Contribution to a strategic policy agenda for Primary Health Care in the Brazilian Unified Health System (SUS)

Research Network in Primary Health Care of Abrasco[1]

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This document expresses the position of the Primary Health Care Research Network (PHC Network) of the Brazilian Association of Collective Health (Abrasco) in a context of threats to the principles and guidelines of the Brazilian Unified Health System (SUS) and the Family Health Strategy (FHS), aggravated in the last two years with the democratic rupture in the Country. The document is signed by the group of researchers of the PHC Network and contains propositions to compose a strategic political agenda for the SUS, main object of the debate held during the XII Brazilian Congress of Collective Health in Rio de Janeiro in July 2018.

In this year of 2018 we celebrated 30 years of SUS, the culminating moment of the Brazilian Sanitary Reform Movement and one of the milestones in the redemocratization process of the Country. The SUS was created by the Citizen Constitution of 1988, which established 'Health as a right of all and duty of the State'. From this milestone, Brazil has established health as a fundamental right, through a universal public system and the interaction between social and economic policies[1]. This year, we also celebrate the 40th anniversary of the Declaration of the International Conference on Primary Health Care held in 1978 in the city of Alma Ata, Kazakhstan, in the former Union of the Soviet Socialist Republics (USSR), under the auspices of the World Health Organization (WHO)[2].

Since Alma Ata, and its slogan of 'Health for all by the year 2000', many initiatives for the implementation of PHC have been undertaken worldwide with different conceptions and approaches: from very selective proposals of minimum baskets to populations in extreme poverty, 'poor medicine for the poor', to integral PHC as the basis of universal public health systems. These approaches have produced different results on the organization of health systems, the right to health and citizenship. Selective PHC corresponds to a conception of residual citizenship, and the integral PHC of the universal systems corresponds to full citizenship[3].

To mark the 40th anniversary of the Alma Ata Declaration, WHO will hold the Global Conference on PHC in Astana, capital of Kazakhstan, in October 2018. At that time, the Astana Declaration will be signed, whose preliminary versions indicate a setback in the defense of integral PHC[4]. The versions in consultation caused concern to the scientific community in Abrascão 2018, by proposing the Universal Health Coverage without emphasizing the relevance of integral PHC and universal health systems in guaranteeing the full right of citizenship and equitable access to health services according to need. Among the critical points of the proposal, there is little emphasis on guaranteeing the universal human right to health and the segmentation inherent in Universal Health Coverage, to be achieved through insurance

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(private or public) differentiated by social groups according to income. Coverage will depend on the rules of each insurance and the ability of payment of the citizen[5]. In Brazil, the adoption of the Universal Health Coverage proposal would be another serious step in the dismantling of the SUS. By restricting the right to health of brazilians to a limited basket of services, Universal Coverage reissues selective PHC and promotes inequities in access[5].

Without the guarantee of an integrated and well-designed universal health system, historical differences in the geographical distribution of services will be amplified, harming underprivileged regions and social groups. In addition, the preliminary documents of the Astana Conference emphasize private sector participation and the responsibility of individuals and communities in the provision of health care. It is socially unfair to delegate to individuals, communities and social groups the responsibility to provide health care on their own, exempting the State from financing and organizing complex and articulated networks of health services[6]. Without funding, regulation and public participation in the provision of health services, it is not possible to guarantee universal access according to needs.

On the 30th anniversary of SUS and 40 years of the Alma Ata Declaration, a conservative wave plagues the Country and the world and requires the mobilization of governments and societies for the construction of free public universal health systems designed on the basis of integral PHC models that contribute to reducing social inequalities and promote equity. At the Alma Ata Conference, Primary Care (PC) was defined as the integrated basis of care in health systems with universal access, public funding and provision. Under the inspiration of Alma Ata, SUS recognizes the intimate connection of economic and social development in the determination of the health-disease process, health promotion and the provision of universal and integral health services, with equity and social participation. The fundamental principles of SUS have guided the elaboration of this Strategic Agenda, in response to actual serious threats to the universal right to health in Brazil.

The consolidation of PHC in the last decades represents one of the most relevant advances of SUS as public policy and universal health system in Brazil. The success of the SUS is anchored in the comprehensiveness of the FHS, the main health care model of PHC, which surpassed the mark of 40 thousand teams implemented throughout the national territory in 2017. The superiority of the FHS care model in relation to the traditional model of care has become national and international consensus. The huge expansion of the FHS coverage over the last 20 years has resulted in an increase in the broad spectrum of actions and services and has contributed to important positive impacts on the health of the population[7-12].

Setbacks and threats to democracy and the historic achievements of the Brazilian people mark the current conjuncture. The parliamentary coup of 2016 had as its purpose to dismantle the Brazilian State, through the withdrawal social rights, such as, for example, through labor reform, the privatization of state-owned enterprises, and the reinforcement of fiscal adjustment policies based on the reduction of social protection spending. SUS is under heavy threat, with the deepening of the defunding, freezing of public expenditure and proposals to strengthen the private sector to the detriment of public services.

In this context, there are already indications of perverse impacts of the dismantling of the SUS on the health situation of the population, with an increase in infant mortality, a reduction in vaccine coverage, and outbreaks of immune-preventable diseases[13]. A recent study projects the occurrence of 20.000 preventable deaths in children under five years old due to the stagnation or

reduction of the coverage of the FHS; in case Constitutional Amendment nº 95 (EC 95), published in 2016, which freezes public expenditure for 20 years, is not revoked[14].

