Performance assessment of Primary Health Care: balance and perspective for the 'Previne Brasil' Program

A avaliação de desempenho da atenção primária: balanço e perspectiva para o programa Previne Brasil

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ABSTRACT This article describes and analyzes the response of municipal governments to the payment-for-performance guideline in Primary Health Care (PHC) in the 'Previne Brasil' (PB) program in the 2020-2022 period. By establishing the PB in 2019, the Ministry of Health (MS) broke with the PHC financing model, which was based on linear per capita transfer to municipalities and the Federal District. Under the new policy, financial transfers from the MS would result from the analysis of the results of seven performance indicators of health teams reported in the National Register of Health Establishments. The article evaluates the response of subnational governments to the indicators defined by the PB, using data from the Health Information System for Primary Care of the Ministry of Health. The municipalities showed low effectiveness in relation to the performance commitments proposed by the tripartite agreement of the PB in the three-year period investigated. In general, the coverage results agreed in PB are exceptionally low and especially indicative of the risk of an epidemic due to failure in vaccination actions. Decisions to implement payment for performance were repeatedly postponed by the MS, favoring the demobilization of municipal governments in the development of PHC actions.

KEYWORDS Primary Health Care. Remuneration. Program evaluation. Family Health Strategy.

RESUMO *Este artigo descreve e analisa a resposta dos governos municipais à diretriz do pagamento por desempenho na Atenção Primária à Saúde (APS) no programa Previne Brasil (PB) no triênio 2020-2022. Ao instituir o PB em 2019, o Ministério da Saúde (MS) encaminhou a ruptura com o modelo de financiamento da APS, que era baseado na transferência per capita linear para os municípios e o Distrito Federal. Pela nova política, as transferências financeiras do MS decorreriam da análise dos resultados de sete indicadores de desempenho das equipes de saúde informados no Cadastro Nacional de Estabelecimentos de Saúde. O artigo avalia a resposta dos governos subnacionais nos indicadores definidos pelo PB, utilizando os dados do Sistema de Informação em Saúde para a Atenção Básica do MS. Os municípios demonstraram baixa efetividade em relação aos compromissos de desempenho propostos pela pactuação na Comissão Intergestores Tripartite do PB no triênio investigado. De modo geral, os resultados de cobertura pactuados no PB são excepcionalmente baixos e especialmente indicativos de risco de epidemia por falha nas ações de vacinação. As decisões de implantação do pagamento por desempenho foram reiteradamente postergadas pelo MS, favorecendo a desmobilização dos governos municipais no desenvolvimento das ações de APS.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Remuneração. Avaliação de programas. Estratégia Saúde da Família.*

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Introduction

This article describes and analyzes the response of municipal governments to the payment-for-performance guideline in Primary Health Care (PHC) referring to the Previne Brasil (PB) program in the 2020-2022 period. PB is linked to the Unified Health System (SUS)[1], a governmental instance for the provision of health care, health surveillance, prevention and promotion, among other actions. By establishing the PB in 2019, the Ministry of Health (MS) broke with the PHC financing model, which was based on linear per capita transfer to all municipalities. It was argued, in justifying the rupture, that performance-oriented financial incentives based on the "fixed and variable floors for basic care"[2(1362)] of previous decades did not favor social responsibility or PHC resolution[2].

According to the PB formulators, the limitation of the Fixed Basic Care Floor was associated with the logic of per capita payment, which disregarded the population effectively covered by the teams, vulnerable populations and clinical effectiveness. The Variable Care Floor, by exclusively valuing the installed capacity (such as the number of family health teams implemented), disregarded the evaluation of municipal health indicators[2].

The new PB financing guidelines modified the policy implemented by the Fernando Henrique Cardoso government, within the scope of the SUS, of recognized institutional stability[3]. Before the BP, changes in the federal funding of PHC were residual: in 2006, the National Policy for Primary Care (PNAB) defined the Family Health Strategy as the preferred option for organizing PHC. The revisions of the 2011 and 2017 PNAB regulations marginally modified the institutional design of federal funding by leaving untouched the original transfer arrangement for the municipality's health actions and services on a per capita basis[4].

The most far-reaching change introduced by the 2017 PNAB was the division of federal funding into two blocks: funding and investment. In the funding block, financial resources were transferred to the maintenance of public health actions and services; in the investment block, financial resources were allocated to the acquisition of equipment, construction of new installations and renovations[5].

The new PB financing model for the provision of PHC per municipality originally defined three blocks for federal transfers: weighted capitation, incentives for strategic and priority actions and payment for performance[6].

