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Primary Health Care financing trends in a Brazilian capital

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Abstract *Established in 2019, the Previne Brasil Program (PPB), the current PHC financing model under the Ministry of Health, comprises four payment criteria. Except for the population-based financial incentive, these criteria vary and are linked to municipal performance in achieving PHC indicators. This study aimed to assess the trend in the availability of PHC funds in a Brazilian capital. This quantitative, analytical, longitudinal study was based on secondary information from intergovernmental transfers. Analyses were conducted using the R program, with a significance level set at p<0.05. Considering the entire period, the results revealed a significant upward trend in costing financial transfers. Weighted capitation was the criterion that most impacted the costing block and remained stable, whereas pay-for-performance and strategic actions indicated a significant fluctuation trend in monthly payments.*
Key words *Health financial resources, Family Health Strategy, Primary Health Care*

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Introduction

Financing is a critical point concerning the sustainability of Primary Health Care (PHC) and the Unified Health System (SUS)[1], widely discussed in the national and international scientific community[2]. The *Previne Brasil* Program (PPB) is the current PHC financing model and has generated doubts and controversies, as it is still not possible to guarantee the expanded financial capitation, that is, an actual increase in the financial transfer when the requirements of the ordinance that established it are met.

The main fear of municipal managers, members of the National Council of Health Secretaries (CONASS), and the National Council of Municipal Health Secretariats (CONASEMS) is the possible loss of financial resources[3]. In this model, the subsidy is given under four criteria: weighted capitation, pay-for-performance, incentive for strategic actions[4], and financial incentive based on population criteria, added later[5].

The Basic Healthcare Package (PAB) was the PHC financing model before the PPB, consisting of fixed PAB and variable PAB[6]. By adopting weighted capitation to the detriment of per capita financial transfers, the PPB replaced the fixed installment previously received with a variable, hindering PHC's planning and security[3]. Regular and automatic resource transfers facilitated the structuring of more impoverished municipalities that lacked basic infrastructure and with low PHC coverage[7]. The list of actions and programs encouraged by the Ministry of Health was maintained with implementing the PPB. Except for three actions, the others were already components of PAB variable[3].

Although pay-for-performance indicators have the smallest share in the total amount of current funding[8], municipal managers endeavor to comply with this criterion because it measures the teams' performance of individual and care-related actions and clinical practices. Thus, PPB's hospital-centric nature[9] is reinforced, which does not imply the actual achievement of results, considering that some targets remain below those stipulated by the Ministry of Health, especially indicator 5, which refers to vaccination actions[10].

Despite the relevance of the PHC[11] financing topic, quantitative studies that analyze the before-after PPB implementation period, possible changes in the trend of financial transfers to PHC, and their consequences[12] are still rare. To date, we have not found publications in journals that have addressed this object of study, nor the analysis methodology that will be presented here. Thus, we affirm the unprecedented nature of this study, which implies potential advancement in the construction of knowledge regarding PHC financing in Brazil, contributing to theoretical-methodological reflections on the subject and allowing comparisons with future studies in other Brazilian locations.

The COVID-19 pandemic influenced the PPB complexly and extended the transition period for its implementation[13]. In light of this, studies that analyze intergovernmental financial transfers are required, as fundraising can vary in different regions of the territory due to the existing heterogeneity and the municipal strategies adopted[14]. This study aimed to verify the trend in the availability of PHC resources in a Brazilian capital, comparing the current period with that prior to the PPB.

Methods

Study design

This quantitative, analytical, longitudinal study was conducted in Campo Grande, Mato Grosso do Sul (MS), under the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE)[15] guidelines.

Context and data collection

We analyzed the trend in the availability of financial resources for the Mato Grosso do Sul (MS) state before and after the implementation of the PPB from January 2018 to December 2023. Moreover, we evaluated the Capital's total monthly transfers (costing and investment), outlining the trend of the three main PPB payment criteria (weighted capitation, pay-for-performance, and strategic actions).

