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# The Family Health Strategy: primary health care and the challenge of Brazilian metropolises

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**Abstract** *This article analyzes the development of primary care (PHC) within the Unified Health System (SUS) in large Brazilian cities. The decision to adopt a policy of PHC represented an incremental reform of the health system through the Family Health Strategy (FHS). The methodological approach of the article uses cross-sectional data grouped around two years (2008 and 2012) to evaluate the development of PHC in the cities. The article demonstrates that the funding of the health sector expanded in all Brazilian cities, regardless of population size, in the early 2000s. The growth of municipal health expenditure in terms of public health actions and services helps to explain the high level of provision of family health teams that was observed mainly in small cities in the early 2000s. The analysis of health provision also shows that the provision of family health teams remained relatively stable during the period that was analyzed in most municipalities of medium and large population size, and also in the metropolises. The development of PHC during the studied period reveals that the risk of the over-supply of health services associated with the decentralization of the health sector did not occur in Brazil. The large cities and metropolises underwent a significant, but unequal, expansion of PHC.*

**Key words** *Primary Care, Decentralization, Federalism, Health policy, Brazil*

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## Introduction

Brazil is internationally recognized for its development of primary health care (PHC) at the local level[1] but few studies have dealt with the deployment of PHC nationwide. This article is intended to contribute to the understanding of the national experience and it analyzes the development of PHC within the Unified Health System (SUS) in Brazilian cities.

The development of the concept of "health for all", which was provided for in the 1988 Federal Constitution (BRASIL, 1988), was associated with great cycles of public policies to meet the needs of the Brazilian population[2]. Because of these concerns, the SUS agenda underwent a radical change to adopt the public policy of PHC as a strategic option to increase the effectiveness of health care. Since 1994 the economic incentive given to municipalities for the adoption of the Family Health Program (which was renamed the Family Health Strategy [FHS] in 2006) in the context of federal cooperation, amended the municipal supply of health services and changed the model of assistance that had traditionally shaped hospital care[3]. The FHS offers a model of care that is centered on health teams, which are composed of doctors, nurses and community health workers, and are operated by municipal governments[1,3]. Furthermore, the FHS introduced key strategic characteristics, such as changes in the remuneration mechanisms of health actions, in the forms of organization of the services, in the care practices at the local level and consequently in the process of decentralization[3].

Viana and Dal Poz consider that the adoption of PHC instituted an incremental reform of the health system in Brazil, considering that the Family Health Program indicates significant changes in the form of remuneration regarding health actions (superseding the exclusivity of payment for procedures), in the forms of organization of services, and in terms of care practices at the local level[3].

Cooperative federalism was a precondition for the effectiveness of the new orientation of government policy on health, which confirmed the conclusions that had been indicated in the relevant literature[4]. Changes in the health care model were intended to overcome the shortcomings in social security arrangements, with the aim of promoting territorial distributive fairness and efficiency in allocations.

By the early 2000s the goal of expanding PHC services and actions has been achieved in most small cities, especially those municipalities with low scores in terms of the Human Development Index[5]. However, the larger Brazilian municipalities (cities with over 100,000 inhabitants) showed a low level of adherence to the FHS. The insignificant implementation of the FHS in major cities was considered to be a limiting factor in relation to the strategy of expanding the effectiveness of the SUS[6]. The FHS was considered to be the preferred gateway the SUS. In that specific context, the large Brazilian cities became the subject of a specific policy, the Expansion and Consolidation of Family Health Project (PROFHS), which was implemented in 2003[7]. The need for the introduction of the PROFHS was reflected by the fact that only three major Brazilian cities provided significant family health cover in 2000[6]. This low level of coverage provided by the FHS raised many questions about what were the obstacles to large cities adopting the proposed FHS model.

The need to improve the effectiveness of public policies remains on the public agenda. The appreciation of the pattern of development of post-democratization public policies is crucial to the effectiveness of the choices made by public officials in the long run. The development of independent research can effectively support the decisions of the Ministry of Health and also the priorities of the SUS.