The transfer of financial resources from the weighted capitation component considers the number of people registered in Family Health teams (eSF) or Primary Care teams (eAP) by the municipality, weighted by equity criteria. For weighting (calculation of weights), three criteria are taken into account: a) socioeconomic vulnerability, calculated by the proportion of the population in the municipality that receives the benefit of the Bolsa Família Program, extinguished in December 2021, and the Benefit of Continued Provision or pension benefits from the National Institute of Social Security of up to two minimum wages; b) population in the municipality up to 5 years old and from 65 years old; and c) the costs of providing PHC in municipalities, which vary according to their distance from urban centers[6].

For the application of this last criterion, the classification and characterization of rural and urban spaces are considered according to the methodology proposed by the Brazilian Institute of Geography and Statistics (IBGE) for municipalities[7]. The weights for each municipality, according to this methodology, consider the registration by team of urban municipalities in relation to the other typologies. In a municipality typified as remote rural or intermediate remote, the registered person will receive twice as much as an urban municipality.

For the socioeconomic vulnerability and demographic adjustment criteria, a weight of 1.3 per person was assigned. This means that, for

each person considered to be in socioeconomic vulnerability or within these age ranges, the municipality will receive 30% more.

Thus, the portion of the financial transfer from the Ministry of Health to the PHC was conditioned to the number of entries made. In this sense, registration is carried out through software systems: Simplified Data Collection; Citizen's Electronic Record and own systems, being gathered in the Health Information System for Primary Care (Sisab)[6].

Incentive payment for strategic actions includes 16 specific programs: Saúde na Hora; Oral Health Team; Mobile Dental Unit; Dental Specialties Center; Regional Laboratory of Dental Prosthesis; Clinic on the Street; Fluvial Basic Health Unit; Riverside Family Health Team; Microscopist; Prison Primary Care Team; eSF and eAP that assist adolescents in conflict with the law; School Health Program; Health Academy hub; Team computerization; Funding for municipalities with Medical and Multiprofessional Residency[6].

Lastly, the PB transfers for performance in the PHC activities of the municipal government and the DF would result from the analysis of the results of seven indicators of each health team accredited in the National Register of Health Establishments system. The PB defines that the amount of payment for performance is calculated from the achievement of the target for each indicator per team and conditioned to the type of health team. The financial incentive of payment for performance passed on to the municipality or Federal District would therefore correspond to the sum of the results obtained per team[6].

In early 2021, arguing about the need to adopt extraordinary federal financial support measures for the APS, the MS defined, through Ordinance No. 166, that the federal transfer related to payment for performance would be equivalent to the potential result of 100% of the Final Synthetic Indicator (ISF) reached of each municipality and the Federal District[8]. That is, the financial transfer of the PB was carried out regardless of the performance reported by the municipality.

In the same ordinance, it was also defined that the transfer of the costing component referring to the weighted capitation would be equivalent to 100% of the registration potential of the municipalities or the Federal District in the first four financial competences of 2021 and that the financial incentive based on a population criterion would be passed on in the same period based on an annual per capita value multiplied by the estimate of the population of the municipalities and the Federal District, according to the 2019 population data released by the IBGE Foundation. Subsequently, Ordinance GM/MS No 985, of May 17, 2021, extended this deadline to cover the financial competences of May, June, July and August of that year[9].

In September 2021, through Ordinance No. 2,254 of the MS, the PB underwent another change in implementation, agreed upon in the Tripartite Intermanagers Commission (CIT). Regarding the financial incentive of weighted capitation, the following inclusions were made: replacement of the concept of limit of registrations by registration potential; recognition of riverside, prison and street clinic populations for weighted capitation in accredited and homologated teams in the municipalities; financial supplementation for municipalities that did not reach the permanent registration potential until said achievement; financial complementation for the municipalities that reached the registration potential and had an ISF equal to or greater than 7 in the mentioned evaluation four-month period; expansion of the weighting of the geographical classification of intermediate and adjacent rural municipalities[10].

In the same ordinance, it is worth highlighting the institution, on a permanent basis, of financial incentives based on a population criterion of value to be defined annually, according to the IBGE[10] population estimate. PHC funding then began to be calculated based

on four components: 1) weighted capitation; 2) payment for performance; 3) financial incentive based on population criteria; and 4) incentives for strategic actions[10]. Finally, the transfer equivalent to 100% of reaching the maximum municipal performance index was again extended until December 2021. In short, the municipalities continued to receive the total value of the PB performance component in the last quadrennium of 2021 without the need to achieve the agreed targets.

The implementation of performance evaluation for the purpose of payment to municipalities was then postponed and reduced in scope to 2022 (Ordinance GM/MS No. 2396, of September 22, 2021)[11]. The new methodology contemplates a significant change in the performance evaluation dynamics by accepting the individual values of the indicators in the four-month evaluation (in the first semester of 2022). The coverage of prenatal consultations and tests for syphilis and HIV in pregnant women were evaluated[11]. With this agreement, the global performance assessment through the ISF was abandoned in the first two quarters of 2022.