With regard to PC, three worrying events are worth highlighting:

- Recent changes in the National Primary Care Policy (PNAB) in 2017 indicate the abolition of the priority for FHS as evidenced by the federal funding for conventional PC modalities; the flexibilization of the dedication of the professionals of the team with reduction of the workload of doctors and dentists that prevents the longitudinality; by the flexibilization of the presence of the Community Health Workers (CHW) in the Family Health Teams (FHS) added to the change in the assignments of this worker, adding nursing practices and actions of the Agent to Combat Endemics. These changes disfigure PHC based on the combination of health needs, territorialization, assignment of users, bonding and sanitary responsibility, and reinforce the modality of selective basic health services, organized under the 'complaint-conduct' attendance logic. The creation of the portfolio of essential services can transform PC into a selective PHC. There is also great possibility of stagnation or reduction in the number of Oral Health Teams.

- The end of the funding blocks for the transfer of federal resources to states and municipalities may lead to dislocation of the resources of PHC to medium and high complexity procedures, especially due to the aggravation of the underfunding of the SUS caused by the fiscal austerity economic policy, expressed in the freezing of the ceiling of public spending over the next 20 years[15].

- The possibility of creating 'popular' supplementary private health plans linked to international financial capital to offer PC in large scale to the population with lower socioeconomic conditions may lead to the capture of clients and professionals from SUS for a selective PHC, of low quality and little resolutive.

The present Strategic Agenda systematizes the discussion on the advances and challenges of PHC carried out by the PHC Research Network during the preparatory seminar of the Abrascão 2018 and during the Congress, based on texts specially produced for the event and available on the Research Network in PHC site[16]. The document presents proposals for overcoming the historical challenges of PHC and coping with the present threats. As a result of a broad collective effort, this Strategic Agenda is part of the struggle to defend the principles of the SUS and the consolidation of a universal, inclusive and civilizing health policy in our country. The document goes beyond the academic scope and can subsidize the debates, public consultations and reflections on the XVI National Health Conference, whose convocation was published in the Union Official Journal (DOU) of August 09, 2018[17].

Also called the 8th + 8 in a rescue to the memory of the VIII National Health Conference, held in 1986, the XVI Conference will take place in a crucial period to reaffirm the principles and policies of the SUS. The preparatory activities of the biggest social participation event in Brazil have already begun, with the accomplishment of workshops, symposia, forums, debates, public hearings, manifestations, marches and participation of the National Health Council in thematic congresses. The proposals of the present Strategic Agenda have a strong convergence with the theme 'Democracy and Health: Health as Right and Consolidation and Funding of the SUS'. The effort undertaken by a large group of participants of the interaction spaces of the Abrasco's Research Network in PHC will gain relevance if it encourages the elaboration and approval of proposals in the municipal stages, scheduled for the period from January 2 to April 15, state and to the district, scheduled for the

period from April 16 to June 15, and in the great national event to be held from July 28 to 31, 2019.

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1 PHC in SUS: advances and challenges

In Brazil, initiatives to expand Primary Health Care services have been undertaken since the beginning of the 20th century, but it was only in the mid-1990s that a PHC national policy was formulated and implemented with the adoption of the Family Health Strategy as a preferential model, with a central role in the SUS organization. In the following years, in addition to the expressive expansion of the population coverage of the FHS teams throughout the national territory, a set of policies and respective normative frameworks related to the FHS were implemented, giving a broad framework for the consolidation of this policy in the Country.

Some of these initiatives must be emphasized by their relevance in the constitution of the PHC policy, such as the federal funding model, with the creation of the per capita funding model; monitoring and evaluation mechanisms, such as the Basic Care Information System (Siab) and the National Program for Access and Quality Improvement in Primary Care (PMAQ-AB); training and formation programs for health professionals, such as the Permanent Education Poles for Family Health Personnel and Multiprofessional Residences; in addition to initiatives to improve the structures of PHC facilities, such as the Requalification Program of the Basic Health Units.

It is emphasized, as well, a set of policies and programs related to the increase in the sustainability of PHC, such as Oral Health with the Smiling Brazil program, Family Health Support Centers (Nasf), Home Care, Integrative and Complementary Practices; National Policy on Food and Nutrition and other intersectoral health promotion policies, such as the Health in School Program and the Health Academy.

Actions aimed at reducing inequalities in access of vulnerable populations have also been implemented, such as the Teams for Homeless, Coastal Family Health Teams, Basic Fluvial Health Units, Health Care for Persons Deprived of Freedom. More recently, the More Doctors Program (PMM) has been an essential strategy for the provision of PHC in areas that are difficult for the population to access basic health services and vocational training.

The amplitude of these initiatives has been associated with positive results of the FHS regarding the health situation of the Brazilian population. The increase of the coverage, access and use of PHC services in this mode of care has contributed to the reduction of important health problems, especially when there is synergy between health actions and other social policies, such as the Bolsa Família Program which provides a transfer of income to brazilians with poor socioeconomic conditions[18,19].

1.1 The Family Health Strategy and the improvement of the health situation of the Brazilian population

Since the first years of implantation, many scientific evidences have demonstrated the positives impacts of the FHS on the health of the Brazilian population, highlighting the reduction of infant mortality and preventable hospitalizations, the expansion of access to health services, and the reduction of social inequalities in health.

Several studies have demonstrated the association of the increase of the coverage of FHS with reduction of infant mortality and under-five mortality in Brazilian municipalities, even when controlled the action of other

determining factors[8,10,11,20]. The reduction has been greater in post-neonatal mortality than in the neonatal component, as expected, since the causes of neonatal mortality include congenital diseases, prematurity and problems related to birth care.

Evidences also indicate the reduction of infant mortality and in children under five years due to diarrhea and respiratory infections, responsible for the majority of deaths in these age groups[21]. The authors highlight that the impact was higher in municipalities with higher initial rates of infant mortality and lower Human Development Index (HDI), revealing the role of the FHS in reducing social inequities in health. The evidenced synergistic impacts of PHC and the implementation of the Bolsa Família Program in reducing infant and child mortality indicate the importance of developing social policies to combat poverty and expand health care in Brazil[19].