Secondary data was used from information provided by the Campo Grande Health Department (SESAU-CG), the Ministry of Health Information System (e-SUS), the e-GESTOR platform, and the National Health Fund (FNS). The public domain information is derived from the Brazilian Institute of Geography and Statistics (IBGE), the CONASS and CONASEMS platforms, and the federal, state, and municipal transparency portals.

Data analysis

Data on financial resources transferred to the municipality were analyzed for trends using control graphs. Initially, monetary values were adjusted for inflation, adopting the Broad Consumer Price Index (IPCA)[16] published by IBGE, adjusted to 2023 values to compare the different study periods. Next, the control limits were estimated. The lower control limit was determined by subtracting three times the standard deviation (SD) from the mean funds, while the upper control limit was established by adding three SDs to the same mean.

Zones A (control), B (alert), and C (central) were defined to study the patterns in this data series. Zone A comprises a range of 2-3 SDs around the mean, B comprises a range of 1-2 SDs, and C comprises a range of one SD around the mean (Figure 1). These limits were then used to assess the variability and stability of transfers during the period under study.

The following criteria were considered to analyze variations in the monthly financial transfers: points outside the control limits, at least six consecutive increasing or decreasing points, at least nine consecutive points on the same side of the curve (above or below the mean), two of three consecutive points in one of Zones A and four of five consecutive points in one of Zones B or beyond[17,18].

Analyses were performed by the R program[19], with a 5% significance level. In the same way as the costing and financing transfers, during the statistical analysis, control graphs were created for the weighted capitation, pay-for-performance, and strategic actions criteria (findings presented in detail in Figures 2, 3, and 4). The variables used are shown in Chart 1.

Ethical aspects

This study was submitted to the Research Ethics Committee of the Federal University of Mato Grosso do Sul and approved under Protocol N° 5.768.371 (CAAE 63214422.0.0000.0021).

Results

Table 1 presents the amounts of the annual financial transfers received through the costing and investment blocks. The amounts received through weighted capitation, performance through the Final Synthetic Indicator (FSI), and strategic actions are also included.

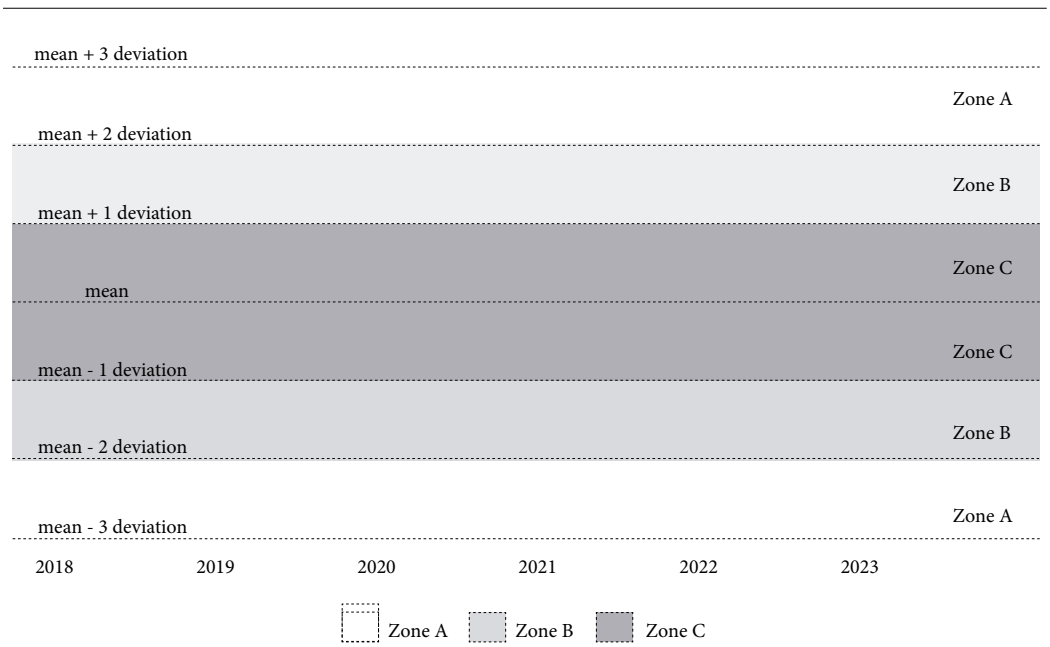

Figure 1. Control graph - Data analysis limit zones.