It is important to point out that the changes in the application of performance indicators were agreed upon by the representations of the municipal and state health secretaries at the CIT, the highest decision-making body of the SUS. It is also worth noting that the proposed model for payment for performance in the PB would replace the National Program for Improving Access and Quality of Primary Care (PMAQ-AB), implemented in 2011 and closed in December 2019[12-14].

Material and methods

The article describes and analyzes the response of municipal governments to the seven indicators defined by the PB for payment for performance, using information in Sisab from DataSUS of MS (https://sisab.saude.gov.br/) from the period 2020 to 2021, highlighting the third quarter of 2021.

The information in Sisab for the production of this article was collected in April 2022 on the DataSUS website and stratified by national level, large region, state and Federal District.

According to the methodology proposed by MS[15], the payment-for-performance indicators were consolidated by the municipalities every four months. The seven indicators selected for the payment-for-performance incentive in PB are the following:

- Indicator 1: Proportion of pregnant women with six or more prenatal consultations, the first being up to the 20th week of pregnancy;
- Indicator 2: Proportion of pregnant women tested for syphilis and HIV;
- Indicator 3: Proportion of pregnant women with dental care performed;
- Indicator 4: Cytopathology exam coverage;
- Indicator 5: Inactivated and Pentavalent Polio vaccine coverage;
- Indicator 6: Percentage of hypertensive people with blood pressure measured each semester;
- Indicator 7: Percentage of diabetics requesting glycated hemoglobin.

Box I lists the payment-for-performance indicators of the PB with the goals, parameters and weights agreed upon in the SUS consultation spheres until December 2021.

Box 1. Expected parameter, goal and weight of the seven Previne Brasil indicators in 2021

Indicator	Parameter	Goal for 2021	Weight
1. Proportion of pregnant women with six or more prenatal consultations, the first being up to the 20th week of pregnancy;	Greater than or equal to 80%	60	1
2. Proportion of pregnant women tested for syphilis and HIV;	Greater than or equal to 95%	60	1
3. Proportion of pregnant women with dental care performed;	Greater than or equal to 90%	60	2
4. Cytopathology exam coverage;	Greater than or equal to 80%	40	1
5. Inactivated and Pentavalent Polio vaccine coverage;	Greater than or equal to 95%	95	2
6. Percentage of hypertensive people with blood pressure measured each semester;	Greater than or equal to 90%	50	2
7. Percentage of diabetics requesting glycated hemoglobin.	Greater than or equal to 90%	50	1

Source: Brasil[5].

The scores are assigned by the MS to the municipality and consider the result obtained in relation to the target assigned to each indicator. Thus, if the result of a certain indicator for that municipality is 30% and the target is 60%, the final score for this indicator will be 5.0 (50% of the maximum possible score since the result was half of the proposed target). Also, if the assigned value is greater than the parameter, the final score for the indicator will be 10.0.

Once the score associated with the indicator is calculated, it is weighted according to the weight described in *box 1*. Multiplying the score by the weight results in the final attribution of the score for that indicator, called the Weighted Score of the Indicator (NPI)[15].

The last step consists of aggregation, in which the weighted results of the indicators are condensed into a single final indicator called ISF. Aggregation is performed by adding the NPI of all indicators and dividing it by 10 (the sum of all weights). This result is the ISF, the final index that brings together the weighted result of all indicators, facilitating the interpretation of the municipality's performance. The value of the performance payment financial incentive for municipalities and the Federal District is linked to the global performance measured by the ISF[15].

Results

Table 1, with nationally aggregated data, shows that the situation of the indicators selected by the PB in Sisab was poor in the third quarter of 2020, with the exception of information on the composite indicator of vaccination coverage of Inactivated Poliomyelitis and Pentavalent, which presented the national average of 66%. Faced with such an insignificant baseline for the other six indicators, there was an improvement in performance in the third quarter of 2021 compared to that observed in the same period in 2020, with a notable exception for vaccination coverage of Inactivated Poliomyelitis and Pentavalent. This indicator suffered a brutal reduction between the two periods, going from 66% to 30%. The performance of vaccination coverage reported by the PB is in line with a study by the Institute of Studies for Health Policies (Ieps) which warned, in 2020, of the risk of blackout in the coverage of the National Immunization Program[16].