Several studies have emphasized the role of FHS in reducing preventable hospitalizations due to resolutive Primary Health Care services[9,22-24]. In 2008-2016, Admissions due to Primary Health Care Sensitive Conditions (ICSAP) in children up to five years old were significantly lower in the poorest municipalities (lower quintile of Gross Domestic Product – GDP per capita) that adhered to the PMM, particularly by reducing hospitalizations for gastroenteritis and asthma. In these municipalities, PMM was also responsible for a reduction in the cost of these hospitalizations[25]. It is highlighted, also, evidence of the impact of FHS in hospitalizations for chronic diseases such as asthma, heart problems, stroke and the reduction of mortality due to these problems[26].

1.2 Expansion of supply, use of PHC services in SUS and reduction of socio-spatial inequalities

The impacts of the FHS on the health situation of the population resulted from the expansion of the coverage and access to PHC services, including medical and nursing consultations, educational activities, home visits, care of people with chronic conditions, prenatal care and immunization. The positive impacts on health were more significant in municipalities with higher FHS coverage.

Two studies with information from the National Health Survey (PNS) deserve to be highlighted[27,28]. The first one revealed the similarity of the FHS coverages estimated for Brazil and the Federated Units, from the PNS and administrative data of the Department of Primary Care of the Ministry of Health, reinforcing the validity of official coverage data. The study indicates the greater access of families with lower schooling to monthly home visits in teams of the FHS[27]. Performance evaluations of the basic health network in different social contexts, ranging from population-based national surveys[29] to studies in large geopolitical regions[7] and large municipalities[30], reveal greater access to home care for the poorest elderly populations living in FHS areas, confirming its relevance in promoting equity in health. The second study related to the PNS investigated the association of the FHS with the existence of a usual source of care (a service or professional that the individual always looks for when he/she has health problems), considered a good indicator of access. The majority of the population reported having a usual source of care, which in more than a third of cases was a PHC unit. A strong positive association between being enrolled in the FHS and having as a usual source of care a PHC unit has been demonstrated. There was also a negative association with the reference to emergency/urgency units as the usual source of care, which was stronger in the poorer regions of the Country (North, Northeast and Central West)[28].

The importance of the FHS to access and quality of care provided in the SUS stands out in the results of the external evaluation of the PMAQ-AB, an initiative agreed

between the Ministry of Health, the National Council of State Health Secretaries (Conass) and the State Council of Municipal Health Secretariats (Conasems). In teams participating in the first cycle of PMAQ-AB (2012), 89% of the pregnant women had six or more visits during prenatal care, and more than 95% had updated the tetanus vaccine and received a prescription for ferrous sulfate[31]. The access to the preventive examination for the control of cervical cancer reached 93% of women between 25 and 59 years old, and the coverage of breast cancer screening was 70%, exceeding the WHO recommendations[32,33]. Over a period of six months, about 90% of users diagnosed with diabetes had access to the consultation at the Basic Health Units and underwent blood tests to control the disease[34].

With regard to Oral Health a range of advances can be highlighted due to the formulation of a set of measures, guidelines and norms that supported the organization of oral health actions in the SUS. There was also investment in oral surveillance, with national epidemiological surveys and fluorine control in water supply. There was a significant expansion of the number of Oral Health Teams in the FHS model, including teams for specific populations (homeless, coastal, pluvial), making up 26 thousand Teams of Oral Health teams (2017), with an increase of more than 600% compared to 2002. It was observed, as well, a significant increase in the financial contribution with improvement of the infrastructure and the creation of new incentives for medium complexity services[35]. The structure and work processes of PHC have helped reduce the rate of oral cancer mortality, although it has not reduced the incidence rate of the disease. Increased investments in PHC and Oral Health are essential to avoid deaths related to oral cancer[36].

Despite the investments in improving the conditions of the Basic Health Units (Requalifica UBS), poor infrastructure conditions persist, mainly installations, inputs and information technology[37,38]. The offer of services is restricted to working days. There is a shortage of professionals in number and adequate training to meet the health needs of the population with quality.

In addition to structural deficiencies, the organization and management of the FHS and the professional practice of its teams suffer from a systemic problem of the incompleteness of the offer of health care actions. For example, the availability of referral standards, guidelines, goals and work protocols was not enough to improve the completeness of actions in women's health[32,33] and people with chronic conditions[34].

The necessary expansion of health services, in the XXI century, can benefit from the more extensive use of modern information and communication technologies such as, for example, Telehealth. Benefits include overcoming geographic and physical barriers, facilities on the interaction between health professionals in the team and in the service network; timely access to diagnostic and therapeutic support resources; the expansion of the capacity of care coordination from/by PHC; in addition to promoting communication among professionals, patients and managers[39].

Social inequality is an important feature of the Brazilian society, and one of its faces is socio-spatial inequality, which mirrors, nowadays, centuries of predatory policies and actions in the constitution of our territory. Santos and Silveira[40], when analyzing the historical and geographic process of the construction of the Brazilian territory, identified the existence of four Brazils that express this inequality: the Concentrated Region formed by the Southeast and the South; the Brazil of the Northeast; the Midwest and the Amazon, each with its own characteristics. It is precisely outside the Concentrated Region that the largest number of poor municipalities is located, in which access to public goods is more difficult. In the case of health, these are the territories of the care gaps, manifested by

the lack of professionals and health services.

Studies indicate that it is the poorest and remote regions, with a population in extreme poverty, those that present greater difficulty in health care access, including in PHC[41]. It is evidenced, as a result, a cruel equation: the lower the population density of the municipality, the more difficult it is to provide the offer, with lower the per capita spending on health and the worse the access to services. Another aspect of inequality occurs within the major cities. As a result of the Brazilian model of urbanization, an important part of the population living in these cities does not have access to the services and goods that the State should provide, which led Milton Santos[42] to coined the term 'incomplete citizens'.

