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Health Innovation Laboratories: towards strong Primary Health Care (PHC)in the Federal District of Brasilia

Renato Tasca (https://orcid.org/0000-0002-1407-5914) [1]
Iasmine Lorena Silva Ventura (https://orcid.org/0000-0003-2471-3331) [1]
Vanessa Borges (https://orcid.org/0000-0001-6884-0856) [1]
Fernando Antônio Gomes Leles (https://orcid.org/0000-0002-3891-0443) [1]
Rosane de Mendonça Gomes (https://orcid.org/0000-0002-6656-738X) [1]
Antonio Neves Ribas (https://orcid.org/0000-0003-2351-4242) [1]
Wellington Mendes Carvalho (https://orcid.org/0000-0002-0448-9152) [1]
Julio Manoel Suarez Jimenez (https://orcid.org/0000-0002-2185-1440) [1]

Abstract *This article emphasizes PHC as a fundamental strategy for the sustainability of the SUS, based on its impact on health indicators. The attributes and requirements for Robust PHC are based on statements from researchers, policy makers and institutions, including the PAHO/WHO Representation in Brazil. The model proposed is the result of discussions with workers, researchers and health managers in Brazil, endorsing the commitments outlined in the Alma Ata Declaration. The article details the methodology of Health Innovation Laboratories used by PAHO/WHO in Brazil to systematize knowledge generated by innovative health experiences, including the Healthy Brasilia Project, an ongoing activity run by the Health Department of the Federal District (DF) of Brasilia, which has made important changes in the healthcare model, with emphasis on the expansion of Family Health Strategy coverage. This article analyzes the results of the Innovation Laboratories in Robust PHC in the FD that will be consolidated in a Case Study. The initiative aims to raise awareness amongst managers and health workers about innovation in health processes and policies that are essential for the sustainability of theSUS, focusing on the exchange of knowledge between peers about relevant initiatives in PHCin Brazil.*

Key words *Primary health care, Innovation in healthcare*

[1] Organização Pan-Americana de Saúde, Organização Mundial da Saúde. Setor de Embaixadas Norte lote 19, Asa Norte. 70800-400 Brasília DF Brasil. tascar@paho.org

Reaffirming the principles of the Declaration of Alma-Ata

It is impossible to write about Primary Health Care (PHC) without celebrating the 40th anniversary of the Declaration of Alma-Ata on the subject. The values and principles of this visionary strategy contemplate three main dimensions that deserve to be recognized and reaffirmed: the first, of a political nature, enshrines health as a fundamental human right, singling out the universality and comprehensiveness of health as the instruments that ensure this right; the second, of a social nature, highlights the social, economic and environmental determination of the population's state of health, affirming the need to take action against the determinant factors, with emphasis on social inequalities; the third dimension, which focuses on healthcare, includes the principles of family and community medicine, which is implemented through universal access to a resolutive system of primary care, that provides full healthcare that is humanized, secure and which can be accessed without financial barriers. In this respect, the terms "Primary Care" and "Basic Care" are synonymous, defining both the strategy as well as the level of healthcare that they represent.

Over the past 40 years, the potential of the Primary Health Care (PHC) strategy has been witnessed by incontrovertible scientific evidence that documents its positive impact in various dimensions: improved basic health indicators (as, for example, seen in the Infant Mortality Rates and the Maternal Mortality Rates), a reduction in the number of people requiring outpatient care, user satisfaction, a reduction in the number of specialist consultations and unnecessary diagnostic and therapeutic procedures and training in care for chronic conditions, the promotion of equity, among others[1].

At a time when the sustainability of universal health systems is being seriously questioned in various countries, these findings unquestionably demonstrate that strengthening Primary Health Care is the best tool currently available to overcome these difficulties[2]. Enhancing access to PHC, improving the quality and problem-solving capacity of the services provided, strengthening the link with users and the community, guaranteeing the continuity of care, are measures that strengthen health systems and render them more efficient and sustainable.

Primary Health Care (PHC) as a central strategy for the sustainability of Health Systems

The core strategy of the Pan-American Health Organization, as the regional office of the World Health Organization (PAHO/WHO), is to encourage and promote the right to quality health for all people everywhere, now being referred to as the Universal Health Strategy. This means that everyone should have access to health services, without any form of discrimination, according to their needs, in a timely manner and in an adequate location[3].The strategy is in accordance with the 2030 Agenda for Sustainable Development, one of the objectives of which is to attain universal health coverage for all countries by 2030[4].