## Design of the study

This article benefited greatly from the wide availability of secondary data at DATASUS. This article analyzes the profile of expenditure related to health actions and services, as well as the standard of provision of the FHS, by using pooled cross-sectional data, combining time-series and cross-sectional data[8]. The use of service provision indicators, which were calculated on the basis of the secondary data, made it possible to describe the amount of health establishments for the target population of a health service or program[9].

Using a design proposed by Wooldridge[8], the pooled cross-sectional data were evaluated at two points in time, 2008 and 2012. In 2008, a stratification of municipalities based on population density is described and analyzed based on the variables of expenditure, public health actions and services, and the provision of family health teams. In 2012, a *new stratification of municipalities* is analyzed by means of the same aforementioned cross-sectional variables.

The choice of these two moments in time was due to the formation of the Health Care Network (RAS), which was formalized in 2010 by the fed-

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eral executive. The RAS stated that, "the current health care model, which was founded on curative actions, centered on medical care and structured on health care actions and services based on offer, has proved insufficient to cope with current health challenges and it is unsustainable in relation to future needs[10]. Given this diagnosis, the RAS proposed the formation of horizontal relationships, which were enigmatically referred to as *attention points*, with the center of communication being based in PHC. The experience in Brazil demonstrated that with PHC as the coordinator of care and administering the network, the RAS could act as a "a mechanism to cope with systemic fragmentation both in terms of internal organization (allocation of resources, clinical coordination, etc.) and also in its ability to meet the current challenges of the socio-economic, demographic, epidemiological and health scenarios"[10]. The relevance of the role of PHC, as a necessary condition for the establishment of the RAS, was also emphasized in Decree/ Law 7.508/2011, which regulated Law 8080 of 1990.

Given this context, this article draws upon longitudinal information regarding health expenditure and provision for the FHS that was available in DATASUS, which is a public access resource. Using this information, a calculation was performed of the FHS provision indicator utilizing the equation [(FHS/pop_year)* 10,000 inhabitants]. The term FHS represents the amount of family health teams in a Brazilian municipality in 2008 and 2012. The term pop_year represents the resident population projected by the Brazilian Institute of Geography and Statistics (IBGE), information that was also available on the DATASUS website.

Municipal spending is described by the indicator of the municipalities' own expenses in relation to public health actions and services according to the calculation provided by the Information System on Public Health Budgets (SIOPS)[11].

Utilizing the design adopted by the Ministry of Social Development and Fight against Hunger (MDS), the municipalities are stratified according to population density into the following categories: small (up to 50,000 inhabitants); medium (more than 50, 000 and less than 100,000 inhabitants); and large (more than 100,000 and less than 900,000 inhabitants). The category of metropolis was used to refer to the 17 Brazilian municipalities with a population equal to or more than 900,000 inhabitants in 2008 and 2012[12].

With reference to this stratification, the MDS emphasizes the importance of large cities and metropolises in the supply of and demand for public services in regional contexts. In the particular case of metropolises, the challenges represented by supply and demand are compounded by territorial boundaries between cities that have significant deficits in terms of public services[12].

The relevance of these two strata (large cities and metropolises) in the provision of health actions and services is due to the fact that 56% of the Brazilian population is concentrated in only 5% of municipalities[11]. The failure to implement PHC in large cities and metropolises has had a crucial significance in judgments regarding the effectiveness and the quality of the SUS.

## Barriers to the development of the Family Health Strategy

Analyses of the difficulties associated with the implementation of the FHS in large cities and metropolises follow three different perspectives. The first analysis concludes that in the large cities that implemented the FHS there was a particular focus on sectors of the population that were vulnerable and at greater social risk. The high level of population coverage of the FHS was intended to be directly linked to, and conditional on, the prevalence of poverty in the cities. From this perspective, large municipalities with a lower proportion of poor people would be less interested in expanding their health coverage. This interpretation ratifies the theses about the nature of focalization and the simplification of offering the SUS through the FHS. According to this reading, this focalization was a response to the need to expand the provision of health services to the poor, and to the specialization of the provision of services to the public using services of lower technological complexity in order to stabilize the costs of health services[13-15].