Source: Authors.

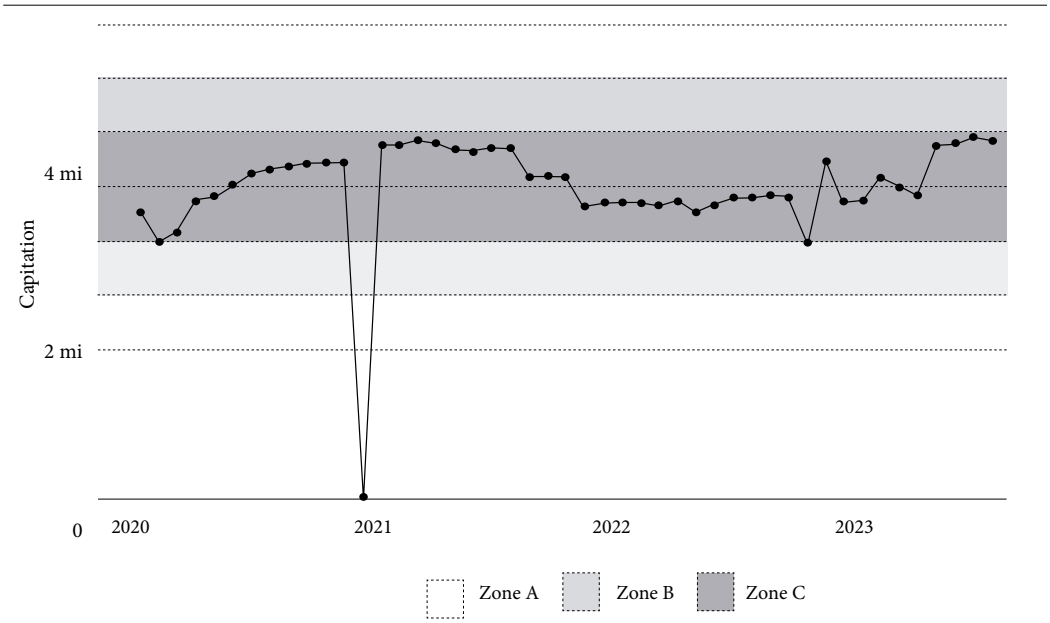

Figure 2. Control graph of monthly payments using the weighted capitation criterion for Family Health Units, Campo Grande-MS, January 2020 to November 2023.

Source: Authors.