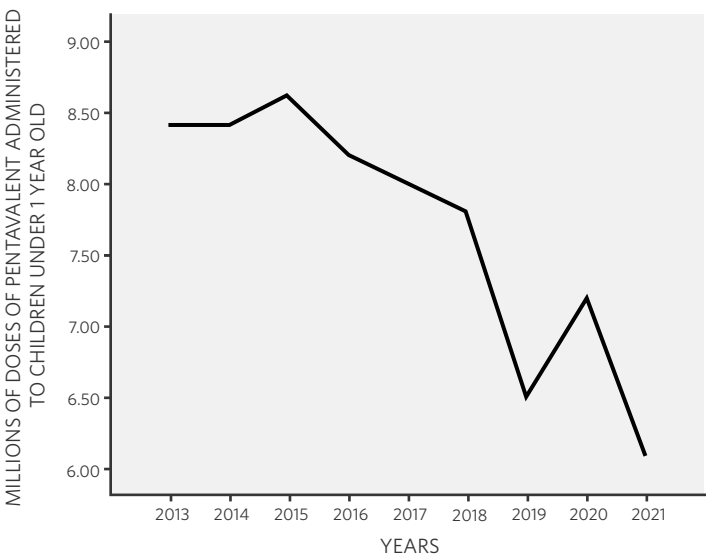
Table 1. Comparison of Previne Brasil indicators – average of the third quarter of 2020, third quarter of 2021 and percentage change

Indicator	Average for the Third Quarter of 2020 (%) (A)	Average for the Third Quarter of 2021 (%) (B)	Variation (B-A/A)*100
Proportion of pregnant women with six or more prenatal consultations, the first being up to the 20th week of pregnancy;	32	48	40%
Proportion of pregnant women tested for syphilis and HIV;	37	57	54%
Proportion of pregnant women with dental care performed;	19	42	121%
Cytopathology exam coverage;	14	15	7%
Inactivated and Pentavalent Polio vaccine coverage;	66	29	-56%
Percentage of hypertensive people with blood pressure measured each semester;	4	12	200%
Percentage of diabetics requesting glycated hemoglobin.	7	23	229%

Source: Own elaboration based on Sisab data from DataSUS[17].

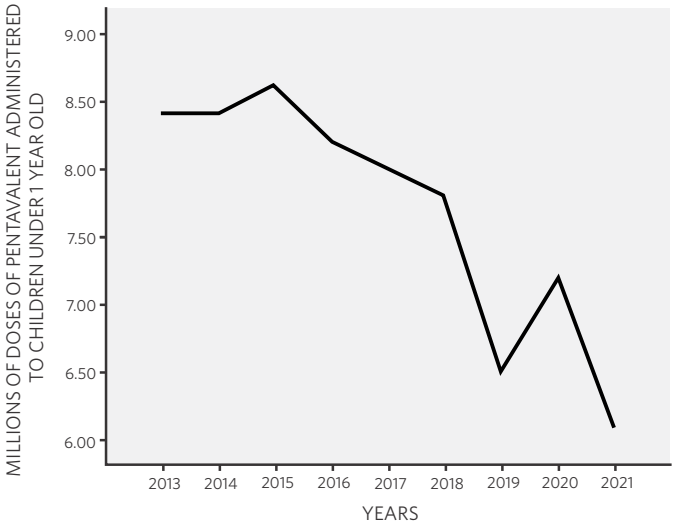
Graph 1 (A and B) ratifies the information on the worrying drop in the application of Pentavalent and Inactivated Poliomyelitis vaccines in children under 1 year of age during the troubled implementation of the PB. There is no doubt that the residual coverage in the application of the two vaccines in the last four months of 2021 points to the imminent risk of a health crisis in the country.

Graph 1 (A). Doses of the pentavalent vaccine given to children under 1 year of age (millions of doses)



Source: Own elaboration based on Sisab data from DataSUS[17].

Graph 1 (B). Brazil – applied doses of immunobiologicals (inactivated poliomyelitis) in children under 1 year old (million doses) – 2016-2021



Source: Own elaboration based on Sisab data from DataSUS[17].

Table 2 shows that the municipalities did not reach the performance goals proposed by the PB agreement for the third quarter of 2021. It should be noted that only the proportion of pregnant women who underwent tests for syphilis and HIV reached almost 100% of the agreed coverage goal for the indicator (60%) in 2021. At the other pole, the agreed target for measuring the blood pressure of hypertensive people reached only 11% of the target population, when the goal was 50%.

In the same four-month period, the achievement of the bold goal of 95% for the vaccination coverage of Inactivated Poliomyelitis and Pentavalent presented the previously mentioned worrying average coverage of 30%. Cytopathology exam coverage was 15%; and the percentage of diabetics requesting hemoglobin was 23%.

The proposal to increase the proportion of pregnant women with at least six prenatal consultations also did not reach the agreed target: only half of Brazilian pregnant women had at least six consultations in the period, the first consultation being up to the 20th week of pregnancy.

Table 2. Coverage goals agreed by Previne Brasil and the results achieved by Brazilian municipalities in 2021

Indicators	Coverage Goals Agreed (%)	Agreed Goals Achieved (%)
1. Proportion of pregnant women with six or more prenatal consultations, the first being up to the 20th week of pregnancy;	60	50
2. Proportion of pregnant women tested for syphilis and HIV;	60	57
3. Proportion of pregnant women with dental care performed;	60	42
4. Cytopathology exam coverage;	40	15
5. Inactivated and Pentavalent Polio vaccine coverage;	95	30
6. Percentage of hypertensive people with blood pressure measured each semester;	50	11
7. Percentage of diabetics requesting glycated hemoglobin.	50	23

Source: Own elaboration based on Sisab data from DataSUS[17].

