Changes in the primary care policy and the (un)sustainability of the Family Health Strategy

As mudanças na política de atenção primária e a (in)sustentabilidade da Estratégia Saúde da Família

Fernanda de Freitas Mendonça[1], Luciana Dias de Lima[2], Adelyne Maria Mendes Pereira[2], Caroline Pagani Martins[1]

DOI: 10.1590/0103-11042023137011

ABSTRACT *Primary Health Care is a strategic level of care for forming a sustainable health system that responds to diverse needs. This article analyzed federal regulation and its implications for establishing primary care teams in Brazil. Exploratory mixed methods research involves analyzing 25 federal ordinances and secondary data of national scope referring to the teams approved in the National Register of Health Establishments from 2017 to 2021. The results indicate changes in the direction of the policy regarding the configuration, funding, and accreditation of teams. There was an expansion of primary care teams, a reduction in community health agents, and a weakening of the Family Health Support Center. The results suggest that the incentives for other team arrangements, the flexibility of the coverage of the community agent, and the multidisciplinary action compromise the sustainability of the Family Health model in the Unified Health System.*

KEYWORDS *Primary Health Care. Health policy. Healthcare models. Patient care team.*

RESUMO A Atenção Primária à Saúde é um nível de atenção estratégico para a conformação de um sistema de saúde sustentável e capaz de responder a necessidades diversas. Este artigo teve como objetivo analisar a normatização federal e suas implicações para a organização das equipes de atenção primária no Brasil. Pesquisa exploratória de métodos mistos, envolvendo a análise de 25 portarias federais e de dados secundários de abrangência nacional referentes às equipes homologadas no Cadastro Nacional de Estabelecimentos de Saúde, no período de 2017 a 2021. Os resultados indicam mudanças na direcionalidade da política quanto à configuração, ao financiamento e ao credenciamento das equipes. Verificaram-se expansão das equipes de atenção primária, redução de Agentes Comunitários de Saúde e enfraquecimento do Núcleo de Apoio à Saúde da Família. Os resultados sugerem que os estímulos a outros arranjos de equipes e a flexibilização da cobertura do agente comunitário e da atuação multiprofissional comprometem a sustentabilidade do modelo de Saúde da Família no Sistema Único Saúde.

PALAVRAS-CHAVE Atenção Primária à Saúde. Política de saúde. Modelos de assistência à saúde. Equipe de assistência ao paciente.

[1] Universidade Estadual de Londrina (UEL) – Londrina (PR), Brasil.
fernandamendonca@uel.br

[2] Fundação Oswaldo Cruz (Fiocruz), Escola Nacional de Saúde Pública Sergio Arouca (Ensp) – Rio de Janeiro (RJ), Brasil.

Introduction

Primary Health Care (PHC) is internationally recognized as a strategic level of care for the conformation of sustainable health systems capable of dealing with diverse needs of the population[1,2], with equity, effectiveness and resolution[3,4]. However, the conceptions and forms of organization of PHC vary significantly between countries in Latin America and the world, being related to the central ideas that guide public policies, models of social protection and health systems in which they are inserted[5].

Historically, as the first level of care, PHC is associated with the constitution of universal health systems in Europe and the Soviet Union, after World War II. In this context, PHC stands out as the foundation for the organization of the system, responsible for the first contact with the population and for ensuring the longitudinality, comprehensiveness and coordination of care – essentially medical at that time[6].

At the Conference and in the Declaration of Alma Ata, of 1978, when the understanding of the factors that determine the health conditions of the population was broadened, PHC acquired new concepts. PHC becomes extensive, based on the individual and collective/territorial dimensions of the health-disease process and comprehensive care, through clinical and health promotion actions and social participation strategies[7].

Selective PHC, on the other hand, is constructed conceptually as opposed to comprehensive, as part of a critique of the scope of its actions, formalized in a World Bank Report, published in 1993. It proposes a limited basket of services, generally focused on populations with greater socioeconomic vulnerability. This conception is closely linked to more restrictive models of social protection and health systems, recommended by international organizations for State reforms in Latin America during the 1990s[8].