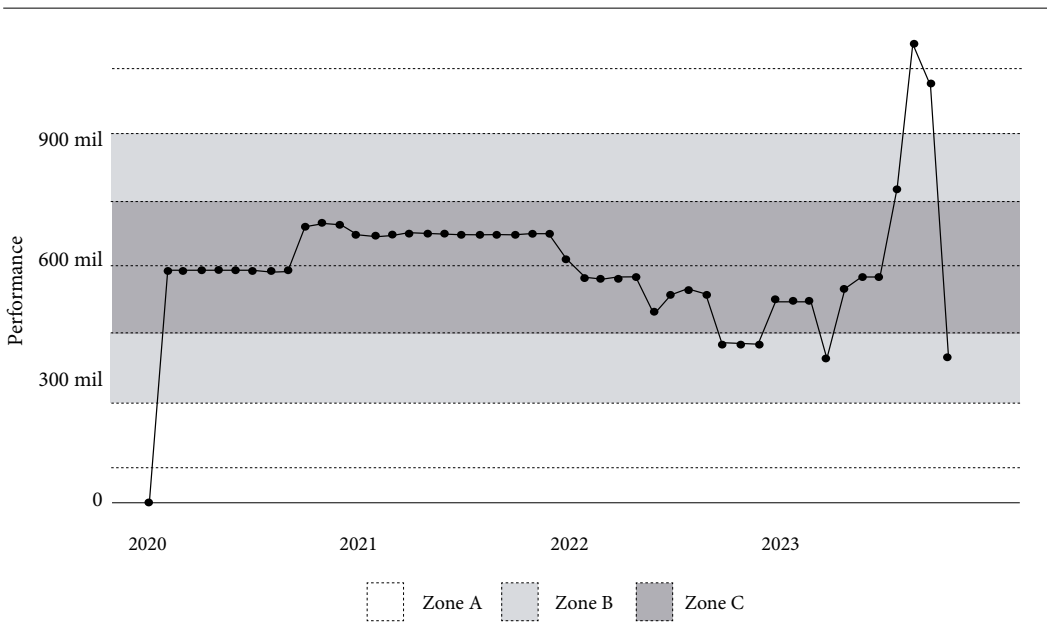

Figure 3. Control graph of monthly payments based on the Final Synthetic Index Performance criterion for Family Health Units, Campo Grande-MS, January 2020 to November 2023.

Source: Authors.

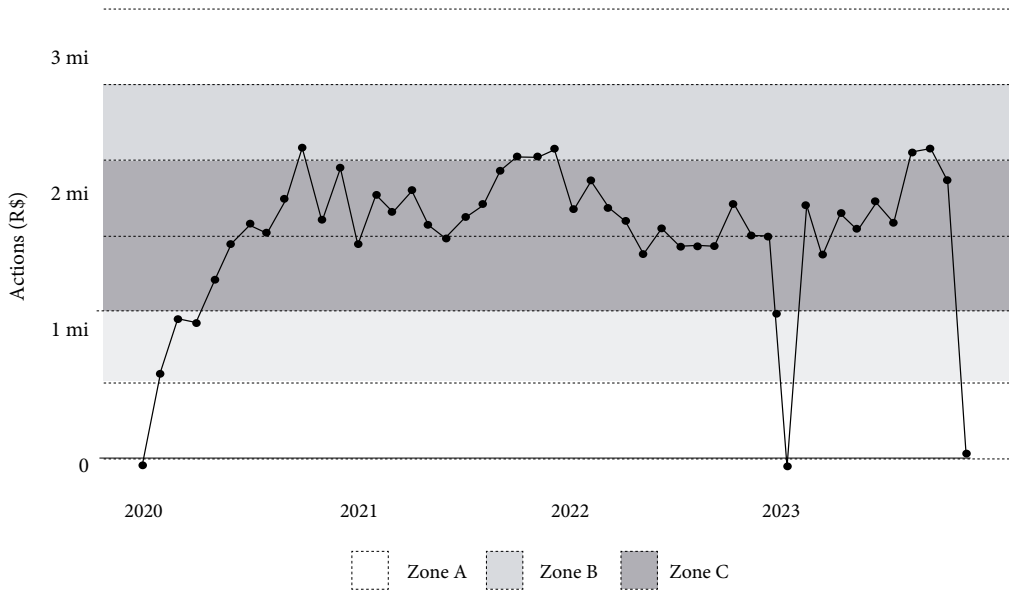

Figure 4. Control graph of monthly payments using the Strategic Actions criterion for Family Health Units, Campo Grande-MS, January 2020 to November 2023.

Source: Authors.

Chart 1. Description of the variables used in the study.

Variable	Description	Source
Costing transfer	Sum of all current expenses with health actions and services	FNS
Financing Transfer	Sum of all health infrastructure expansion expenditure	FNS
Weighted capitation	Sum of all monthly transfers, adjusted by the IPCA. Values calculated based on the number of people registered by the eSF, eAPS, riverside eSF, street clinic teams, and prison eAPS.	FNS
Pay-for-performance	Sum of all monthly transfers, adjusted by the IPCA. Values calculated based on the Final Synthetic Indicator (FSI), using the formula in Technical Note N° 05/2020 DESF/SAPS/MS.	FNS
Strategic actions	Sum of all monthly transfers, adjusted by the IPCA. Values calculated based on financial transfers to municipalities that implemented programs, strategies, and actions the Ministry of Health encouraged.	FNS

IPCA: Broad Consumer Price Index; FNS: National Health Fund; eSF: Family Health team; eAPS: PHC team; SAPS/MS: Primary Care Secretariat/Ministry of Health.