In order to attain such an ambitious objective, PAHO/WHO believe that the most effective strategy is to construct health systems based on Strong PHC[3]. There is a wealth of evidence in the extant literature that illustrates the advantages of PHC. One of the best-known researchers on the subject, Barbara Starfield, announced in 1996 that "A Health system based on PHC is more effective, is much cheaper, brings the greatest satisfaction to the population and is more equitable, even in contexts of social injustice"[5].

There is an abundance of research work, from all over the world, proving the effectiveness of PHC. PHC is associated with improved health outcomes in countries with low and average incomes, with regard to dimensions of effectiveness (improvement in the health situation, access to health service coverage, response capacity and the enhancing of the health system), equitability (reducing inequality both in access and outcomes) and efficiency (health care costs)[2]. Other research conducted in 30 countries of the European Union concluded that PHC is associated with better health for the population, lower rates of unnecessary hospital admissions and fewer socio-economic health inequalities[1].

In Brazil, Primary Health Care (PHC) has steadily developed, with a significant evolution occurring from 1994, with the implementation of the Family Health Program (FHP), being officially re-designated by the 2006 National Policy for Primary Healthcare as the Family Healthcare Strategy (FHS).With the implementation of Family Health, PHC in Brazil has had an important impact, over the years, in improving the population's health, especially with regards to the reduction of infant mortality and hospital admissions for outpatient care-sensitive conditions.

Amongst the innumerable signs that prove how much PHC has progressed, up until 2017, 18 good quality articles were published about the impact that the FHS has had on infant mortality, in that 92% of these identified that this had had a significant impact on the reduction of infant mortality[6]. In addition, 12 good quality studies concluded that the expansion of the FHS in Brazil contributed towards a reduction in the number of admissions for Ambulatory Care-sensitive conditions (ACSCs). These studies identified a reduction of up to 52% in areas where the FHS coverage is over 75%[7].

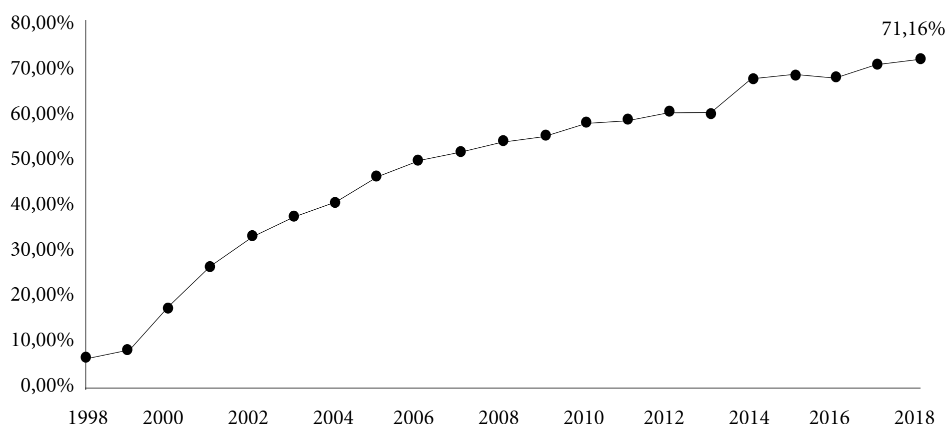
Over the past 10 years, the number of Family Health teams increased by more than 50%, whereby an estimate of the Brazilian population covered by the FHS rose from 51.23% in 2007 to 71.16% in 2018.The last growth spurt was observed between 2013 and 2014, with the implementation of the *Mais Médicos* (More Physicians) Program, which enabled medical personnel to be appointed by the FHS to locations that are difficult to access and that have higher levels of social and economic vulnerability (Graph 1).

Furthermore, in times of both global and national financial crisis and an on-going search for greater efficiency in public spending, PHC proved to be a core strategy, due both to its macro-economic as well as micro-economic cost-effectiveness. A report by the World Bank presented in 2017 which analyzed the efficiency and equity of public spending in Brazil, highlighted the fact that PHC services are the most efficient amongst all those analyzed. It also pointed out that the increase in systematic efficiency correlates to the presence of a system that is coordinated and integrated by PHC and stressed the fact that the more efficient PHC becomes, the more efficient the medium and high complexity specialist care it provides will be[8].

