in terms of management and of service utilization, what seems to occur is that the rise of PFPB redefines the role of AFAB indirectly, once the space occupied by the latter policy is modified when it starts coexisting with the first one. Thus, there is no coordination between the actions.

Guimarães and Giovanella (2004) indicate that, despite the importance of the cooperation between administrative levels as a key factor in the implementation of health policies in federative countries, competitive relations have prevailed in Brazil. In the case in question, on the one hand, PFPB is perceived as a top down action distant from the cooperation between federated levels. In contrast, initiatives such as the creation of Hórus system and the Qualifar-SUS program go in the opposite direction, as highlighted by the administrators. This indicates that MS has different attitudes towards other AF management levels, depending on the action or policy in question.

Still on the MS performance, Fonseca and Costa (2015) analyzed high-cost pharmaceutical services and concluded that there was choice on re-centralizing activities at federal level, aiming to stimulate the health industrial and economic complex development. It has been argued (Pinto; Costa; Osorio-de-Castro, 2011) that PFPB has been used for the same purpose, which would partially explain its top down administration and its strength within the federal agenda. An additional function of centralization in the program would be the possibility of using the policy as a Federal Executive Government brand (Pinto; Costa; Osorio-de-Castro, 2011)

The use of interviews and the exploratory character of this study proved to be adequate, since it allowed to evidence problems already known and to identify new hypothesis. However, the nature and scope of the study limits its external validity, even though the attempt to address administrators from municipalities of different sizes has sought to incorporate different perspectives on questions generated by PFPB at this management level.

Final considerations

The interviewed administrators' different interpretations on the role and objectives of PFPB

were evidenced, probably reflecting the lack of clear directions and scarce dialogue between the federal level and the subnational spheres during policy implementation.

Questions raised on the relations between the two policies are a direct consequence of a context in which - on the one hand - the public provision policy, designed in the framework of decentralization with shared responsibilities between federative levels, suffers from chronic problems despite important advances. And - on the other hand - another policy emerges with similar goals (PFPB), led exclusively by the federal government, which, unlike the AFAB's case, has been investing greater efforts and resources for implementation.

Overall, in the speeches competition was associated to a greater directing of federal resources to the PFPB in contrast to the lack of adjustment of AF's budget, to a possible effect in the market - which would hinder purchasing, to the overlapping of medicines list which would lead some administrators to choose not to offer PFPB medicines in AFAB, to a possible migration of patients from one policy to another, and to the differences in offered care. The policies were considered complementary by the administrators in cases in which AF is not fully structured, with PFPB working as an access alternative in case of stock-out in the public primary care facilities, or when the program assists different patients from AFAB.

The notion of "complementarity" should be questioned when applied to the relations between AFAB and PFPB. The word evokes the connotation of a virtuous relation between policies, as if their characteristics reinforce and potentialize themselves. However, many of the consequences described in this study do not seem to go in that direction. Some situations seem to happen not due to a complementary design among the policies, but originated from AFAB failures.

Thus, it is possible to state the coexistence between the two policies has redefined the role of AFAB, even if indirectly. The extent of its fragilities, added to the vigorous implementation of the PFPB, have consequences in the use at local level and influence the decisions of municipal administrators in conducting the local AF policy.

Several statements of the interviewed administrators' are supported by the literature, whereas others raise important hypotheses of topics to be investigated.

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Authors' contribution

Mattos has conceived the study, conducted data collection and processed the interviews. All other authors contributed equally to data analysis, writing, and approval of the final text.

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