The second analysis concludes that the federal incentives prior to Constitutional Amendment 29 (EC-29) were insufficient, and the need for financial contribution by municipalities towards the funding of the FHS was a factor that inhibited its expansion in the large municipalities. The growth of the coverage of the FHS would be solely dependent on the economic capacity of the municipality. Within the Brazilian federation it was considered that the FHS would create equal incentives for all municipalities to adhere to the preferences of the Brazilian central government. In this respect, Marques and Mendes[14] have highlighted the fact that the introduction by the federal government and the Brazilian states of large

numbers of health teams transferred the main financial burden to the municipalities. Therefore, the transfers were not sufficient to pay the total costs of the teams. The linear incentives used by the Ministry of Health were not adequate for the municipalities, which were financially differentiated[15].

The third analysis argues that with the expansion of the FHS, the cities with high expenditure on health actions and services tended to limit their spending because of legal restrictions that prevented the growth of expenditure by municipal government as a whole. The negative consequences of the expansion of the FHS in terms of expenditure on personnel expenses in large cities have been identified[16]. These difficulties were exacerbated by restrictions contained in the Fiscal Responsibility Law (Complementary Law No.101/2000) in relation to spending on staffing. This was reflected in the clash between the requirements of the period which formalized the formation of family health teams with civil servants in the statutory regime, and the necessity that doctors had to have a contract of employment that lasted 40 weeks.

### Decentralization and cooperative federalism: reviewing the 1990s

Despite these limitations on the implementation and consolidation of the FHS, the analyses of the process of decentralization of health provision stress the convergence of the agendas of government at the national and sub-national levels[17]. This convergence became possible from the 1990s onwards due to the delegation of what Bossert[18] refers to as the important "decision space", which was assigned to sub-national levels of government (i.e. the states and municipalities).

The emergence and development of the decentralization of social policies in Brazil were favored by the low cost of performance management, by the attractive transfer of resources, and by the administrative attributes of the states and municipalities. In the area of health, decentralization was especially successful in expanding PHC because the health sector shared an agenda of appropriate sectoral reform with capacity at the local level, which offered instruments for electoral competition in municipalities[19].

Borges rightly draws attention to the fact that in contemporary Brazilian democracy the public policy choices made at sub-national levels of government take into account horizontal political competition (between political parties) and vertical competition (between spheres of governmental), as well as socioeconomic and demographic factors[20]. This article defends the idea that the policy to expand PHC played an important role in enabling the political elites to distribute local public resources under the universal guidelines proposed by the federal executive.

The redefinition of powers and duties in the social sphere was part of the transformation process from a centralized federative model to a type of strongly cooperative federalism. The transformation of the functions exercised by the federal government in the context of democratization assisted the creation of specific mechanisms of governance, powers and duties in relation to the sub-national entities. The states and municipalities became responsible for implementing and managing policies and social programs which were defined at the federal level[21].

In this context, the municipal provision of PHC occupied a central position in the governmental agenda and it established continuous mechanisms of federal financial transfers to the sub-national entities. Obstacles to decentralization were the lack of stability of funding sources and financial autonomy of local government[22]. In response to these limitations, the agenda of decentralization of health was shaped by the decisive intervention of the federal executive throughout the 1990s. The central government was extremely inductive in establishing mechanisms to financially encourage decentralization, even partially delegating the implementation of the federal health budget to the sub-national level of government[23].

This partial delegation of decision-making was performed through innovative mechanisms of financial transfers from the federal government: the introduction of "fund to fund transfers" in place of the previous agreements and direct payments by the federal government to the health departments of the states (SES) and municipalities (SMS). By definition, the mechanism of the agreements and the direct payments determined that the SES and SMS were in practice reduced to a condition similar to that of other service providers which were accredited (contracted or subject to an agreement) by the SUS (either philanthropic or private)[22].

In this condition, public health policy assumed clearly shared characteristics, further indicating that all the actors within the federal pact could claim recognition for policy development at the regional and local levels. This meant that the federal government reduced its level of dom-

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inance in terms of implementing the policies, strategies and health programs that were implemented and developed by the SUS.