Health Innovation Laboratories as a strategy of PAHO cooperation

The Health Innovation Laboratory (HIL) is a knowledge management tool with the sensitivity to transform tacit knowledge, which is the result of the specific experiences and expertise of health workers and personnel, with the aim of optimizing such knowledge by giving greater visibility to the innovative and successful experiences of managers, workers, researchers, politicians, civil society representatives and other actors involved in this issue.

Based on the understanding that the purpose of Knowledge Management is to seek to improve institutional performance[9], it is considered that knowledge and its applications are essential for



Graphic 1. Estimated population coverage ratio of FHS teams per year, Brazil 1998 – 2018.

Source: prepared by the authors based on data from the Primary Healthcare Department/Ministry of Health (DAB/MS) and the Brazilian Institute of Geography & Statistics (IBGE).

the development of societies, organizations and individuals. The possibility of knowledge application is the driving force behind productivity and innovation processes[10].

In this respect, the input that the Innovation Laboratory proposes to observe, systematize and share, is the knowledge of health providers and workers, in addition to the practices of good management that add value to the health services and which address the problems routinely faced by health managers in a satisfactory manner.

The core strategy of the Laboratory is to generate knowledge based on an analysis of innovative and successful healthcare management practices. This operation enables knowledge to be systematized and shared, thereby promoting the sustainability of the innovative practices in the institution, while evoking a collective sense that change is possible and can serve to inspire similar initiatives in other states transform realities.

The strategy of the Laboratories was developed by the Regional Office of the Pan-American Health Organization – the World Health Organization (PAHO/WHO) in Brazil in 2008, in order to support technical cooperation activities, initially carried out in conjunction with the Brazilian Ministry of Health. In the last ten years, this instrument has been adopted by several other actors, such as the National Council of Health Departments (CONASS), the National Health Council (CNS) and the National Agency of Supplementary Health (ANS).By June 2018, 164 innovative experiences were identified, analyzed, systematized, published and disseminated[11].

Innovation Laboratory in Strong Primary Health Care

In January 2018, as part of the *30 years of the Brazilian Unified Health System (SUS).How will it be in 2030?* Agenda, promoted by PAHO/WHO in Brazil, so as to encourage debate about relevant issues for the sustainability of the SUS on the 30th anniversary of its creation, the Innovation Laboratory in Primary Health Care (Strong PHC) was established to identify initiatives that respond satisfactorily to Level 1 Healthcare challenges.

Initially, the objective was to observe and identify solutions discovered by PHC managers to help improve access to users of Level 1 Clinical Care. With the affiliation of three states of the federation, through the Municipal Health Departments of Porto Alegre and Teresina and the Health Department of the Federal District of Brasilia, the scope of the Innovation Laboratory was broadened. In addition to issues related to expanding access to Strong PHC, the Innovation Laboratories activities also addressed the use of technology for the integration of the network of services, the development of methodologies for inclusion in PHC and the strategies needed to train more qualified human resources to work in the PHC system.

With regard to methodology, the specific socio-economic features of each municipality and of the Federal District of Brasilia are taken into consideration, together with the contexts of the healthcare system trials under study. This includes information about how PHC is organized, the health situation of the population, the management goals, as published in their respective Health Plans, and the outcomes achieved through the implementation of new practices aimed at strengthening PHC.

The Innovation Laboratory does not compare outcomes between the states being monitored. On the contrary, it seeks to promote and highlight the need to share knowledge among the participants, by staging workshops and conducting technical visits to the different states, as well as seminars, preparing material, amongst other activities. Monitoring each case *in loco* and the systematization of best practices and innovations identified are conducted by researchers recommended by the PHC Research Network, of Associação Brasileira de Saúde Coletiva (Abrasco).

Towards Strong Primary Health Care

The consensus of the academic community and the abundance of scientific evidence does not mean that strengthening PHC is a priority on the agenda of all administrators, since few countries now invest in PHC as a strategy to transform the health system.

Three major structural problems hinder a greater output of PHC health outcomes in Brazil. The first is the chronic under-funding of Primary Healthcare. The second is represented by a shortage of adequately trained human resources. The third is a minimalist concept of PHC, from the highest management levels down to where healthcare services are being provided, involving difficulties in acknowledging and incorporating PHC attributes, namely first contact access, longitudinality, comprehensiveness, coordination of care, family and community counselling and cultural competence.