Source: Authors.

The state of Mato Grosso do Sul (MS) comprises 79 municipalities, with approximately 2.756 million inhabitants[20]. It received BRL 2,796,595,540.40 to fund PHC, with a monthly average of BRL 466,099,256.73. The annual transfer for costing rose from BRL 436,853,814.10 in 2018 to BRL 527,155,762.28 in 2023. The Capital received 24% of the funds allocated to the state, a total of BRL 654,949,448.44 for USF costing, with a monthly average of BRL 9,224,640.12. Costing annual transfers increased from BRL 87,043,837.91 in 2018 to BRL 127,440,886.16 in 2023. We observed an increasing trend throughout the analyzed period for costing.

For investments, BRL 194,640,092.97 were invested in the Family Health Units (USF) of MS,

Table 1. Annual transfers of financial resources to Primary Health Care in the State of Mato Grosso do Sul (MS), 2018 to 2023.

Year	Total de repasses				Critérios de pagamentos					
	Costing (R$) - Capital	Costing (R$) - MS	Investiments (R$) - Capital	Investiments (R$) - MS	Weighted capitation (R$) - Capital	Weighted capitation (R$) - MS	FSI performance (R$) - Capital	FSI performance (R$) - MS	Strategic actions (R$) - Capital	Strategic actions (R$) - MS
2018	87,043,837.91	436,853,814.10	712.078,52	31,879,416.83	-		-		-	
2019	92,779,535.16	394,883,606.48	666.018,44	16,806,795.98	-		-		-	
2020	111,347,984.01	405,607,261.21	617.019,11	11,895,177.01	44,143,559.09	154,760,659.97	6,652,651.45	36,687,916.43	17,597,633.93	57,699,099.14
2021	120,229,098.26	488,130,539.68	16.262.519,51*	71,549,456.43*	45,030,631.97	167,028,627.27	7,975,508.04	25,861,555.97	23,757,056.17	69,447,188.28
2022	116,108,126.94	543,964,556.65	64.328,78	26,407,486.33	42,322,981.90	173,957,614.21	6,040,575.86	25,495,105.46	21,135,426.35	64,546,110.50
2023	144,793,987.91	527,155,762.28	883.699,00	36,101,760.39	46,508,437.88	182,022,757.95	7,836,324.97	31,853,656.96	21,371,894.85	69,446,582.88
Total	672,302,570.19 [1]	2,796,595,540.40 [1]	2.943.143,85 [1]	123,090,636.54 1	178,005,610.84 [2]	677,769,659.40 [2]	28,505,060.32 [2]	119,898,234.82 [2]	83,862,011.30 [2]	261,138,980.80 [2]
Mean	9,224,640.12	466,099,256.73	270.502,30	24,618,127.31	3,696,677.95	169,442,414.85	584,539.09	29,974,558.71	1,704,669.56	65,284,745.20
Capital/MS	24.0%		9.9%		26.3%		23.8%		32.1%	

[1] From 2018 to 2023; 2 From 2020 to 2023. *Amounts allocated to structuring the PHC and municipal and state oral health service network.

Source: Authors.

with a monthly average of BRL 32,440,015.50. The annual transfer hiked from BRL 31,879,416.83 in 2018 to BRL 36,101,760.39 in 2023, with a peak of BRL 71,549,456.43 in 2021. BRL 19,205,663.36 were allocated for the Capital, with a monthly average of BRL 270,502.30. In this regard, the annual transfer rose from BRL 712,078.52 in 2018 to BRL 883,699.006 in 2023, with a peak of BRL 16,262,519.51 in 2021, allocated to structuring the PHC service network and state and municipal oral healthcare.

