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Primary health care financing changes in the Brazilian Health System: advance ou setback?

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Abstract *In 2019, the Brazilian government launched a new Primary Health Care (PHC) policy for the Unified Health System (SUS). Called "PrevineBrasil", the policy changed the PHC funding for municipalities. Instead of inhabitants and Family Health Strategy (ESF) teams, intergovernmental transfers are calculated from the number of people registered in PHC services and the results achieved in a selected group of indicators. The changes will have a set of impacts for the SUS and the health of the population, which must be observed and monitored. In this paper, possible effects of the new policy are discussed from a brief context analysis of global trends in health systems financing and health services' remuneration models, as well as on the advances, challenges, and threats to PHC and the SUS. Based on the analysis, the new policy seems to have a restrictive purpose, which should limit universality, increase distortions in financing and induce the focus of PHC actions on the SUS, contributing to the reversal of historic achievements in reducing health inequalities in Brazil.*

Key words *Primary Health Care, Health Financing, Unified Health System*

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Introduction

Financing models for health systems and payment for health services are widely debated topics in global health due to the increased sector costs. Moreover, both have a robust inductive power on how to organize access to services and technologies, use of available resources, with impacts on health outcomes.

At a recent United Nations high-level meeting on Universal Health Coverage – one of the Sustainable Development Goals (SDGs) – a resolution that emphasizes the need for countries to ensure sufficient public funding to strengthen health systems, maximize health expenditure efficiency to provide accessible, timely and quality services, and increase the allocation of resources for Primary Health Care (PHC), a pillar for achieving the health-related SDGs[1], was adopted.

In Brazil, over the thirty years of implementation of the Unified Health System (SUS), innovations in the health system financing model and the design of organizational arrangements for health services have enabled a rapid and consistent growth in PHC coverage, transforming the healthcare model in a continental country with significant regional, economic and socio-cultural differences[2]. The decentralization of federal resources to municipalities, combined with the implementation of the Family Health Strategy (ESF), was decisive for the expansion of PHC in the country. The ESF increased access to primary health care services and promoted improvements in health outcomes, reducing social and regional inequalities[3,4], and was recognized internationally as an example of successful public health policy[5].

However, despite the advances obtained, the SUS and PHC are at a crossroads in Brazil[6]. Structural weaknesses in the SUS and the huge heterogeneity among the 5,570 Brazilian municipalities led to different patterns of expansion of the ESF[7] and quality of services provided[8], limiting the performance of essential PHC functions. Since 2015, these problems were aggravated by changes in the country's economic and political context. In 2016, a constitutional amendment that froze federal spending for 20 yearswas approved, dramatically compromising the budget of social policies[9].

In 2019, besides the recrudescence of the fiscal austerity policy, the ideological shift towards the extreme right promoted by the Jair Bolsonaro government brought about profound changes in the scope of social, educational, and environmental policies. In health, one of the main changes was the modification in the PHC financing. Launched by the Ministry of Health, the "Brasil Previne" program introduced management tools, such as capitation and performance evaluation, as criteria for calculating intergovernmental transfers, replacing the number of inhabitants and ESF teams in a municipality[10].

The new PHC financing policy will have several impacts for the SUS and the health of the population that must be identified and monitored. This paper discusses the possible effects of the new policy from a brief analysis of the context of global trends in the financing of health systems and remuneration for health services, as well as the advances, challenges, and threats to PHC and SUS in Brazil.

Financing of health systems and payment for health services

According to the World Health Organization, the increased health expenditure – due to the aging of the population, the higher prevalence of multiple chronic diseases, the incorporation of new technologies – has occurred at a level higher than the growth of national GDPs[11]. A change in the pattern of global health financing, in which resources for the sector come increasingly less from direct household spending more from common funds, mainly from government sources is observed[11].

However, some differences in the financing and use of available resources between countries interfere in the equitable access to services and technologies, the efficient use of resources, and the improved health outcomes. Comparative analysis shows that countries with highest percentages of public funding and resource allocation in PHC have better health outcomes and lower inequalities among population groups[12].

Comparing countries based on economic groups, we can observe that health financing is predominantly public and PHC has an active role in the organization of the health system[12] in high-income nations, except the U.S., which has a total health expenditure of roughly double that of other wealthy countries, reaching 17.8% of its GDP in 2016. The highest percentage is private (53.4% of the total). The country's higher expenditure, however, is not reflected in better health outcomes compared to other countries in the group[13].

On the other hand, low- and middle-income countries have predominantly private health financing, health systems with structural weak-

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nesses, and worse health outcomes. In general, PHC and public health programs are focused on specific diseases, and health care is mostly paid by direct disbursement, burdening the budget of households and individuals[14]. As an exception to this group, Cuba is a low-income country with a virtually public health financing, and where PHC has an active role in the health system. Its health indicators are among the best in the Americas[15].