Much needs to be done, but some important measures have been taken in recent years in the PHC scenario. Among them, the PMM stands out. Structured in three strategic axes, the More Doctors Program provides: 1) training for the SUS, with investment in the creation of more vacancies for graduation and residency and new medical courses based on curricular guidelines that respond to the health needs of the population; 2) the expansion and improvement of the Basic Health Units infrastructure and 3) the emergency provision of Brazilian and foreign doctors[43].

Several studies highlight the importance of PMM in the reduction of regional inequalities in the distribution of doctors in Brazil[44-47]. In the years 2013 and 2015, that is, after the implementation of the PMM, using an index to measure the scarcity of doctors, one of the studies showed that the Program contributed to a substantial increase in the number of doctors in the country, with a reduction in the number of municipalities with scarcity of doctors from 1.200 to 777[45].

In 2015, almost a third of the Basic Health Units received doctors from the PMM, and 55% of the professionals were inserted into teams that already existed, that is, they had doctors in some period in the years of 2013 and 2014, especially in teams with high turnover of these professionals. The insertion of PMM professionals in these teams should not be considered negative, since it means the permanence of the professional on a more stable basis than the intermittent insertion, prior to the implementation of the Program[45].

Finally, there is evidence of the impact of PMM on the increase in the number of medical consultations in all age groups considered, the number of prenatal consultations, referrals for physiotherapy, occupational therapy, psychology and others, number of exams and home visits[48]. Despite the short time of implantation, some studies also show positive PMM impacts in hospitalizations in general and some infectious and parasitic diseases, as well as respiratory diseases[49].

However, it should be highlighted that regional and socioeconomic inequities still persist and are manifested in inequalities in the provision of services and procedures, which can hardly be overcome without financial investment and without the clear political option of reversing this situation. Ensuring the universality and comprehensiveness of health care in the unequal and continental scenario of our country has been, and will continue to be, a constant challenge in the implementation of SUS.

1.3 PHC and care comprehensiveness

The concept of comprehensiveness, an objective image of the SUS, recognizes the individual as a whole, proposing the integration of health actions and the intersectoral action of social policies. The comprehensiveness is expressed in organizational processes and professional practices within each FHS team, in the health services network and in relation to geopolitical territory. It evokes the necessary interdependence between actors and organizations involved in care

to achieve integration and coordination of health policies, services and actions, in addition to more efficient management of resources[50]. Coordination of care, defined as 'coordination of comprehensiveness', is made possible through strategies of horizontal integration (programmatic actions and spontaneous demand, actions of health surveillance and care, multiprofessional and interdisciplinary work and team work) and vertical integration between the various levels of attention that compose the health care networks[51].

The priority to universalize the FHS is essential for the achievement of comprehensiveness, in the SUS, thanks to its superiority in the realization of the PHC attributes. The integration of the teams with other devices of the territory where they are located is part of the territorialized conception of PHC in the Brazilian model of the FHS. In fact, the FHS can be considered as a model that induces changes in health practices regarding the adoption of new objects[52], in addition to individual attention and traditional public health practices, incorporating the territory and its populations, understood as dynamic and live space of establishing social relations. This way of action implies the recognition of the territory, through the process of mapping families, community devices, geographic and environmental conditions related to health risks and potentialities, in order to organize the offer of actions based on the characteristics and problems observed.

The idea of work and community organization as an inherent element of the concept of PC, which in turn is subsidiary to the expanded health concept adopted by the Brazilian Sanitary Reform Movement, poses as an additional challenge the development of practices of coordination that are beyond the traditional walls of health services, penetrating the community social space. In fact, a set of health promotion actions aimed at intervention on social determinants of health has required coordinated action with other sectors and organizations located in the territories.

In the context of PHC and FHS teams, the Community Health Worker is a strategic worker with actions oriented towards the comprehensiveness of care and intersectoriality, namely: building a link and recognition of the population assigned to the territory, with direct articulation between services and life in the territory; community work; development of actions to promote health, tracking of hypertensive and diabetic patients, follow-up of prenatal care and child growth and development. In July 2018, more than 260.000 workers were present in 97% of the municipalities, which numerically reflects the importance of the Community Health Workers to the FHS teams and emphasizes his/her role of combining actions of care, prevention and health promotion[53]. The Community Health Workers in the FHS have faced great challenges throughout the historical trajectory of the SUS. The PNAB published in September 2017[54], makes the presence of Community Health Workers more flexible in the FHS teams and alters its attributions, by incorporating nursing practices. The Technical Training Program for Health Workers, instituted by Ordinance nº 83/2018[55], under discussion in the Federal Chamber, proposes the technical training in nursing for agents in a generalized manner. The proposal is considered incompatible and inadequate in a context of flexibilization of the scope of the team that weakens the labor relations and the principles of the SUS. The initiative dilutes the specificities of the community health agents, the agents to fight endemics and the nursing technicians with risks of reduction of the contingent of workers, work overload of the remainders, predominance of simplified health care procedures to the detriment of education and promotion of health[56].

With the insertion of psychology, nutrition, physiotherapy, physical education and social work professionals, besides medical

specialists, among others, Expanded Nucleus of Family Health (Nasf-AB) constitute an important arrangement in strengthening PHC, by increasing the provision of care in the service network, resolution, comprehensiveness and the target of actions[51,57]. Through integrated action to the health teams, Nasf allows to conduct discussions of clinical cases, enables shared care among professionals both in the health unit and home visits, allows the joint construction of individual therapeutic projects in a way that expands and qualifies the interventions in the territory and in the health of population groups. These health actions may also be intersectoral, with a priority focus on prevention and health promotion actions.