The state amounts received regarding weighted capitation, pay-for-performance (FSI), and strategic actions criteria correspond to monthly averages of BRL 169,442,414.85, BRL 29,974,558.71, and BRL 65,284,745.20, respectively, from 2020 to 2023. The financial transfers received by the Capital regarding these criteria corresponded to monthly averages of BRL 3,696,677.95, BRL 584,539.09, and BRL 1,704,669.56 from 2020 to 2023. These corresponded to 26.3%, 23.8%, and 32.1% of the total allocated to MS (Table 1).

Figures 2, 3, and 4 show the control graphs of the three main payment criteria of the PPB of Campo Grande (MS): the monthly fluctuations in payments under the criteria of weighted capitation, FSI performance, and strategic actions for the Health Units.

The weighted capitation criterion initially showed, for nine consecutive months, an increasing trend (February 2020 to October 2020), up from BRL 3,410,613.10 to BRL 3,984,203.24. In January 2021, we noted a point below the lower control limit, as there was no payment that month under this criterion. From February to December 2021, we observed 11 points above the mean. However, from January 2022 to January 2023, the control graph indicated 13 points below the mean. In other words, after the initial growth in 2020, we identified decreasing payments for weighted capitation (Figure 2).

Regarding the FSI performance, nine consecutive points below the mean were observed between January and September 2021, followed by 16 consecutive points above the mean (October 2020 to January 2022), indicating increased payments from October 2020. However, 18 points below the mean were observed from February 2022 onwards, indicating a decrease in payments based on this criterion, returning to growth in August 2023. Considering the period as a whole, we note a significant fluctuation in the monthly payments made under the FSI performance criterion (Figure 3).

For payments based on the strategic actions criterion, from January to April 2020, points were observed in the lower alert and control zone, indicating lower payments in this period based on this criterion. From July 2021 to April 2022, 10 points were above the mean, suggesting increased payments during this period. Also, we detected wide monthly fluctuations for this payment criterion.

Discussion

The findings of this study suggest a significant upward trend regarding financial transfers for costing, considering the period as a whole. However, financial transfers for investments remained stable.

When analyzing the three main PPB payment criteria separately, it became clear that weighted capitation, after initial growth from 2020 onwards, has remained stable to date, given that 96.7% of the population has already been registered[20], which is compatible with 61.8% of Brazilian municipalities with 100% registered population[21]. On the other hand, pay-for-performance and strategic actions tended to significantly fluctuate in monthly payments, justified by the municipality's requirements for compensation regarding indicators, programs, actions, and strategies[4,12]. We should recognize that PPB has limitations[22], although it has provided, in general terms, a more significant amount of funds against the previous PHC financing model in this initial implementation stage. These limitations refer to the capacity of this program to promote the expansion of the registered vulnerable population (data suggested by the weighted capitation behavior)[21] and subjecting other indicators to factors proximal to the work process that do not depend exclusively on management. In this case, financing becomes intrinsically linked to micropolitical professional decisions, which do not necessarily interact with management[23].

There was a tendency to increase PHC financing considering all values adjusted by the IPCA - IBGE, adjusted to 2023 values. This result is compatible with studies from other regions of the country[13,14,24] and can be explained by the fact that the financial transfers for costing in the period studied are also on an increasing trend.

In this sense, data confirming a fluctuating pattern in financial support can be explained since funds intended to maintain public health actions and services are transferred through the costing block. This block is subdivided into regular costing and temporary costing increments. The "regular costing" is currently the PPB. The "temporary costing increases" mainly refer to parliamentary amendments and emergency funds[22]. At the same time, funds intended to acquire equipment, works for new installations, and renovations[25] are transferred to the investment block. Therefore, due to these characteristics, fluctuations are justified. They may be related to the work process but are also subject to funding sources that are naturally unstable and dependent on macropolitics.

The most significant portion of funds was transferred through the "regular costing" block, that is, through the PPB, which was favored during the transition period of the financing program. During this period, the amount received from the Fixed and Variable PAB was planned to be replaced by a transfer equivalent to 100% of the weighted capitation and pay-for-performance financial incentive that the municipalities or Federal District would be entitled to if they met all the requirements. Therefore, in 2020, the municipalities received all these funds even without having their total registered population or meeting the performance indicator targets. Furthermore, in the same year, the transition per capita financial incentive was transferred, with BRL 5.95 (five reais and ninety-five cents) paid multiplied by the IBGE estimate of the population of the municipalities or the Federal District[4,22].