Besides the health system financing, the health services' payment method also produces incentives with a robust inductive power over the configuration of health practices. Among public services, the health sector is one of the most innovative in adopting management instruments aimed at making payment for services provided more strategic, in order to promote improved quality, volume, or productivity[16].

In addition to the remuneration for salaries and services produced (fee for service), it is increasingly common among countries to adopt payment models that employ management instruments such as performance evaluation, global budget for the provision of pre-contracted services, registration of people weighted by risk (capitation); as well as payment per cases based on groups related to the diagnosis and values associated with results achieved.

The different remuneration models have advantages and disadvantages, and their effects can vary with the context of each country. The introduction of reforms with a payment-for-service mode can also produce perverse and unexpected impacts. Therefore, it is recommended that changes be incremental and avoid sudden ruptures that can cause side effects on the health system[16].

Advances and challenges of primary health care in the SUS

In Brazil, while the percentage of public health expenditure has historically been lower than that of the private sector – a contradiction for a universal health system – the implementation of the SUS promoted innovations in the health system's financing model that led to changes in the national care model[2].

Initially, basic operational rules (NOB) published by the Ministry of Health guided the process of transferring federal financial resources to states and municipalities that progressively assumed the coordination of the health system management at regional and local levels. Amid the decentralization of the system, the Ministry of Health started to play a strategic role in the formulation of health policies and directing financial incentives for the implementation of health programs, mainly PHC services.

Inspired by successful loco-regional experiences, PHC financing resources were established by the Ministry of Health in 1996 (NOB-96), in transfers directed to municipalities to implement Community Health Workers (PACS) and Family Health (PSF) programs. However, the implementation of the Primary Care Baseline (PAB) in 1998 has been the most important initiative to boost PHC expansion in the country[17]. Consisting of a fixed component, calculated by the number of inhabitants of a municipality, and a variable component, associated with the incentive of priority policies, the PAB modified the payment rationale until then based on the number of procedures performed. The transfer of resources allocated to PHC on a regular and automatic basis by the National Health Fund to Municipal Health Funds allowed financing health services in poorer, primary infrastructure-deficient municipalities, fostering a gradual and continuous change in the health care model[17].

Subsequently, the National Primary Care Policy (PNAB), published in 2006, defined the Family Health strategy as a priority model for implementing PHC services in the SUS. As a result, federal resources were added to the variable PAB to encourage municipalities to implement ESF teams to develop individual and collective health actions for the population of a defined geographical territory[18].

In 2011, the PNAB was revised, and different values were established to calculate the per capita PAB fixed value, based on socioeconomic vulnerability criteria in the municipalities. Moreover, the National Program for the Improvement of Access and Quality (PMAQ) was established, linking resources to the variable PAB associated with the performance evaluation of the ESF teams. From the number of participating teams and the more than 100 million users involved, the PMAQ was considered one of the most significant performance compensation programs in the world in PHC[19].

The implementation of the ESF provided consistent advances in increasing the coverage of Brazilian PHC services. From 1998 to 2018, the ESF was adopted by more than 95% of Brazilian municipalities, and the number of ESF teams hiked from 2,000 to 43,000, now covering about 130 million people (62.5% of the Brazilian population)[20]. Studies show that higher ESF coverage in the municipalities is associated with increased

access to health services, lower hospital admissions for primary care-sensitive conditions, and improved results, with a declining infant mortality in all regions of the country, benefiting more vulnerable populations, as a positive impact in reducing inequities in the country[3,4].

However, despite the advances achieved, the Brazilian PHC faces challenges and threats. Studies indicate that the expanded PHC coverage occurred in different patterns in the country, facing hurdles associated with structural weaknesses of the SUS, such as budget restrictions, fragile regional organization, and low capacity to allocate strategic resources, particularly for medical professionals[7]. Furthermore, disparities among the 5,570 municipalities (68.2% have less than 20,000 inhabitants, while 5.8% have more than 100,000 inhabitants) translate into varying levels of the quality of services provided, limiting the performance of strategic PHC functions, such as first contact access, care coordination, comprehensiveness and longitudinality[8].

These problems have deteriorated following the economic and political changes in the country. In response to a severe economic recession, the national congress approved in 2016 an amendment to the constitution that limited the growth of federal spending to the inflationary adjustment for 20 years[6]. In the context of budgetary constraints, a new review of the PNAB was carried out in 2017, making the composition of ESF teams more flexible, reducing minimum requirements for professionals to serve the population in a territory[21].

Looking ahead, economic projections suggest that reducing federal funding for municipalities should shrink ESF coverage and access to primary services, leading to worse-off health indicators, such as infant mortality. These effects tend to affect mainly more impoverished regions and dependent on federal transfers, increasing health inequalities[2,22].

The projections were confirmed by a study that evaluated the effect of the economic recession on Brazilian municipalities[23]. A 4.3% increase has been observed in adult mortality rates between 2012 and 2017, with an estimated 31,000 deaths associated with the effect of the recession. However, the impact was not homogeneous nationwide, and it concentrated on black and brown, male, and people of working age. On the other hand, municipalities with higher expenditures in the SUS and the *Bolsa Família* (Family Grant) showed no or negligible increase in mortality.