Despite the continued expansion of services since its implementation, which reaches, in 2018, more than five thousand nucleus[53], Nasf faces challenges of several orders, from the high number of municipalities that do not have coverage of this service to nucleus that informally cover a large number of FHS teams. Also of concern are the low investment in working conditions, transportation, equipment and materials; the difficulty of interaction between Nasf professionals and the FHS teams adds to organizational problems, jeopardizing coordination and continuity of care and regulation of access. The conceptual and formulation challenges encompass the desirable extension of the scope of offers of the FHS and the adequacy of other points of attention in the network, highlighting the polarization between 'attending patients' and 'doing collective actions'.

The remarkable expansion of Oral Health in SUS, especially after 2004, with the Smiling Brazil Program, contributed to the strengthening of comprehensiveness in health. The program structured actions for promotion and surveillance, prevention and recovery of oral health, expanded access to dental treatment in the three levels of care[58]. Despite this, the Oral Health faces challenges that permeate all PHC policies in Brazil, such as the tension between the biomedical model and the family health model; the permanence of iniquities in the provision of services and procedures. Models of hiring of upper and middle level personnel that maintain the precariousness of labor relations persist. The challenges also reach the training and permanent education of Oral Health professionals to the SUS and require strategies to defend and sustain the advances of the National Oral Health Policy, with social participation in the micro-politics of services[59].

Another relevant initiative for the comprehensiveness of PHC is the National Policy on Integrative and Complementary Practices (PIC), institutionalized in 2006 and with gradual insertion in the SUS with expansion of the offer in 2015[60]. Currently, Brazil has 29 implemented practices and reaches 78% of the offer, especially in the FHS and Nasf. PICs enhance integral care by expanding the range of therapeutic options offered, by acting as a resource for harm reduction and health promotion, as well as representing a pleasant integration strategy and a perspective of care for the work of the teams in PC. Its presence in the PHC also fosters the reorganization of the team's work process and promotes the centrality of the user and their needs in the health system. In addition, it reinforces the link between staff and users, advancing in an integral perspective of health care overcoming the biomedical care model[61]. In the current context, three relevant axes are delineated for the strengthening of PICs in PHC, namely: institutional expansion, with the aim of increasing its supply and democratizing access; research promotion about the PIC regarding effectiveness, safety, way of action and institutional experiences of its offer in PHC; training or qualification of professionals in PIC, necessary for the exercise and supply of these practices in an effective way in the health system.

The consolidation of an integral PHC in Brazil depends on the regular contribution of investments that prioritize the FHS and the set of arrangements and devices necessary to address the entire health needs of individuals and populations.

2 Strengthening the management of PHC in Brazil

By constitutional definition, the SUS is a national public system of universal and integral nature[1]. Since the 1990s, efforts have been multiplied in the construction of a federative health model, with the definition of the role of each sphere in the management of the system, along with the creation of specific institutional structures and mechanisms of relationship between SUS managers together with society. Federal, state and municipal management responsibilities cannot be delegated[62], as a consequence, outsourcing and privatization of the PHC management contravene the constitutional definition of the SUS.

In support of the public management of PHC, this Agenda highlights advances and challenges in the adequate training of professionals for PHC and in work stability, in normative and institutional aspects of SUS, in the financing and institutionalization of mechanisms for monitoring and evaluation of actions and services. The management of PHC has been strengthened in the last decade by promoting a program to improve the quality of the actions offered to the population in the basic health network of the Country, articulated to progressive financial incentives to municipalities and FHS teams, according to the performance certified by external evaluation. PMAQ-AB and performance incentives are at risk of discontinuity in the SUS, due to financial constraints arising from EC 95[15].

2.1 Professional training and work management

Concerning the training of professionals for PC, several efforts were undertaken after 2003, with the creation of the Secretariat of Labor Management and Education in the MH. The experiences of the Educational Program for Health Work (PET-Saúde), the Experiences and Stages in the Reality of the Unified Health System (Ver-SUS), the Aprender-SUS, the Ensina-SUS, the National Program of Reorientation of Vocational Training in Health (Pro-health) and the National Policy on Continuing Education were considered innovative incorporating students in PHC[63,64].

In recent times, the PMM, in its educational component, has induced changes in curricular guidelines and increased the number of vacancies (5.300 new vacancies by 2015) and in degree courses in medicine[65]. The Program also had a positive impact on the expansion of the offer of Medical and Multiprofessional Residency Programs in Family Health, Family and Community Medicine, with an increase of 4.742 places in various specialties up to 2015, in public and private universities throughout the Country[65] and in Courses of Specialization in Family Health, in the Distance Learning modality, through the Open University of SUS (Unasus)[66]. The effects of PMM also reached the post-graduation strict sense in PHC, by encouraging the activities of the Northeast Network of Family Health Training (Renasf) and promoting the creation of the Professional Master's Degree in Family Health (Profsaude), through a National Network of 20 institutions, under the leadership of Abrasco and the Oswaldo Cruz Foundation (Fiocruz). In 2015, PMM incorporated the Program of Valorization of the Primary Care Professional (Provab), started in 2011, with the offer of a scholarship to act in the PC and score for admission to medical residency programs[63].

However, many problems in workers training persist throughout SUS implementation, reaching numerous levels and organizational structures of the system, including PHC. Namely: dissociation between teaching, research and professional practice; health units with inadequate structure to receive undergraduate students; insufficient quality of student and professional training; fragmentation in the training of the future professional and in the continuing education of the in-service professional, both of superior and technical level; low institutionality of permanent education actions, which leads to the discontinuation of the training of workers. The privatization of medical and nursing education has been configured as a major problem, among other reasons, due to the low regulation of the educational system in the Country. Despite the increase of vacancies for medical residency in Family and Community Medicine, its filling is still low, in relation to the available institutional capacity[65]. There are also difficulties in integrating health and higher education policies aimed at training health workers, including meeting the demands of PHC management[63].