The significance of this quasi-abdication of the monopoly of ownership of health policy in the 1990s - reducing the vertical electoral competition - was overshadowed by the intellectual production of the period, which focused on identifying the limits that macroeconomic adjustments would impose on Brazilian federalism. From this economic perspective, the federalist model, which had only produced constraints and federal imbalances, would inexorably be made unviable by the force of the economic stabilization policy and the containment of health spending.

Alternatively, it can be argued that within the context of the re-democratization of the 1980s and 1990s Brazilian society resisted the process of the diffusion of macroeconomic adjustment. Undoubtedly, the decisions related to macroeconomic adjustment also responded to conditionalities regarding policies that were set by the international financial community. In Brazil, between 1979 and 1994, there were nine stabilization plans, five currencies, five price freezes, twenty-two proposals for renegotiation of Brazil's foreign debt and nineteen changes in foreign exchange rules.

With the establishment of stabilization proposed by the Real Plan in 1994, it can be said that the Brazilian government's economic policy instruments suffered an organized centralization that was designed to stabilize public spending, which had significant effects on the Brazilian economy entering the global scene. Previous similar plans had failed due to internal political problems, as well as technical inconsistencies and the absence of international conditions which might have resulted in success[24].

Even with the success of the Real Plan, there was no discontinuity in the growth of social protection in the years following its implementation: public spending was expanded and universal criteria for the definition of new social rights were introduced. This increase in the incorporation of new clienteles to the social protection system was made possible by the successful implementation of the new Brazilian Constitution in 1988. The effects of the macroeconomic adjustment agenda were therefore significantly mitigated by the lack of political unity on the part of the Brazilian democratizing elites regarding the scope of macroeconomic adjustment and by the affirmation of federalist interests[25]. This meant that the debate about the effect of the macroeconomic adjustment agenda on Brazilian social protection was reopened in the 1990s. The latter was overestimated by intellectuals, especially in the field of public health, who emphasized the role of "external agents, multilateral agencies and private interests"[26].

On the other hand, it is necessary to consider that the unique political circumstances of Brazil's re-democratization can explain the proposals made by the federal executive in the 1990s; changes were made that involved high transaction costs in order to arrive at the stability of funding sources for the health sector. The definition of a source of resources through the Provisional Contribution on Financial Transactions (CPMF) and the reform of the 1988 Constitution by Constitutional Amendment 29 (EC-29) were key events in the construction of institutional stability in relation to health funding.

As a result of action by the federal executive, the CPMF was established by Constitutional Amendment No.12 on August 15, 1996. This constitutional amendment included Article 74 in the transitional provisions, which introduced the creation by the Brazilian Union of the provisional contribution in relation to the movement or transmission of monies and of credits and rights of a financial nature. The proceeds obtained by the CPMF were intended to be fully allocated to the National Health Fund to finance health actions and services. The CPMF was regulated by the ordinary Law No. 9311 of 24 October 1996. Additional laws, provisional measures and constitutional amendments (21/1999, 37/2002 and 42/2003) extended the duration or modified the rate of the new financial contribution. It was promised that the CPMF would not be collected for a period exceeding two years [27].

The CPMF was abolished by the Senate in December 2007 at the beginning of the second term of President Lula's government despite a huge effort by a coalition within the federal government to maintain it. It should be noted that the same coalition tried unsuccessfully to derail the CPMF in 1996 during legislative procedures[27].

Analyzing the allocation of the CPMF highlights the fact that resources were only used exclusively for health purposes during the first two years of its implementation (1997 and 1998). The following year, a portion of the funds were directed to financing social security and in 2001 another portion was utilized to form the Fund for Combating and Eradicating Poverty. Thus, a significant percentage of the CPMF was used by Treasury cash in other areas, so much so that the

portion actually passed on to health in the latter years was approximately 40% of the total that was collected[22].

Viana draws attention to the fact that there was no extension of the CPMF in 2007, which represented the end of a major source of funding for health and also compromised the ability of the federal government to execute policies through the Ministry of Health[22].

The trajectory of the EC-29 was less troubled. It was approved in 2000 and established minimum percentages of linked resources to be invested annually to finance public health actions and services in the states (12%) and municipalities (15%) based on the revenue from tax collection and governmental transfers[23].