Due to the COVID-19 pandemic and the intense confrontation between the managers of the 5,570 Brazilian municipalities, CONASS and CONASEMS, upset with the imminent financial loss, the Ministry of Health, through consecutive decrees, extended the financial competency. As of August 2021, the weighted capitation criterion was required, and the pay-for-performance was required gradually in 2022[22,25-28]. Therefore, the value of the financial transfer referring to the pay-for-performance before the third four-month period of 2022 does not represent the actual result obtained[13].

The PPB implemented strategic actions adopted by the municipality that did not exist at the time of the Variable PAB, such as the *Saúde na Hora* Program, the PHC Computerization Support Program, and the incentive for municipalities with medical and multidisciplinary residency, also contributing to increased fund transfers[14]. Subsequently, in 2021, after the transition per capita financial incentive extinction by

ministerial action, the PPB rules were changed, incorporating a fourth payment criterion, the Financial Incentive Based on Population Criteria[5].

Although the PPB only influences the federal financing block for PHC funding, this study also evaluated the financial transfers for investments from 2018 to 2023. BRL 17,319,183.63 were transferred to the municipality for investments, an IPCA-adjusted amount[16]. This block remained stable except for the transfer for investments made in November 2021 (BRL 15,023,465.15). In other words, only the costing block, influenced by the PPB, showed a trend of increasing transfers. This fact highlighted the relevance of the PPB in this Capital and nationwide[22], regarding the elements financed with resources from the costing block. Regarding the items financed by the investment block, the results reveal many challenges to increasing financing.

The study results show that the transfer for funding was adjusted in the period evaluated but did not necessarily imply expanded access, the link with service users, and respect for the PHC attributes, as justified when implementing the PPB[29]. Sufficient financing and adequate management of funds received are essential[30] to achieve this. SUS decentralized financing, coupled with the lack of political-economic knowledge of many local managers, means that funds are not always allocated appropriately[31].

When analyzing the trends of the three main PPB payment criteria in the capital independently, we noted that the most significant portion of the costing transfer is allocated to weighted capitation (61.5%), followed by strategic actions (28.5%) and pay-for-performance (10%). This study's findings are compatible with those recommended by the creators of the PPB for each payment criterion[8]. This result allows the reflection that municipal managers scale up efforts toward pay-for-performance, because it allows for measuring team performance. However, this payment criterion has the smallest share of the costing block.

Although the period evaluated initially evidences an increasing trend in weighted capitation financial transfers due to the transition period and the extended financial period due to COVID-19, data relating to the immediate effects of adopting weighted capitation should be observed with caution, as the increase in transfers for 2020 and 2021 did not necessarily reflect an increase in registrations[13,14,24].

According to Lopes *et al.*[32], the Northeast region did not show an increasing variation in the percentage of individual assessment registrations from the third four months of 2019 and 2020. On the other hand, in the 14 macro-regions of Minas Gerais, a continuous increase in the registered population was observed from 2018 to 2022, edging closer to or even exceeding the population estimated by IBGE[14]. Similar results were found in the municipalities of Amapá from 2020 to 2021[24].

This study observed decreased financial transfers to weighted capitation from August 2021, when PPB financing was transferred per the actual number of registrations. Finally, as of the last four months of 2022, we observed that the weighted capitation remained stable, as 96.7% of the Campo Grande population had already been registered, approaching the IBGE population[20].

The increase in registration may not be an indicator of strengthening PHC attributes. In this sense, its reach does not always reflect the attached clientele, the responsibility of the ESF teams for people, and the link with health teams. On the other hand, it can favor producing information for recognizing the epidemiological profile, planning the provision of health actions, and adopting clinical management tools, such as active search, case monitoring, and measuring outcomes[7,8].