During this period, the advance in information and communication technologies enabled the incorporation of new support strategies for professionals, such as, for example, Telehealth, which has the potential to support and assist in the training of workers, besides amplifying the comprehensiveness and resolving capacity of professional practices.

Work management under the PHC is subjected to what is set not only for other professionals of the SUS but also for workers in general, which compromises the sustainability of the system. The systematic process of precarious working conditions goes beyond the health sector, and is evidenced, among other characteristics, by the flexibilization of working hours and salaries, common practice of social organizations and other forms of privatization of the management of health units and services.

2.2 Normative and institutional aspects of public health management

According to the results of the first and second cycles of the external evaluation of the PMAQ-AB, carried out in 2012 and 2014, direct administration is still the main form of contracting the workforce in PHC in Brazil. Direct management is present in most Brazilian states and municipalities, but in only 77% of FHS teams. Practically one FHS team out of four is under the management of indirect administration, which expands rapidly in the PC of the largest municipalities, with the argument of circumventing the limits of the Fiscal Responsibility Law and the obstacles of the traditional public administration. By 2013, 1.216 Brazilian municipalities (21.8%) had established management contracts with social organizations (SO) in the health area[67]. Another fact that draws attention is the contracting of health services through SO in 22 (56.4%) of the 39 municipalities with more than 500 thousand inhabitants[67]. In the PHC, the social organizations and state foundations of private law assumed the operational management in the state of São Paulo, in the city of Rio de Janeiro and in the state of Bahia[68-71].

After some years of implementation of these institutional formats in the Country, the proposals remain without consensus among the different actors of the public health system. Some experiments were evaluated within the sector, some related to social organizations[68,72-81], and others on state foundations[71,79,82,83].

The lack of a regulatory framework that guides the formalization of partnerships, establishing responsibilities, rights and duties between contracting parties and contracted, in order to ensure social protection and work, has generated iniquities and compromises the quality of care provided. The debate on normative and institutional aspects of health management recognizes that the undeniable advances achieved in the last decades coexist

with the challenges inherent to comprehensive care and the guarantee of the wide participation of organized social sectors. Added to this is the need to regulate and monitor heterogeneous practices of municipal health management, notably in the regulation of the public-private relationship in contract management[84]. Ensuring the autonomy of the manager 'on the edge', ensuring inducement in what goes beyond his/her scope, should be done observing governance practices with effective social control and transparency of usual management procedures.

2.3 Funding

Responsibilities with management and funding of the SUS are shared between the three spheres of government: federal, state and municipal. PC is the only level of attention in which the transfer of federal resources to municipalities is population-based, according to the definition of the Basic Operational Norms of SUS (NOB/SUS) published in 1996[85] and implemented since 1998. This logic opposes to payment for procedures that define the financing of medium and high complexity care. This decision made a major contribution to reducing regional inequalities in the allocation of federal resources to PC[86]. In 2017, new criteria were introduced for the calculation of the fixed PAB, including, in addition to population, GDP per capita, percentage of the population with Bolsa Família or percentage of the population in Extreme Poverty, the percentage of the population with health insurance and the population density. However, the annual per capita values transferred to the municipalities remain negligible, ranging from R$ 23.00 to R$ 28.00, according to the levels in which municipalities are classified[87].

The logic of transfer of financial resources conditioned to the accession of municipalities to specific programs formulated by the federal government (variable PAB) induced the expansion of FHS, oral health, the Program of Community Health Agents, Nasf and PMAQ-AB. Despite the restriction of municipal autonomy regarding the definition of expenditures with PHC in its territory, the incentives linked to the variable PAB favored the coordination and national expansion of important strategies of qualification of the PC, with deconcentration of the delivery of services and redistribution of financial resources to poorest regions.

Despite the relevance of federal and state transfers, about 70% of expenditures on PC are covered by municipal resources, the main source of livelihood of PC[88]. The strong dependence on municipal resources is considered unstable because it focuses on personnel expenses limited by the Law of Fiscal Responsibility.

Among the challenges for financing PHC, the heterogeneity of Brazilian municipalities stands out, which is revealed by the regional inequalities that affect the management capacity of the system. A considerable number of municipalities in the Country is small-sized and have a restricted economic base to support them, being, therefore, very dependent on intergovernmental transfers. In several of these municipalities, there is not even a local technical structure to formulate and implement health policies, or even assume the management of the health services network. The instigating role of state health secretariats has been insufficient to assume regional planning, its part in financing and regulating the service network, in order to contribute to the integration between PHC and other levels of care in the regionalized network.

Expanding the democratic discussion and proposing the revocation of the provisions of EC 95/2016 are fundamental efforts in the present context of underfunding of the SUS. It is necessary, as well, to expand the role of the states and the Federal District in regional planning, financing and regulation of the service network, allowing the integration of PHC with other levels of care, as well as

the expansion of redistribution mechanisms and equitable allocation of federal and state resources to PHC, considering the differentiated capacity of self-funding of municipal managers, the regional specificities, the priority and the need to strengthen the FHS. The participation of Health Councils in the processes of policy formulation, control and supervision of the application of financial resources to the PC, at national, state and municipal level, is crucial to overcome the challenges of the funding of SUS and PC.