The failure to provide information to Sisab demonstrates that the reduction in financial transfers to municipalities would be very significant if the proposition of performance evaluation was maintained through the seven PB indicators.

In this scenario, *table 3* shows the result achieved by the capitals in the performance evaluation indicators – the coverage of the six prenatal consultations carried out, the first being up to the 12th week of pregnancy, and the coverage of tests for syphilis and HIV in pregnant women – which will be considered in the evaluation of the first four months of 2022. It is observed that the coverage of prenatal consultations in these municipalities is absolutely poor (median of 25% of the target population). The coverage of tests for syphilis and HIV in pregnant women performs a little better, however, half of the Brazilian capitals do not reach 50% of the population of pregnant women targeted by the PHC. The ISF calculation also reveals the critical situation in achieving the seven agreed indicators in many Brazilian capitals – half of them had an ISF score below 5 – even considering the lenient coverage targets agreed in 2021 (shown in *box 1*)

Table 3. Coverage of agreed indicators for the first semester in the capitals* – first four months of 2022

Capital cities	Proportion of pregnant women with six or more prenatal consultations, the first being up to the 20th week of pregnancy;	Proportion of pregnant women tested for syphilis and HIV;	Final Synthetic Indicator (ISF)**
Porto Velho	0.36	0.56	5.34
Rio Branco	0.38	0.65	5.21
Manaus	0.43	0.88	7.48
Boa Vista	0.30	0.87	5.02
Belém	0.16	0.53	4.24
Macapá	0.30	0.67	5.15
Palmas	0.38	0.53	5.48
São Luís	0.08	0.57	4.58
Teresina	0.25	0.37	4.46
Fortaleza	0.02	0.32	4.07
Natal	0.48	0.63	6.13
João Pessoa	0.08	0.24	2.21
Recife	0.24	0.30	3.96
Maceió	0.02	0.66	6.22
Aracaju	0.09	0.47	4.51
Salvador	0.01	0.37	2.66
Belo Horizonte	0.04	0.25	3.25
Vitória	0.07	0.29	4.44
Rio de Janeiro	0.57	0.76	6.24
São Paulo	0.50	0.25	3.60
Curitiba	0.08	0.70	6.57
Florianópolis	0.53	0.62	6.57
Porto Alegre	0.42	0.53	5.97
Campo Grande	0.08	0.48	5.03
Cuiabá	0.37	0.39	4.68

Table 3. Coverage of agreed indicators for the first semester in the capitals* – first four months of 2022

Capital cities	Proportion of pregnant women with six or more prenatal consultations, the first being up to the 20th week of pregnancy;	Proportion of pregnant women tested for syphilis and HIV;	Final Synthetic Indicator (ISF)**
Goiânia	0.50	0.29	3.93
Brasília	0.07	0.73	5.50
Mediana	0.25	0.53	5.34

Source: Own elaboration based on Sisab data from DataSUS[17].

* Includes all teams operating in the municipality. ** Using the targets reported in *box 1.*

Discussion and final considerations

The launch of the PB in the management of Minister Mandetta, in the first months of the Bolsonaro government, was involved in great controversy. For the advocacy coalition in defense of the changes implemented by the PB, the payment for performance of the PHC would encourage the registration of users in the information system, reducing treatment failures; and expand the control of chronic diseases (controlled blood pressure, controlled glycated hemoglobin) and screening actions (HIV, cervical exam, depression), improving medication prescription and reducing hospitalizations sensitive to primary care[18]. The function of monitoring and evaluating the performance indicators agreed by the Ministry of Health would also promote the use of electronic patient records and longitudinal and coordinated care[19].

The PB veto coalition considers that the new PHC funding logic puts the principle of integrality at risk, insofar as it only recognizes evidenced and stratified demands. The program also modifies the enrollment logic, which now focuses on the search for standardized clienteles. In addition, the resource distribution criteria do not incorporate the characteristic diversity of the territories and the disparities between the country's regions. Likewise, the veto coalition criticizes the remuneration model for performance, which focuses exclusively on evaluating results based on standardized and biomedical criteria, incapable of incorporating the variability of situations experienced. It figures that the PB can aggravate the underfunding of public health in Brazil, reversing historical achievements of expanding the reach of services and reducing inequalities[20-23].

In common in both approaches (advocacy and veto), there is the idea of PB as a sustainable public policy throughout the conjunctural cycle of implementation. Sustainability supposed that the institutional conditions for implementing the program would remain unaffected by sudden changes in the scenario due to political and health crises.