In Brazil, the Family Health Program (PSF) was configured as the main PHC model in the Unified Health System (SUS) from the second half of the 1990s, through mechanisms of regulation and federal funding, continuing as a priority policy in the 2000s[9]. Among the milestones of this process, the following stand out: the creation of the PSF, in 1994, and its transformation into the Family Health Strategy (ESF), in 1996; the implementation of modalities for the transfer of funds and federal incentives aimed at financing PHC (the Fixed and Variable Basic Care Floor), starting in 1998; and the publication of the National Primary Care Policy (PNAB), in 2006, and its revision, in 2011. It is important to emphasize that, even with difficulties and gaps, it was the policies aimed at strengthening PHC in Brazil that most favored the implementation of the SUS principles and guidelines, since they produced several changes in the care model and in the management of health work in the municipalities.

Studies indicate that a significant part of the advances observed in the SUS are due to the implementation and expansion of the Family Health model in the national territory[10-15]. This is characterized by the composition of multidisciplinary teams, which operate in the individual, family and collective/territorial dimensions of health care, and is aimed at a wide range of situations and health needs, related or not to specific population groups[16,17]. The performance of Oral Health teams (ESB), Community Health Agents (ACS) and Family Health Support Centers (NASF) are part of the model, contributing to the achievement of more resolute practices that are consistent with health needs of the territory[18-20].

More recently, the role of PHC in health systems has been highlighted in countries' responses to the COVID-19 pandemic. PHC was important both in early diagnosis, monitoring of mild cases and health surveillance[21] and in the continuity of care and social support to specific populations through intersectoral actions[22]. Also noteworthy is its performance in telemarketing, in tracking cases and contacts, in articulation with epidemiological surveillance and vaccination[23-25]. More or less robust results are related to the previous capacity of the PHC and the health system, including financing and availability of workers[26].

However, since 2017, changes have been observed in the national primary care policy, which affect the composition of PHC teams and suggest inflections and setbacks in relation to the advances made with PHC, which primary strategy is family health[27-31].

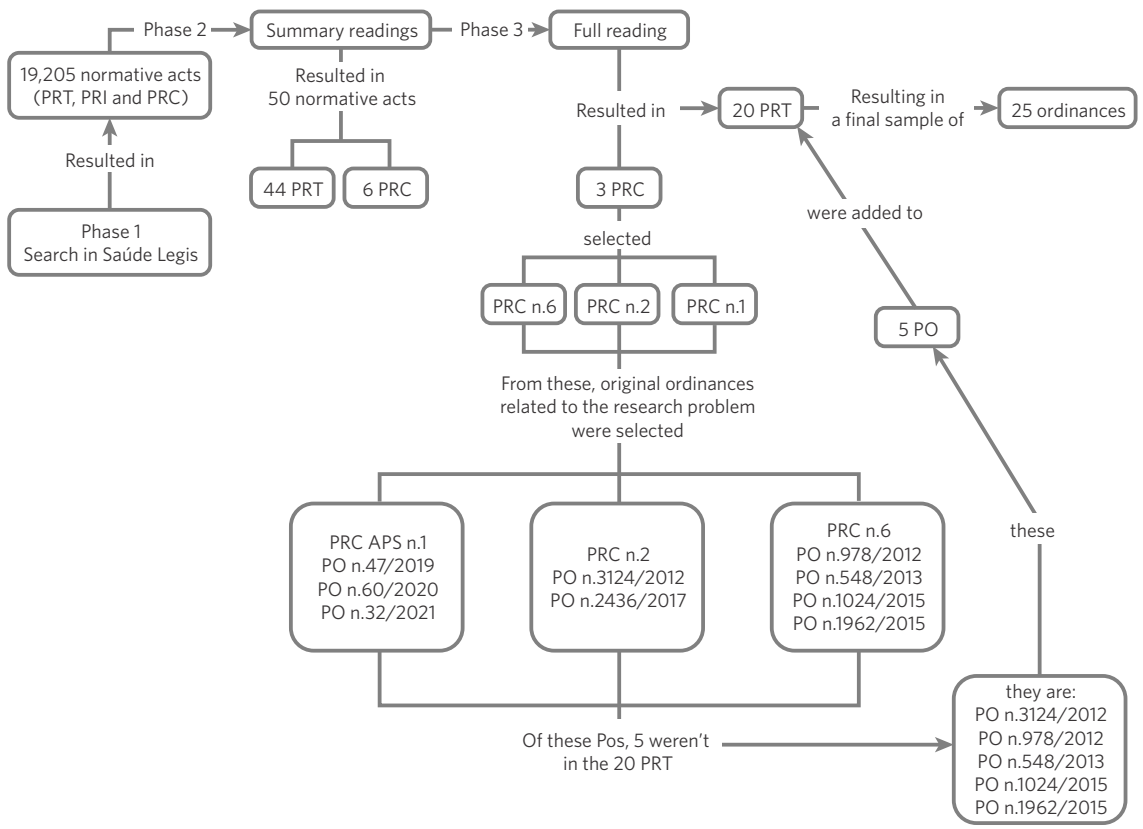
Based on this discussion, this article aims to analyze federal regulation and its implications for the organization of PHC teams in Brazil, from 2017 to 2021. It seeks to identify the directionality of the national health policy and its effects on sustainability of the Family Health model in the SUS.