Despite disagreement about criteria and federal commitments, the EC-29 had a significant effect on the dynamics of health funding in terms of the construction of consensus on the following: 1) the definition of what should be considered to be public health actions and services for the purpose of resource linking; 2) the minimum amount of resources necessary for the sector, considering that the SUS recommended universalization; c) and the criteria in relation to resource linking. Regarding the last item, the funds to be invested in health care for the states and municipalities were linked to a percentage of current revenue. For the federal government, the allocation of resources for health was subject to the performance of the gross domestic product (GDP)[23,24].

### The expansion of the health sector in relation to the Brazilian metropolises

After the introduction of the EC-29 in 2000, the funding of the health sector was expanded in all Brazilian cities, regardless of their population size. It is noteworthy that in all the municipal strata the expenses incurred in relation to public health actions and services were much higher than the minimum expected by the EC-29 (15% of municipal net revenues), as shown in Table 1.

Despite the abolition of the CPMF in 2007, the propensity to raise expenditures for the health sector was not affected because municipal governments were aided by an expansion in revenues[26]. Table 1 demonstrates that small, medium and large municipalities invested heavily in health expenditure. The metropolises were less expansive but they also expanded their spending on health. The growth of municipal expenditure on health produced an unexpected expansion in the proportional participation of local government in national public expenditure on public health actions and services. In 1995 the municipal percentage share was 12.3% and by 2012 it had reached 18% of total public expenditure, while the expenditure of the state governments remained stabilized at around a quarter of national public spending. On the other hand, there was a notable slowdown in the proportional share of the federal level between 1995 and 2012, which was reduced from 61.7% to 57%[27]. As a recent study has shown, contrary to the inexplicable consensus that exists in the literature of the field of public health, funding has ceased to be a priority for the federal executive in recent years[25].

The growth of municipal expenditure on public health actions and services explains the high level of provision of family health teams which reached the small cities in the early 2000s[28]. Furthermore, the rate of provision observed during the following years shows that the availability of family health teams was not only sustained but was actually increased in small cities[29]. Table 2 shows that the average rate of provision of family health teams in small cities (4712 municipalities in 2008) was three family health teams per 10,000 inhabitants. Table 2 also demonstrates that in 2012 the rate of provision in small cities reached the surprising level of 3.3 family health teams per 10,000 inhabitants. This high level of provision in 2012 indicates that the entire population of cities with up to 30,000 inhabitants could have been reached by the FHS, considering that each family health team was responsible for at least three thousand and a maximum of four thousand people[10].

**Table 1.** Average percentage of municipal expenditure according to population, 2002-2010.

| Municipal population/ Year | 2002 | 2010 | Variation 2002-2010 |
|---|---|---|---|
| Small and medium (< 100,000) | 16.6 | 21.3 | 4.7 |
| Large (> 100,000 and < 900,000) | 17.8 | 22.5 | 4.7 |
| Metropolises (> 900,000) | 18.1 | 20.6 | 2.5 |

Source: DATASUS/SIOPS (available at http://www2.datasus.gov.br/DATASUS/index.php)

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In the medium-sized cities, the provision was 1.8 family health teams per 10,000 inhabitants in 2012, indicating the equally important effect of the expansion of PHC. However, Table 2 shows that the standard of provision of family health teams was inversely proportional to the size of cities. In 2008, the difficulty of providing family health teams was clear in the big cities (1.2 family health teams per 10,000 inhabitants) and especially in the metropolises (0.9 health workers per 10,000 inhabitants). The change in the pattern of supply shows that the supply of family health teams remained relatively stable for the medium and large municipalities and for the metropolises in the transition between the 2000s and 2010s.

Table 3 shows a disaggregated analysis of the variables of 16 municipalities and the Federal District (classed as a metropolis) at two moments in time (2008 and 2012).