2.4 Evaluation, monitoring and improvement of the quality of PHC

The accomplishment of normative evaluations of the Family Health Program, the creation of the General Coordination for Monitoring and Evaluation of Primary Care (CGAA) in 2003, the Baseline Studies of the Proesf in 2005, the proposal for Evaluation for Quality Improvement (AMQ) of the FHS, followed by PMAQ-AB and the Self Evaluation for Access and Quality Improvement of Primary Care (Amaq-AB) represent relevant efforts of the monitoring and evaluation of PC in the Country[7,89,90]. However, enormous challenges still remain to institutionalize these initiatives in the daily life of PHC management. Among the main obstacles, the production and treatment of information and its full utilization, essential resources to support the planning, monitoring and evaluation of health actions, not only by local teams, but also by the management of the PC in the three spheres of the SUS.

It is urgent the universalization of the Health Information System for Primary Care (Sisab/e-SUS) and the solution of data interoperability problems among multiple information systems, so as to advantageously overcome Siab, discontinued in 2015. The full implementation of the e-SUS should ensure the computerization of the work process and the qualification of the information, but also the production of automated reports of individual and aggregated information within the scope of the health team and the scope territory of the FHS and the access to health information in all points of the SUS care network.

3 Proposals for a political and strategic agenda for PHC in SUS

Revitalizing the principles of integral PHC in the Alma Ata Declaration in its essence requires, above all, to elucidate its implications in the global context for the universal right to health. Tensions and contradictions remain regarding PHC approaches in Brazil and in the world. In the last years, the international debate about different conceptions of health universality has become more lively, polarized in the proposals of the universal system versus universal coverage in health[5].

In the 'universal coverage' agenda, PHC represents a basic package of essential services and medicines defined in each country, corresponding to a selective approach to reach a basic universalism through some type of insurance (private or public) in developing countries. It distinguishes itself from the integral approach of universal public systems, in which PHC guides the design of the system and must order the care network.

It is urgent to focus on the formulation of the Letter from Astana 2018 being prepared by WHO and to demand primacy in the defense of the universal right to health of all peoples, expanding the narrow conception of universal coverage now widespread and defending the construction of universal public health systems.

The PHC we want for SUS incorporates the essence of Alma Ata principles: essential care, the basis of a public health system of universal access with public funding and provision; inseparable from economic and social development and from confronting

social determinants to health promotion, strengthening social participation.

The PHC we want to guarantee the universal right of access to health services in SUS establishes first contact with easy and decisive access to quality, which guarantees timely, integral, integrated and continuous care with family and community orientation. Its care model emphasizes the promotion of health, guarantees the balance between individual and collective care responding to individual and population needs. It strengthens the democratic spaces of social control and promotes active participation for potent community action in the territory to mediate intersectoral actions for the promotion of health. It is carried out by multidisciplinary teams with health professionals with adequate training for integral PHC. It is supported by sufficient and equitable funding and democratic, participatory and transparent public management.

We demand the revision of the National Policy of Primary Care published in 2017, considering this conception made explicit in the following propositions:

Universalization of access to resolutive and quality PHS

- Consolidate PHC as an open entrance door, accessible and resolutive for regionalized health networks.

- Reduce organizational, geographical and cultural accessibility barriers, ensuring respect for gender, ethnic and local values.

- Ensure access to integral care through the coordination of care by PHC, both within the FHS teams and in the regionalized health care networks.

- Expand the scope of practices and resolutivity of PHC.

- Develop strategies to improve the quality of individual and collective care.

- Defend the centrality of the territory in the PHC: encourage the follow-up of the user in the territory in order to provide the social support required, strengthening the informal support network, family and caregivers that has in the CHW one of its fundamental pillars.

- Reduce the number of people assigned to each FHS teams, adapting it to the population health needs.

- Ensure the internalization and fixation of medical professionals, enhancing actions of the PMM.

- Match the number of Oral Health Teams to FHS teams and improve access to medium complexity procedures in dentistry for areas with a lower HDI.

- Ensure that all FHS teams are covered by Nasfs and assistantial support with adequate sizing to the needs of the population.

- Expand the composition of multiprofessional family health support teams. To recommend the articulated work of the teams with a view to the most effective care of the users and to expansion of the scope of the practices of other professionals to respond to the population needs.

- Qualify the proficiency profile of professionals with higher education in individual and collective care for action in resolutive and quality PHC.

- Promote the debate with managers to qualify the access of the rural, forest and water populations to Primary Health Care services.

- Recommend the accomplishment of a situational diagnosis on the work processes of

Primary Health Care teams in rural areas.

● Adapt the territorialization of teams to include sparse population groups.

● Incorporate the new information and communication technologies, contributing to the better resolutivity of PHC, broadening access and training of workers.

● Recognize the indigenous health subsystem as one of the differentiated approaches of PC that considers and articulates other knowledge and practices of health production.

● Ensure to indigenous people access to integral care that contemplates social, cultural, geographical, historical and political diversity of each community, so as to favor the overcoming of the factors that make this population more vulnerable to health problems, recognizing the effectiveness of their medicine and the right of these peoples to their culture.

● Indicate the expansion of popular and traditional practices of care through access to Integrative and Complementary Practices in Health (Pics) and to medicinal plants and phytoterapics.

Community Health Workers: subjects of community action in the territory for the promotion of health

● Strengthen the role of CHW as a subject of action in the territory, ensuring his/her link with the population.

● Encourage the work of CHW in mediating intersectoral actions in the territory to improve living conditions and promote population health.

● Reinforce the performance of the CHW as a link between the community and health services, and between the health sector and other public policies that promote quality of life.

● Ensure technical level training for CHWs to act as subjects of collective health.

● Promote specific forums for the discussion of the assignments, the professional profile and the curricular referential for the course of technical level of CHW. This debate should be articulated with the discussion of the work process in the FHS, of the common and specific attributions of the professionals and the models of attention, planning and management.