Possible impacts of the new PHC financing

In 2019, the beginning of Jair Bolsonaro's administration marked an ideological shift to the extreme right in Brazil, causing profound changes in a set of federal government policies. In health, the government listed PHC as a priority, creating a specific secretariat for the area in the Ministry of Health[24]. However, the change in the PHC financing model will affect the SUS and the health of the population, which must be identified and monitored, especially given the long-term maintenance of fiscal austerity measures that should aggravate the public health under financing in the country.

Established through Ordinance N° 2.979, in November 2019, the "Previne Brasil" program replaces the criteria used until then in the fixed and variable PAB to finance PHC funding in the SUS. Instead, the number of people registered in Family Health and Primary Care teams registered in the Ministry of Health was introduced – weighted by criteria of socioeconomic vulnerability, demographic profile, and geographic location; payment-for-performance based on the results achieved by the teams on indicators and goals defined by the Ministry of Health; and financial incentives for priority actions and programs of the Ministry of Health[10]. The new policy was supported by the Brazilian Society of Family and Community Medicine[25] and criticized by the Brazilian Public Health Association[26].

The use of capitation and performance evaluation for the remuneration of services in public health systems in the world is not new. England stands out for its comprehensive National Health System reform, adopting these instruments for the payment of PHC services[27].

The English model was cited as a reference for the development of the new PHC financing policy. However, there is a fundamental difference. Instead of using capitation and performance evaluation for service remuneration, these instruments have become criteria for the calculation of intergovernmental transfers, which are intended to subsidize the financing of local health systems – given that SUS is decentralized, and municipalities pay for PHC services. This should distort any positive aspects of the instruments and expand their possible side effects.

When used as a payment instrument for the provision of health services, capitation has advantages such as the inclusion of clients, accountability for a specific population, and strengthening the link with health teams/services. The

information produced by the registration of people can be of great value for the recognition of the epidemiological profile and planning of the offer of health actions. Moreover, the training can provide the user with the option of linking to the service of their choice, stimulating competition between teams. A possible perverse effect is the selection of patients (*risk selection*) that is described through the creation of obstacles for the registration of people who overuse the health system or who perform expensive treatments[28].

By adopting capitation as a criterion for PHC financing in the SUS, replacing per-capita financing, a condition that previously did not exist for the transfer of resources to PHC is created, with direct and indirect consequences for the health system.

PHC financing in the country ceases immediately to be universal and is restricted to the population registered by the municipalities. At the launch of the program, the Ministry of Health showed that there are 90 million people registered, and another 50 million are being registered[29]. Therefore, the federal government's goal is not to finance PHC for the total Brazilian population.

Second, while it is expected that the policy will increase the number of people registered in PHC services and that the weighting values more vulnerable regions, the financing will depend on the effectiveness of the registration, which should vary substantially in the country[3]. Municipalities in underserved areas should show greater administrative difficulty in registering people, while for populous cities, with significant population agglomerations, the registration of the population can be a highly complex task[30]. Consequently, it is possible to reduce resources for PHC in regions of great need.

Third, special attention should be paid to possible systemic side effects of using capitation as a financing instrument. On the one hand, it can attract the attention of municipalities to the expansion of registered patients, to the detriment of the quality and scope of services (especially those without performance incentives). On the other, barriers can be set to register certain population groups that require greater care or have health problems with more expensive treatments. Possible restrictions on access, reduced scope, and quality of services in PHC tend to divert patients to other levels of the system, primarily to emergency units.

Fourth, although the remuneration of services for performance evaluation seeks to encourage teams to increase productivity to achieve pre-established goals, evidence suggests modest improvements in process indicators under evaluation[31] and no consistent improvement in health outcomes[32]. Furthermore, the instrument may have the side effect of reducing the teams' attention to health problems that are not included in the assessment metrics. Consequently, when establishing performance evaluation as a criterion for PHC financing in SUS, municipalities may focus on indicators that will be monitored, changing the scope of work of PHC teams, whose object should be community health problems.

Finally, the coverage of the PHC services can also be compromised because of new policy's discontinued financing of Family Health Support Center (NASF) teams, whose performance has been described as of high relevance to increase the resolution capacity of the PHC, as well as supporting their integration in health networks[33].

Conclusion

Despite the modernizing coating of the new PHC policy, the adoption of capitation and performance evaluation as criteria for calculating intergovernmental transfers seems to serve more restrictive purposes than the qualification of services. It should limit universality, increase distortions in the financing, and induce the focus of PHC actions on the SUS. In a perspective of prolonged budget constraints, which will exacerbate public health under financing in Brazil, the new policy can contribute to reversing historic gains in reducing health inequalities, which have occurred since the implementation of the SUS and the ESF. It is, therefore, a setback that must be faced by Brazilian society as a whole.

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