The results presented in this text demonstrate that the PB faced obstacles that were not anticipated in the original design, which widened the gap between the initial formulation and its implementation as a public policy, redesigning the PHC pay-for-performance agenda.

As the literature warns, the implementation of guidelines issued by the central government for subnational entities should not be analyzed at face value, even for established policies, due to the possibility of discrepancy between the initial formalization and the implementation in the decision-making process. In this sense, the analysis of the implementation can consider the flow of actions and decisions of government agents vis-à-vis the conjunctural obstacles. These obstacles can be particularly paralyzing for government decisions in situations where public policy imposes concentrated losses on one of the parties in the

federative environment[24]. There is no doubt that the original PB pay-for-performance arrangement required the MS to impose specific and concentrated financial losses on municipal governments. However, as previously demonstrated, the original design of the PB had to adopt several course corrections over the 2020-2022 period.

It should be remembered that the Bolsonaro government's governance crisis, which began in the second half of 2021, made the MS's normative competence unsustainable. At this juncture, in addition to the pressure of the pandemic, the condition of governability of the federal Executive depended on the formation of a broad alliance with the center-right patrimonialist parties (called Centrão) in the National Congress to guarantee governability. The literature points out that the need for negotiation between the Federal Executive and the center-right parties, for reasons of political survival, can increase the mischaracterization of Brazilian public policies[25,26].

The firing of the Minister of Health Henrique Mandetta in April 2020[27], in the clash about social isolation, had already produced a massive evasion of the specialists who formulated the guidelines for the PB from the MS. The normative influence of these specialists favored the creation, at the beginning of 2019, of the Secretariat of Primary Health Care in the MS structure, with the objective of sustaining the new financing model[28]. The departure of these specialists left PB without the anchoring of advocacy by part of the MS public bureaucracy, a crucial condition for the implementation of federal government action[29].

Finally, the ratification by the Federal Supreme Court[30] of the concurrent competence of the states, the Federal District and municipalities to take normative and administrative measures of health police against Covid-19 overloaded the agenda of local governments, affecting actions in the PHC.

Under these conditions, the original PB proposal of 2019, which subordinates MS transfers to the proportion of the population effectively covered by the teams, the registered population and the performance of the PHC, did not go ahead in the period analyzed in this article. The repeated adjustments by the MS made the full application of conditionalities for financial transfers based on the ability to register, focus and inform without effect. Thus, the attribution of direct benefits to society promoted by the new PHC financing model in the analyzed period is questionable[31].

Decisions to implement payment for performance were, in fact, repeatedly postponed by the Ministry of Health through specific decisions[32,33] that affected the mobilization of municipal governments to develop strategic PHC actions.

Thus, the picture that emerges in the analysis of the response of the municipalities in the third quadrennium of 2021 and in the first quadrennium of 2022 is disturbing because it demonstrates the weak coverage in the provision of essential services of maternal, child and adult care in Brazilian municipalities. In general, the coverage of the agreed indicators in the PB informed by local governments is very low.

In this context, the decline in the supply of Inactivated Poliomyelitis and Pentavalent vaccines is particularly noteworthy, which could lead Brazil to a situation of epidemiological disarray. It is, in fact, worrying that, between 2020 and 2021, a reduction of more than 1 million doses of the Inactivated Poliomyelitis and Pentavalent vaccine applied to children under 1 year of age has been recorded.

Finally, in more general terms, it is worth remembering that the survival of the performance evaluation under the terms defined by the BP is uncertain due to the conflicting positions of the community of specialists in relation to the new PHC financing model described in this article. For example, Ieps and Umane, which rely on the advice of important Brazilian public health leaders, defend that the current structure of the PB should be assumed as a PHC financing model, contemplating the systematic increase of resources for this level

of care. They also advocate that the payment-for-performance component of the PB should reward municipalities not only according to the achievement of targets for the indicators, but also by evaluating the percentage of improvement in relation to previous periods, thus encouraging municipalities that started from low levels and are advancing, even if they have not reached the ideal parameters[34]. On the other hand, the Research Network on Primary Health Care of the Brazilian Association of Collective Health defends purely and simply

> the revocation of the Previne Brasil Program and the strengthening of mechanisms for the redistribution of resources according to health needs and the reduction of inequalities[35(63)].

It should be noted, however, that Brazilian federalism has managed to promote high symmetry in the decision-making process within the scope of the SUS36. In this context, no change in the current institutional arrangement of the primary care policy will be carried out without broad negotiation on the MS's monitoring and evaluation functions. In this trajectory, the preservation and improvement of Sisab are of great importance to strengthen the transparency and social control of PHC actions in the SUS.