PHC is frequently the object of misunderstandings and, for some, is viewed as a strategy that promotes packages of basic services for the

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poorest and most vulnerable segments of the population. However, evidence shows that the exact opposite is the case; guaranteeing the sustainability of health systems requires a robust and problem-solving PHC system to serve as its backbone[12].

These problems are structural and produce innumerable challenges and weaknesses for PHC within the Unified Health System (SUS). Many people clamor for the creation of "Strong PHC," capable of facing the challenges of the coming decades. However, what does it really mean to construct Strong PHC in practical terms? How should this be implemented? What are its attributes? What conditions are required for its consolidation?

In the following sections of this work, we will attempt to answer some of these questions, in order to foment a debate for the construction of an articulated proposal to strengthen PHC within the SUS. At the same time, it is necessary to find concrete solutions within the SUS practices themselves, seeking and enhancing innovative actions, such as those that were identified in the Federal District of Brasilia during the 2014-2018 period, where a very significant increase of PHC coverage was recorded, through the implementation of creative and sustainable solutions.

Attributes of Strong Primary Health Care (PHC)

In spite of the conceptual and practical difficulties involved in describing the complexity of "Strong PHC" and the density of its realities, by using only one definition, it is possible to understand this based on the attributes described below, which should be considered by the health policies that strive to construct universal health while guaranteeing the right to health for all:

- *Assume responsibility for health care in conjunction with the population affiliated to the Primary Healthcare Unit (PHCU):* Whenever local operating conditions of Primary Health Care Units allow, this responsibility extends throughout the state, as is the case of rural and remote areas and some urban areas. The PHC teams establish an effective link with the population on two levels: a) health care for individuals and their families by means of a healthcare model that guarantees access and entry into the system, longitudinality, comprehensiveness and coordination of care; b) actions relating to health determinants, by means of studies related to the community health situation. This is achieved by developing priority activities promoted by managers and social actors to improve local conditions, as well as places of residence, work centers, schools, markets and other significant community spaces, as well as promoting healthy lifestyle habits amongst the population.
- *Have available adequately trained multi-professional teams and guarantee timely ongoing training:* The PHC teams represent the central core of the organization and performance of the Primary Healthcare Units. They know and interact on a daily basis with the community and the families and individuals within their area of responsibility. They also respond to the spontaneous demands resulting from acute conditions or other non-programmed needs and they plan the care needed for those with chronic conditions in accordance with their levels of risk and take action according to the health determinants around them. Members of these teams develop specific skills to work in PHC, supported by ongoing training programs to strengthen the specific knowledge and skills required for this type of healthcare in response to existing health determinants. This involves studying the health situation of the community and developing actions prioritized by health managers and social actors to improve local conditions, places of residence, work centers, markets and other significant community spaces that promote healthy lifestyles and habits amongst the population.
- *Establish a healthcare network and guarantee the continuity of care.* Healthcare for members of the population throughout the care network is coordinated and monitored by the PHC team in order to guarantee continuity, which is a prerequisite for quality healthcare. In order to attain this goal, PHC uses methods and instruments to improve first contact access, by extending working hours and care facilities, either via the telephone, internet and other resources; by expanding the service portfolio to increase clinical resolution; having a clinical and healthcare information system available that connects different network levels and services, uses healthcare protocols; relies on a good communication system between units, has adequate logistical systems available and a network of integrated governance to empower and strengthen PHC.
- *Incorporate new functions for healthcare personnel and include new professional categories:* Nursing personnel who are part of the PHC teams are designated to undertake diagnostic and therapeutic procedures traditionally carried out exclusively by physicians, by means of prior qual-

ification and regulation. In addition, the team relies on structured support from other personnel who increment their resolution capacity, such as physiotherapists, pharmacists, dentists, psychologists and others, who may be allocated in the Primary Healthcare Unit itself or in another unit that is part of the interconnected network.