● To allocate financial resources, provided for in Administrative Rule nº 83/2018 of the Ministry of Health (Profags), recently revoked, for the offer, on national scale, of the Technical Course of Community Health Agent, by the Technical Schools of SUS (ETSUS) and schools of the Network Federal of Professional, Scientific and Technological Education.

● Strengthen the training of the agents of indigenous health.

Sufficient and equitable funding for integral PHC

● Create front in defense of adequate public funding for SUS and PC, and demand the revocation of EC 95/2016.

● Increase public investment in health to the level of 8% of GDP, guaranteeing, at least, 20% of the amount for PC funding with emphasis on family health.

● Increase the per capita value of the fixed PAB, since its expressive increase would expand the volume of resources for PC rapidly, given its capillarity in the Country.

● Ensure the exclusivity of the resources of the variable PAB for the universalization of the FHS in the Country.

● Guarantee the use of the resources from the performance incentive of the teams that joined PMAQ-AB exclusively for PC actions.

● Expand the mechanisms of redistribution and equitable allocation of federal and state resources to PC, considering the differentiated capacity of self-funding of the municipalities, the regional specificities, the priority and the need to reinforce the FHS.

● Promote equity in the distribution of resources to remote and unattended areas.

● End health tax waivers. Abolish subsidies and tax exemptions in health, such as deduction of expenses with services and health plans, in the Income Tax of individual and corporate taxpayers.

● Promote a tax reform with fiscal justice, progressive tax collection and adequate tax burden to ensure the universality of social rights.

Strengthening of democratic spaces of participation and social control

● Strengthen the performance of the Health Councils (local, municipal, state and national) in the processes of policy formulation, control and inspection of the application of resources aimed at PH funding.

● Encourage the political training of health counselors at all levels of representation (local, municipal, state and national).

● Support the strengthening of spaces for popular participation in health.

Mediation of intersectoral actions to focus on social determination, promote health and reduce inequalities

● Establish strategies to prioritize intersectoral actions related to the promotion of health and the strengthening of healthy municipal networks already existing in the Country, through a continuous program of dissemination of information, training of municipal managers and creation of opportunities and spaces of interaction between managers for the exchange and evaluation of successful experiences.

● Expand territorial governance with the participation of the different agents involved in social policies: local leadership and representation (right to voice and vote) of the population, ensuring the social control of governmental actions.

● Heavily invest in overcoming social inequalities, by means of actions that stimulate equity in government interventions, although, for that, some emergency actions may be necessary (transfer of income to families in situations of poverty; food security; harm reduction; emergency provision of professionals in specific areas; racial, social and gender quotas; actions to populations in permanent or transitory disadvantage).

● Regulate the communication and expansion of social commitment in the dissemination of advertisements that stimulate the consumption of products that directly or indirectly impact on health. In defense of public communication and against concentration/media monopoly.

Democratic, participatory and transparent public management

● For a direct, democratic, participatory, transparent and without corruption public administration.

● Ensure and strengthen the public management of SUS.

● Expand public provision in the service rendering of health services in the network, overcoming the dependence of the private sector, especially in strategic areas (diagnostic equipment, specialized examinations and hospital network), in order to guarantee the rearguard of PHC and continuity of health care, as opposed to segmentation by popular plans and privatization of direct management of services.

● Implement strong public regulation for indirect management contracts, in order to guarantee legal certainty in work relations.

● Reinforce the role of states in regional planning, funding and regulation of the service network, making it possible to integrate PH with other levels of attention.

● Implement a career plan for PHC professionals in SUS.

● To institute mechanisms for the deprecation of work in the SUS, guaranteeing the entry of professionals by public tender.

Training of health professionals for integral PHC

● Direct the training of health professionals to the skills required by the resolutive and quality PHC, at all levels of education (graduation, residency, specialization, masters and doctorate professionals).

● Expand permanent education offerings for PHC professionals.

● Strengthen and boost health and education networks for technical training for the SUS with the valuing of the articulation of municipal, state and federal public institutions.

● Promote strategies for teacher qualification at all levels of training of health professionals for a quality and effective PHC.

● Develop actions of training of preceptors in services and health to support the teaching-services articulation.

● Promote training in matrix support in medical and multiprofessional residences.

● Expand the scope of multiprofessional residences in health.

● Support the extensive training of Family and Community doctors, following the recommendations of the law of the PMM for Brazil.

● Include in the training of the professionals of the PHC the themes of interculturality

● Encourage the use of technologies in health, such as e-health in PHC, telemedicine, more precise indicators and associated with professional practices that allow greater and better evaluation and monitoring of work.

Research Agenda in PHC

● Strengthen the commitment of the research in PHC with the defense of the SUS and the health of the population.

● Deepen the studies on access and quality in PHC, with a view to ensuring the universalization of the FHS and the comprehensiveness of actions in the basic health network, with emphasis on reducing social and regional inequalities.

● Develop and implement methodological strategies to measure and estimate the impact of interventions in PHC.

● Establish a monitoring system of health

inequities and discuss the challenges of the impact evaluation of intersectoral actions on health.

● Explore and disseminate results of PMAQ-AB external evaluations, in order to compose a complex panel on patterns and trends in the Brazilian PC, in support of management and health workers.

● Promote research that produces comparative indicators on the impact of economic adjustment policies on the health of the most vulnerable population groups.

● Encourage studies on the dynamics and impact of the educational market and the labor market and their implications for the planning of human resources in health.

Collaborators

Collective elaboration of the researchers of the Research Network in PHC of Abrasco at the preparatory Seminar 'From Alma Ata to the Family Health Strategy: 30 years of PHC in Brazil – advances, challenges and threats', held at the National School of Public Health Sergio Arouca (Ensp/Fiocruz), March 20 and 21 of 2018. Agenda revised on August 25 of 2018 during the XII Congress of Collective Health.

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