Collaborators

Costa NR (0000-0002-8360-4832)* participated in the design, analysis and interpretation of data, writing of the article and approval of the version to be published. Silva PRF (0000-0003-0811-4080)* and Jatobá A (0000-0002-7059-6546)* participated in the design and interpretation of data for the work, critical review of the intellectual content and approval of the version to be published. ■

References

1. Costa NR, Vaitsman J. Universalization and Privatization: How Policy Analysis Can Help Understand the Development of Brazil's Health System. J. Comp. Policy Anal.: Res. Pract. 2014; 16(5):441-456.
2. Harzheim E, D'Avila OP, Ribeiro DC, et al. Novo financiamento para uma nova Atenção Primária à Saúde no Brasil. Ciênc. saúde coletiva. 2020; 25(4):1361-1374.
3. Arretche M, Marques E, Faria CAP. As Políticas da Política – Desigualdade e Inclusão nos Governos do PSDB e do PT. São Paulo: Editora UNESP; 2019.
4. Melamed C, Costa NR. Inovações no financiamento federal à Atenção Básica. Ciênc. saúde coletiva. 2003; 8(2):393-401
5. Brasil. Ministério da Saúde. Portaria nº 2436 21 de setembro de 2017. Política Nacional de Atenção Básica (PNAB). Diário Oficial da União. 21 Set 2017.
6. Brasil. Ministério da Saúde. Portaria nº 2.979, de 12 de novembro de 2019. Institui o PB, que estabelece novo modelo de financiamento de custeio da Atenção Primária à Saúde no âmbito do Sistema Único de Saúde, por meio da alteração da Portaria de Consoli-

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dação nº 6/GM/MS, de 28 de setembro de 2017. Diário Oficial da União. 13 Nov 2019.

7. Instituto Brasileiro de Geografia e Estatística. Classificação e características dos espaços rurais e urbanos do Brasil – uma primeira aproximação. Rio de Janeiro: IBGE; 2017.

8. Brasil. Ministério da Saúde. Portaria nº 166, de 27 de janeiro de 2021. Dispõe, excepcionalmente, sobre a transferência dos incentivos financeiros federais de custeio da Atenção Primária à Saúde, no âmbito do Programa Previne Brasil, para o ano de 2021. Diário Oficial da União. 27 Jan 2021.

9. Brasil. Ministério da Saúde. Portaria GM/MS nº 985, de 17 de maio de 2021. Prorroga o prazo dos incisos I e III do art. 2º da Portaria GM/MS nº 166, de 27 de janeiro de 2021, que dispõe, excepcionalmente, sobre a transferência dos incentivos financeiros federais de custeio da Atenção Primária à Saúde, no âmbito do Programa Previne Brasil, para o ano 2021. Diário Oficial da União. 17 Jan 2021.

10. Brasil. Ministério da Saúde. Portaria GM/MS nº 2.254, de 3 setembro de 2021. Altera o Título II da Portaria de Consolidação GM/MS nº 6, de 28 de setembro de 2017, que dispõe sobre o custeio da Atenção Primária à Saúde. Diário Oficial da União. 3 Set 2021.

11. Brasil. Ministério da Saúde. Portaria GM/MS nº 2.396, de 22 de setembro de 2021. Dispõe, excepcionalmente, sobre a transferência dos incentivos financeiros federais de custeio da Atenção Primária à Saúde, no âmbito do Programa Previne Brasil, para o ano de 2021. Diário Oficial da União. 22 Set 2021.

12. Kovacs R, Barreto JOM, Silva EN, et al. Socioeconomic inequalities in the quality of primary care under Brazil's national pay-for-performance program: a longitudinal study of family health teams. Lancet Glob Health. 2021; (9):e331-39.

13. Macinko J, Harris JM, Rocha MG. Brazil's National Program for Improving Primary Care Access and Quality (PMAQ) Fulfilling the Potential of the World's Largest Payment for Performance System in Primary Care. J Ambul Care Manage. 2017; 40(2):S4-S11.

14. Giovanella L, Mendonça MHM, Medina MG, et al. Contribuições dos estudos PMAQ-AB para a avaliação da APS no Brasil. In: Mendonça MHM, Matta GC, Godim R, et al., organizadores. Atenção Primária à Saúde: conceitos, práticas e pesquisa. Rio de Janeiro: Editora Fiocruz; 2019. p. 569-610.

15. Brasil. Ministério da Saúde, Secretaria de Atenção Primária à Saúde, Departamento de Saúde da Família. Nota Técnica nº 5/2020. [acesso em 2022 dez 2]. Disponível em: https://egestorab.saude.gov.br/image/?file=20200204_N_SEIMS-0013327270-NotaTecnicaIndicadores_3604088260565235807.pdf.