- *Implement effective management of PHC personnel, including the use of incentives:* Building a successful team of healthcare providers is a prerequisite in order to guarantee the longitudinality and continuity of healthcare. This depends on the health system structure as a whole and how it affects the work of PHC units, as well as on effective management that uses adequate incentives to secure the permanence of healthcare personnel within the teams, especially physicians. Having a functional and resolute healthcare network, that provides different levels of care, is independently governed and has integrated management, makes it much easier to attain this objective, while the fragmentation of the system into units that do not have the capacity for scaled management, makes it more difficult.
- *Certify the physical structure, equipment and supplies used by PHC services:* This attribute highlights the fact that good PHC requires an adequate physical and technological infrastructure, including a welcoming environment in the Basic Units, the availability of diagnostic equipment and clinical procedures, medication and dressings, amongst other materials.
- *Incorporate innovative technologies, in accordance with local needs and scientific evidence:* PHC accompanies scientific and technological advances and incorporates these according to the different realities in which it functions to attain greater resolution and quality of individual care, as well as successful interventions to address health determinants.

Requirements to implement policies towards Strong Primary Health Care (PHC)

In addition to the attributes related to its intrinsic characteristics, achieving Strong PHC requires a favorable institutional environment and permanent political support. Also, in this case, despite being aware of the difficulties involved in synthesizing the multiple variables involved, the principle requirements that can make it possible to effectively establish Strong PHC, were identified as follows:

- *Effective commitment from the Health System governance to PHC values and principles:* Expressed through laws, policies and sectorial and inter-sectorial strategies based on the Primary Health Care Strategy.
- *Sufficient and stable funding:* Financial guidelines should go hand-in-hand with and strengthen PHC so that it becomes the central core of the health system. This involves investments in physical and technological infrastructure, the flow of resources to PHC should be adequate and stable, using innovative funding models and by adopting instruments that facilitate the production of scientific evidence that prove its efficacy.
- *The system should be organized so that PHC can develop as a regulatory agency for healthcare networks:* In order that PHC can fulfill its role as a regional network coordinator, the health system as a whole should be structured and organized based on the principles and values of PHC. The organization of the system into PHC-based healthcare networks is legitimized through a specific legal framework and regulated by institutional arrangements.
- *Human resources policies in favor of PHC:* In alignment with this goal, the system that trains human health resources is guided by the need to comply with PHC requirements and to adopt incentives for development and the professional fulfillment of the teams. In this sense, it is important to maintain permanent negotiations with the different categories of distinct healthcare providers.
- *Monitoring and evaluating health procedures and outcomes:* The governance of the system includes indicators related to the performance of PHC, as the central core and coordinator of the health system. In addition to periodically monitoring and evaluating its procedures and outcomes, Strong PHC values the knowledge it holds and analyzes the work it does in comparison with other national and international scenarios, systematically seeking to strengthen and enhance itself, by focusing on improving the health of the population.
- *Innovation and strengthening mechanisms to improve social participation:* Rather than focusing solely on providing care for people and communities, Strong PHC should be constructed in partnership with its users. Aside from the formal social participation mechanisms developed by the SUS, PHC needs to ensure that it develops an effective bond with the population under its care. It is these people who can legitimize the actions of the PHC, and they will only do this if they feel that their needs are being respected and met.

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Innovation in Health for Strong PHC

The changes in the structures of health systems imposed by two practices, conceptualized by Vianna[13], as the Medical-Industrial Complex and the Medical-Financial Complex, that highlight the multiple and complex inter-relationships established between actors from different health sectors and between these and the other economic sectors, impose fiscal, technological, political and social pressures on health systems around the world.

For countries that have opted for universal health systems, as in the case of Brazil, the pressures from the financial sector to attain the capital appreciation of the health sector, demands more governmental, political, economic and social commitment concerning the Right to Health, as foreseen under the Brazilian Constitution of 1988[14].

The Right to Health as a principle of citizenship in Brazil is not linked to narratives involving Consumer Rights issues, which address the supplementary health sector that regulates healthcare care services provided to private health plan beneficiaries – nearly 47 million people[15].

Taking into consideration the global context, the chronic under-funding of the SUS and the administrative, organizational challenges and the healthcare model that public administrators have to cope with on a daily basis, show that there is an increasing need to attract, make relevant, highlight and develop innovations so that the health system in the country can move forward as regards the quality of care it offers its users and its cost efficiency.

In this sense, the 'more of the same' formula does not work. It is often necessary to make profound changes to the instruments of management. The problem of the incoherence between the supply of services and health needs cannot be resolved by increasing the supply in an indiscriminate way, but by introducing new practices, new instruments, new ways of providing health care, in a more integrated, efficient and equitable way. In other words, it is necessary to introduce changes that produce concrete and commensurate improvements, which can involve different areas, such as performance, quality, efficiency and user satsifaction[16].