In a perverse effect, linking the financial transfer to the number of people registered in PHC services can lead to losing funds in regions of great need. Defunding PHC restricts access, potentially directing patients to other system levels, mainly to emergency units, or also establishing barriers to registering specific population groups that need more expensive care and treatments[7].

Pay-for-performance indicated a tendency for significant fluctuation in monthly transfers, as this transfer is linked to the results achieved by the ESF and Primary Care. The PPB proposal included 21 population health indicators, cumulative from one year to the next. It would start in 2020 with seven new indicators, which would be gradually incorporated for the next two years[12,33]. However, only seven indicators were established due to the reorganization of PHC imposed by facing the COVID-19 pandemic[34,35]. During this period, the municipalities did not reach the goals proposed by the PPB[10] agreement. Indicators 5, 6, and 7 were the most impacted, possibly due to the readjustments of the work process during the pandemic[33-38]. However, the financial transfer was fully transferred regardless of its compliance[13].

The indicators came into force gradually from January 2022. Indicators 1 and 2 were required

during the first four months (Q1), and indicators 3, 4, and 5 were added in the second four months (Q2). The pay-for-performance considered the natural result obtained[25-27] only from the third quarter (Q3). The amount is calculated based on achieving the target for each indicator, respecting their weights. The financial incentive transferred to the municipality or Federal District was now obtained by combining the results into a FSI[39]. The weighting of the respective weights is provided for in Ordinance No. 3,222/2019[12]. Indicators 3, 5, and 6 have weight 2, unlike the others (weight 1), and are evaluated by four months[4,39].

Figure 4 reflects the socioeconomic and political situation experienced in the country from 2020 to 2023. Initially, during the pandemic, payment was constant due to the extended financial period. From 2022 onwards, it became variable, considering the transfer per the teams' performance in the four months evaluated. Payment for production was now uncertain due to its linkage to the teams' production and the outdated amounts in the SUS table[3].

By making financing conditional on compliance with indicators, municipalities can be encouraged to focus solely on their compliance, resulting in a change in the teams' scope of work and discouraging teams from caring for health problems not covered in evaluation metrics. Therefore, the indicators should evaluate the quality of the service rather than just the amount of procedures performed[7].

Another way to raise funds with PPB is to adhere to the strategic actions listed in Ordinance No. 2,979/2019. The results of this study indicated a tendency for significant fluctuation in monthly payments for this criterion, as just adhering to the actions does not guarantee the transfer. Financial transfers require compliance with the rules set out in current rules that regulate the organization, operation, and financing of the respective actions, programs, and strategies adhered to[4].

The municipality's USFs, in general, are working precariously, with a reduced number of professionals and a shortage of materials, resulting in low-quality care and precarious healthcare[40]. These factors hamper adherence to and compliance with strategic action requirements, leading to suspending or canceling this financial incentive.

The complementary incentive, with the creation of Residency Programs as a criterion, enabled qualified training through financial transfers to municipalities with health professionals, such as Medicine, Nursing, and Dentistry. These programs can increase users' access to health services, improve the healthcare professionals provide, and increase resolution[13]. However, multidisciplinary work remains a challenge for PHC, and this incentive needs to be expanded to cover other professional categories[9] to be overcome.

This study has limitations inherent to designs based on secondary data. It used PPB goals, which changed the evaluation due to the dynamic process and the fight against the COVID-19 pandemic. Furthermore, IBGE data do not consider the floating population in the municipality and who uses SUS services.

Few or no studies evaluate the implementation of the PPB and its consequences. Each federation unit may experience revenue losses and great efforts must be made to obtain a real gain in financial resources[22]. This study innovates by outlining the trends in the availability of PHC resources for the current financing criteria globally and independently. Thus, interpreting the performance and capitation within the PHC scope is uniquely improved.

Conclusion

Regarding financial transfers for costing, we observed an increasing trend when considering the period before and after the PPB. The individual analysis of the three PPB payment criteria suggested stable trends for weighted capitation (linked to the high percentage of registered population) and significantly fluctuating trends for pay-for-performance and strategic actions.

Collaborations

All authors contributed to all phases of the study.

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