This table shows that in the metropolises (especially Rio de Janeiro, São Paulo and Belo Horizonte) the scope and the scale of the implementation of the FHS were absolutely monumental at the beginning of the current decade. Rio de Janeiro, São Paulo and Belo Horizonte had 734, 1088 and 502 family health teams respectively in 2012 (column 3 of Table 3). However, the late growth in the provision of family health teams in the cities of Rio de Janeiro and São Paulo is striking when compared to the coverage that the PHC

**Table 2.** Average rate of provision of family health teams per 10,000 inhabitants according to size of municipalities, 2008-2012.

| Municipal size | Provision per 10,000 inhabitants in 2008 (A) | Provision per 10,000 inhabitants in 2012 (B) | Variation 2008-2012 (B-A) |
|---|---|---|---|
| Small | 3.0 | 3.3 | 0.3 |
| Medium | 1.7 | 1.8 | 0.1 |
| Large | 1.2 | 1.3 | 0.1 |
| Metropolises | 0.9 | 1.0 | 0.1 |
| Total | 2.9 | 3.1 | 0.2 |

Source: DATASUS (available at http://www2.datasus.gov.br/DATASUS/index.php)

**Table 3.** Numbers of family health teams (FHS) per 10,000 inhabitants in Brazilian metropolises, 2008 – 2012.

| Metropolises and Federal District | Number of FHS 2008 (A) | Number of FHS 2012 (B) | Variation (B-A) | Provision per 10,000 inhabitants in 2008 (C) | Provision per 10,000 inhabitants in 2012 (D) | Variation (D-C) |
|---|---|---|---|---|---|---|
| Manaus | 175 | 185 | + 10 | 1.0 | 1.0 | 0.0 |
| Belém | 97 | 64 | -33 | 0.7 | 0.5 | - 0.2 |
| São Luís | 85 | 82 | -3 | 0.9 | 0.8 | - 0.1 |
| Fortaleza | 214 | 237 | + 23 | 0.90 | 0.9 | 0.0 |
| Recife | 232 | 237 | + 5 | 1.5 | 1.5 | 0.0 |
| Maceió | 71 | 84 | + 13 | 0.8 | 0.9 | + 0.1 |
| Salvador | 80 | 104 | + 24 | 0.3 | 0.4 | + 0.1 |
| Belo Horizonte | 497 | 502 | + 5 | 2.0 | 2.0 | 0.0 |
| Rio de Janeiro | 128 | 734 | + 606 | 0.2 | 1.1 | + 0.9 |
| São Gonçalo | 172 | 185 | + 13 | 1.8 | 1.8 | 0.0 |
| Campinas | 117 | 98 | -19 | 1.1 | 0.8 | - 0.3 |
| Guarulhos | 71 | 178 | + 107 | 0.5 | 1.3 | + 0.8 |
| São Paulo | 850 | 1088 | + 238 | 0.8 | 1.0 | + 0.2 |
| Curitiba | 169 | 147 | - 22 | 0.9 | 0.8 | - 0.1 |
| Porto Alegre | 93 | 129 | + 36 | 0.7 | 0.9 | + 0.2 |
| Goiânia | 114 | 76 | - 38 | 0.9 | 0.6 | - 0.3 |
| Brasília | 39 | 133 | + 94 | 0.15 | 0.5 | + 0.5 |

Source: DATASUS (available at http://www2.datasus.gov.br/DATASUS/index.php)

policy had already achieved in Belo Horizonte at the end of the 2000s.

As can be seen in columns 5, 6 and 7 of Table 3, during the studied period there were three distinct situations in the metropolises: 1) megacities with an outstanding, and above all sustainable, standard of provision of family health teams in the cities of Recife, São Gonçalo and, notably, Belo Horizonte; 2) stabilization, reduction or residual variation in the availability of family health teams in the cities of Belém, Fortaleza, São Luís, Salvador, Campinas, Goiânia and Porto Alegre; 3) significant expansion, in both absolute and relative terms, in the provision of family health teams in Brasília and in two cities in the southeast: Guarulhos and Rio de Janeiro. In the analyzed period (2008 compared with 2012) Rio de Janeiro was the city that experienced the largest growth in the rate of provision of family health teams per 10,000 inhabitants. The performance of these metropolises is an invitation to qualitative studies to reflect on the motivations of local actors in relation to the expansion of the public policy of PHC.