For a manager, innovation should be a fundamental function and, in order to incorporate this, it is necessary to have the capabilities that make it possible to administer the process of change, with the aim of minimizing risks, maximizing impact, keeping costs down and managing time[16]. Although there are several conceptual and analytical studies in different sciences regarding innovation, unfortunately, its practical application is not available in manuals for managers and technicians and learning about this requires a process of trial and error. Thus, getting to know about other experiences can help the decision-making process aimed at improving processes and outcomes in health[17].

The experience of the Federal District of Brasilia

Although the Federal District is still considered to be a "young city," estimates from the Brazilian Institute of Geography and Statistics (IBGE) show that it now has a population of over three million inhabitants and, like other large Brazilian cities, it has gone through a period of demographic change, including migratory movements, ageing of the population and a reduction in birth rates, in addition to other epidemiological issues, which have altered its morbimortality profile.

Although it has the highest Human Development Index (HDI) among the Brazilian States, the Federal District has significant internal socio-economic inequalities, to such an extent that its territory can include neighborhoods or locations that have a HDI similar to that of Nordic countries and, at the same time, others that are comparable to countries which have enormous difficulties related to income, education and health. These inequalities, reinforced by the socio-epidemiological changes in its profile represent a huge challenge in the organization of health services, especially in the more vulnerable areas. In addition, the health network of the Federal District is a point of reference for an additional population of around 1.4 million people who live in the surrounding cities, especially in the States of Goias and Minas Gerais, which form part of the Integrated Development Region of the Federal District and Surrounding Areas (RIDE).

Motivated by these challenges, among other reasons, the Federal District has gone through a process of healthcare reform based on the framework of the *Healthy Brasilia Project*; the aim of which is to "organize the Unified Health System so that the Right to Health can be fully exercised". This process was formally implemented with the publication dated February 14, 2017 of Ordinance No. 77, namely the Federal District's *Primary Health Care Policy*[18], which was inspired

and based on the Family Health Strategy (FHS). It is worth stressing, however, that its viability was also ensured by Federal District Health Council Resolution No. 465/2016, which provided support to decisions made by the Federal District administration, since the social control acknowledged the need for and importance of reformulation. Following this, in the year 2018, the Legislative Chamber of the Federal District approved Law No. 6.133, on April 6, 2018, which legally and officially established the FHS as the model for Primary Health Care organization within the Federal District.

Taking into account the principles, guidelines and fundamental building blocks of PHC[5], the Healthy Brasilia Project stipulates that all Basic Health Care Units in the Federal Districts hall operate with FHS teams as a healthcare model to replace the conventional model. The aim of this is to increase user access and bonds with the services, provide greater resolution, efficiency and a way of organizing healthcare management in a longitudinal, comprehensive and articulated fashion within the Health care network. In order to put this measure into operation, health personnel who worked within the logic of the traditional model had the option to decide if they wanted to go through a functional change process to form part of the Family Health (FHS) teams. For this reason, the project became popularly known as "Convert" and was regulated by Ordinance SES/DF No. 78, of February 14, 2017, thereby allowing these health providers to form transition teams, once they had completed training and fulfilled the necessary requirements to form an FHSteam[19].

The training program destined mainly for nurses and physicians specializing in the areas of gynecology, paediatrics and general practice, involved an hour load of 222 hours divided between theoretical and practical content and activities. Personnel who finished this process (there were those who dropped out, since they were given the option not to proceed) underwent an evaluation and, those who attained a satisfactory level of performance, could opt to change their specialty area of activity at the Health Department of the Federal District (SES-DF) for Family and Community Health (MFC). In February 2018, 110 physicians completed all these stages and received the necessary approval to work in the FHS.

In terms of concrete changes, it is important to note that, in January 2017, the Federal District had 277 active FHS units, of which243 were established in the National Registry for Health Establishments System (SCNES), representing a total coverage of almost 34% of the population. One year later, after the process of "conversion" had been completed, there was a further input of 272 units, namely a total of 549 FHS units, 322 of which were established within the SCNES, representing a population coverage of 69%. As a result, the population that received assistance from the FHS practically doubled in size, rising from 1,038,750 to 2,058,750 inhabitants within a period of one year from the beginning of the reorganization process. Although this occurred in all regions administered by the DF, this measure made it a priority to expand coverage in areas of greater economic and social vulnerability, reaching 100% coverage in some of these districts. In 2019, the SES-DF's aim is to have 630 FHS units, in addition to 310 Oral Health Teams (ESB's) and 40 Family Health Support Teams (NASF), so as to attain 75% Family Health Strategy coverage.