16. Nunes L. Cobertura Vacinal do Brasil 2020. Rio de Janeiro: Instituto de Estudo de Política de Saúde; 2020.

17. Brasil. Ministério da Saúde. DataSUS. SiSab. [acesso em 2022 jan 20]. Disponível em: https://sisab.saude.gov.br/.

18. Zacharias FCM, Schönholzer TE, Oliveira VC, et al. e-SUS Atenção Primária: atributos determinantes para adoção e uso de uma inovação tecnológica. Cad. Saúde Pública, 2021; 37(6):e00219520.

19. Sellera PEG, Pedebos LA, Harzheim E, et al. Monitoramento e avaliação dos atributos da atenção primária à saúde e, nível nacional: novos desafios. Ciênc. saúde coletiva. 2020; 25(4):1401-1411.

20. Miranda AS. A focalização utilitária da Atenção Primária à Saúde em viés tecnocrático e disruptivo. Saúde debate. 2020; 44(127):1214-1230.

21. Massuda A. Mudanças no financiamento da Atenção Primária à Saúde no Sistema de Saúde Brasileiro: avanço ou retrocesso? Ciênc. saúde coletiva. 2020; 25(4):1181-8.

22. Morosini MVGC, Fonseca AF, Baptista TWF. Previne Brasil, Agência de Desenvolvimento da Atenção Primária e Carteira de Serviços: radicalização da política de privatização da atenção básica? Cad. Saúde Pública. 2020; 36(9):e00040220.

23. Mendes A, Melo MA, Carnut L. Análise crítica sobre a implantação do novo modelo de alocação dos recursos federais para atenção primária à saúde: operacionalismo e improvisos. Cad. Saúde Pública, 2022; 38(2):e00164621.

24. Hanf K, Toonen TAJ. Policy Implementation in Federal and Unitary Systems. Dordrecht: Martinus Nijhoff Publishers; 1985.

25. Goulart LN, Vieira DM. Construção de um modelo de análise de redes de políticas públicas em contextos de federalismo e de presidencialismo. Cad. EBAPE.BR. 2020; 18(1):91-103.

26. Abrucio F. O Centrão e Bolsonaro. O Globo Valor Econômico. 2021 out 10.

27. Folha de S. Paulo. Bolsonaro Demite Mandetta e Anuncia Nelson Teich como Ministério da Saúde. 2020 abr 16. [acesso em 2022 jan 20]. Disponível em: https://www1.folha.uol.com.br/poder/2020/04/bolsonaro-demite-mandetta-e-convida-nelson-teich-para-o-ministerio-da-saude.shtml?origin=folha.

28. Reis JG, Harzheim E, Nachif MCA, et al. Criação da Secretaria de Atenção Primária à Saúde e suas implicações para o SUS. Ciênc. saúde coletiva. 2021; 24(9):3457-3462.

29. Costa NR. Burocracia pública e política social no Brasil. Ciênc. saúde coletiva. 2017; 22(11):3505-3514.

30. Brasil. Supremo Tribunal Federal. STF reconhece competência concorrente de estados, DF, municípios e União no combate à Covid-19. 2020. [acesso em 2022 jan 20]. Disponível em https://portal.stf.jus.br/noticias/verNoticiaDetalhe.asp?idConteudo=441447&ori=1.

31. Harzheim E, D'Avila OP, Pedebos LA, et al. Atenção Primária à Saúde para o Século XXI: Primeiros Resultados do novo modelo de financiamento. Ciênc. saúde coletiva. 2022; 27(2):609-617.

32. Conasems. Ministério da Saúde atualiza notas técnicas sobre os indicadores por Desempenho do Previne Brasil. [acesso em 2022 jan 20]. Disponível em https://www.conasems.org.br/ministerio-da-saude-divulga-nota-tecnica-sobre-indicadores-de-pagamento-por-desempenho-do-previne-brasil/.

33. Brasil. Ministério da Saúde, Secretaria de Atenção Primária à Saúde, Departamento de Saúde da Família. Nota Técnica nº 11/2022. [acesso em 2022 jan 20]. Disponível em: http://189.28.128.100/dab/docs/portaldab/documentos/financiamento/nota_tecnica_11_2022.pdf.

34. Instituto de Estudos para Políticas de Saúde. Caminhos para Fortalecer a Saúde Pública no Brasil. [acesso em 2022 jul 20]. Disponível em: https://ieps.org.br/agenda-mais-sus-evidencias-e-caminhos-para-fortalecer-a-saude-publica-no-brasil/.

35. Rede de Pesquisa em APS. Bases para uma Atenção Primária à Saúde integral, resolutiva, territorial e comunitária no SUS: aspectos críticos e proposições. Rio de Janeiro: Abrasco; 2022. p. 75.

36. Abrucio FL, Grin E, Ianni CI. "Brazilian Federalism in the Pandemic". In: Peters BG, Grin E, Abrucio FL, editores. American Federal Systems and Covid-19. Responses to a Complex Intergovernmental Problem. United Kingdom: Emerald Publishing Limited; 2021. p. 63-88.

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