## Conclusion

The development of the FHS in the period under consideration shows that the risk of oversupply of health services associated with so-called "municipal decentralization"[30] did not occur. The large cities and metropolises played an important part in the expansion of PHC within a cooperative standard with regard to national guidelines. This expansion did not reach the poorest in all cities despite the general increase in spending on health programs by local government.

The decentralization experience has not received adequate attention judging by the surprising proposal for a recentralization of the public health system by the federal government[31]. It is well to remember that in Brazil the centralization of public policies was directly correlated to the suppression of the federation by coercion[32].

Concern about the activism of local government was undoubtedly due to the challenge of developing health policy within a democratic context. The expansion of PHC produced an unexpected dispute about the model of governance of public administration. The municipal and state executives carried out singular organizational changes in an attempt to respond to the demands of the implementation of the FHS. These changes resulted in reforms by the state that were disjointed and fragmented, as could have been expected in a federative environment[33].

The managers of the SUS were driven to adopt a variety of organizational arrangements to circumvent the rules of Law No. 8666/1993 (bidding) and Law No. 8112/1990 (statutory basis), the burden of public welfare payments and, in particular, the restrictions imposed by the Fiscal Responsibility Law (Complementary Law No. 101/2000) regarding personnel expenses in the public sector. This single reform resulted in a high level of organizational experimentation that went contrary to the rules regarding vertical, direct public administration, which was the standard for the whole of Brazil[34].

Before these changes are vetoed it is important that further independent research is conducted regarding innovations in governance mechanisms in the field of PHC, opening up a necessary dialogue with legitimately elected public administrations.

The limitations on the expansion of PHC in large cities and metropolises, which have been identified in this article, draw attention to the regressive and ambiguous role of the Ministry of Health in the development of the SUS in recent years. It is currently important to require a *positive and comprehensive* blueprint for action from the Ministry of Health, with the same standard of methodological rigor as was adopted for the analysis of the federal government's actions in the 1990s, especially in relation to promoting equality and reducing regional imbalances. The resumption of a critical perspective would be helpful in order to understand the barriers to the development of PHC; if the provision indicators show that in small and medium cities universalization was considerable, in the large cities and metropolises the low level of provision of FHS is a legitimate source of concern in relation to the erratic response by the public sector regarding the crisis of health care.

One reason for concern is the recent proposal by the Ministry of Health for the qualification of PHC through the National Policy on Basic Care (PNAB), which was launched in 2011[35]. The PNAB establishes a public policy agenda with measures aimed at the diversification of the health care model (a creation of the NASF, the Street Office) and the relaxation of the rules for hiring doctors to work in family health teams.

For the first time in a document issued by the federal government, the PNAB legitimizes partial work contracts, removing the unrealistic obligation of doctors to work 40 hours exclusively per

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week in family health teams. An exploratory study in the mid 2000s concluded that the rule relating to contracting doctors exclusively for 40 hours was a critical obstacle to expanding the FHS[36].

However, instead of concentrating on the large cities and metropolises, the PNAB outlines a format for federal funding for basic health care that would favor the poorest, smaller municipalities, with the highest percentage of poor and extremely poor people and lower demographic density[35].

What is the justification for this critical decision to prioritize small cities in the face of the obvious weakness of the provision of PHC in large cities and metropolises? Would the PHC policy have been subject to the vertical electoral agenda implied by the federal executive, which was implicit in the proposals of the "Brazil without Poverty" program, and which was formulated in the same scenario[37]?

The ambivalent relationship of the federal executive in relation to PHC in large cities and metropolises was further complicated by the its implementation of the important program "More Doctors", which was also explicitly dedicated to vertical electoral competition[38].

What can be expected over the coming years? Studies show that on a national scale the successful targeting of the PHC policy towards the low-income sector of the population is directly correlated to the growth of private health care plans for the middle and upper-income strata of the population[39]. If this is so, there is no doubt that PHC summarizes the widespread failure of the Brazilian government and it fails to act as an effective gateway to the health system or ensure access to specialized and hospital care[1]. Whenever Brazilian citizens reach a certain level of income they try not to rely on the public health system[39]. Consequently, there is no doubt that the civic challenge still remains in Brazil to organize the health system so that it is both effective and universal.

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