Even though, as mentioned, the initial stage formed the central core of the changes made to the Federal District's healthcare model, other actions have been implemented to attain even broader FHS coverage within the Federal District. These include: (1) hiring healthcare personnel approved through a competitive examination staged in 2014 (161 specialist MFC physicians) and a further competitive examination in 2018 for different categories; (2) making alterations to the requirements needed to apply for the position of a family and community physician– resulting from the increase in medical residencies in this specialist area; (3) certifying the infrastructure of the Basic Health Care Units; (4) reviewing the PHC Services Portfolio in the Federal District and the publication of the second edition of the Health Services Portfolio Reference Guide; (5) reviewing the flow of referrals between different health care levels, bearing in mind that the health services in the Federal District presented a co-existence of supply at primary and secondary level in the traditional BHU model; (6) reorganizing the Family Health Support Teams (NASF's) highlighting areas of greater vulnerability; and (7) increasing opening hours at some of the BHUs.

Bearing in mind all the planning and the achievement of important outcomes involved in the process to strengthen PHC and to re-organize the SUS in such a short space of time, the Federal District experience has since become the object of analysis by the PAHO/WHO Strong Primary Health Care Innovation Laboratory in Brazil.

It is worth highlighting the fact that this example substantiates what some facts prove: that

the innovations most frequently implemented in health management are radical innovations, based on a drastic change in the development of one or more health practices. The changes refer to one or more processes and generally focus on organizational change[17].

In addition, another point noted by the Innovation Laboratory is the proposal put forward by the Health Department of the Federal District to improve the regulatory complex for healthcare, by creating the Regulatory Complex (*Panoramas*) and by organizing Secondary Healthcare in the Federal District, thereby tackling one of the greatest challenges involved in the implementation of the SUS, which is to make the system operate as a network, facilitating access and certifying the healthcare it provides to its users. The Panorama models consist in establishing a Regional Panorama, which envisages concentrating existing health services within the Health Regions, to be regulated by each Region, the Central Panorama being responsible for bringing together and grouping strategic services in accordance with the regulations of the Regulatory Complex of the Federal District of Brasilia.

Final considerations

Choosing the Primary Health Care strategy as their initial focus, the health administrators of the Federal District successfully implemented a courageous health policy. This experience showed that, despite the obstacles caused by a complex political-institutional situation, involving major restrictions on the use of resources, it is possible to obtain results by introducing innovative practices and knowing how to administer the reaction resulting from the change. The significant increase in coverage by the FHS teams, focused on the more vulnerable areas of the Federal District, represents an enormous step forward in reducing health inequalities among the population of the Federal District.

Nevertheless, it is important that the Federal District administrators spare no effort to maintain and, as far as possible, to strengthen these innovative practices.

A year after the implementation of the Convert Project, which abandoned the traditional model and began to operate using the Family Health Strategy model in the whole area of the Federal District, it was seen that healthcare personnel, physicians and nurses, are going through a learning curve as regards clinical practices dealing with family and community medicine. To this end, it is vital to have permanent, ongoing educational activities so that the changes seen in the expansion of the PHC coverage can also reflect improvements in the quality of care provided, thereby strengthening the model of healthcare adopted. It is considered appropriate to invest in the work process of the Family Health Strategy teams in each Basic Healthcare Family Clinic, with the aim of obtaining healthcare qualifications.

It is believed that strengthening the Family Health Strategy model provides guidelines for the organizational process of specialized care, from the intensification and certification of Primary Health Care matrix-based strategies, with a view to expanding the resolution capacity of this level of care, which has a direct impact on the reduction of waiting times for consultation with specialists.

The challenge facing health administrators and workers is that the Healthy Brasilia Project, after the model's transition period, should invest in the quality of the practice of care it offers the population, so that the outcomes that are to be monitored produce positive impacts on the health indicators of the population of the Federal District of Brasilia.

Collaborations

Contextualization and bibliographical review: RM Gomes and W Carvalho. Fieldwork and data collection: AN Ribas, ILS Ventura and V Borges. Methodological development and critical analysis: R Tasca. Final revision: FAG Leles and JMS Jimenez.

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