Materials and Methods

This is an exploratory study of mixed methods, involving document analysis and secondary data of national coverage.

The documents were obtained from 'Saúde Legis', a system that brings together the regulations of the SUS, including the federal normative acts made available by the Ministry of Health (MS) (http://saudelegis.saude.gov.br/saudelegis/secure/norma/listPublic.xhtml)[32]. The document selection process unfolded in three phases, systematized in *figure 1*.

Figure 1. Methodological stages of the process of selecting normative acts



In the first stage, the documents were selected according to the following criteria: a) type of normative act: ministerial ordinance (PRT), inter-ministerial ordinance (PRI) and consolidation ordinance (PRC); b) date of publication: 09/21/2017 to 12/31/2021 (date of publication of the new Primary Care Ordinance until the end of 2021); c) origin: Minister's Office (GM), Health Care Secretariat (SAS) and Primary Health Care Secretariat (Saps). In the second stage, the summaries were read and normative acts related to the financing and organization of the teams that work within the scope of PHC were identified. In the third stage, the documents were read in full, identifying the normative acts systematized in the consolidation ordinances, which content was related to the research problem and which were in force during the study period.

At the end of this process, 25 documents were selected for thematic analysis, with their respective stages of categorization, description and interpretation[33]. The results of the document analysis were grouped into: configuration (composition, coverage parameters and workload), financing (incentive amount and source of incentive) and team accreditation process (accreditation flow, registration, team setting and monitoring, monitoring and evaluation).

Secondary data were obtained from the MS health information system, made available by SUS' Department of Informatics (http://datasus.saude.gov.br/), referring to the teams that work in the PHC approved in the National Register of Health Establishments. Health (CNES) in the period from 2017 to 2021. Data were extracted from the CNES on the number of teams of Family Health (eSF), Primary Care (eAB)/Primary Care (eAP), as well the Health Support Center of Family/ Primary Care (eNASF-AB) and ACS, and its processing considered the country's macroregions and the calculation of the percentage change in the study period.

The results of the documental analysis were confronted with the percentage variations of the types of approved teams, seeking to show the directionality of the national health policy and its implications.

It is noteworthy that, as this is a research that used documents and secondary data publicly available in information systems, it was not necessary to submit the project of this study to an ethics and research committee involving human beings.

Results

The results are organized into two sections. The first presents the normative determinations regarding the configuration, financing and accreditation of the teams that work in the PHC, and the second addresses the evolution of the composition of these teams in the period from 2017 to 2021.

Team setup, funding, and accreditation process

Boxes 1 and 2 systematize the 25 normative acts selected and analyzed according to the axes of configuration and financing of the teams.

Box 1. Systematization of federal norms related to the configuration of PHC teams. Brazil, 2017 to 2021

Family Health Team	**Normative acts**
Composition	Ordinance 2436/2017 (not in force, but with part of its content incorporated on PC 2) Physician, preferably family and community medicine specialist; Nurse, preferably Family Health Specialist; Assistant and/or Nursing Technician and Community Health Agent (ACS). The team of Endemic Fighting Agent (ACE) and Oral Health professionals: Dental surgeon, preferably specialist in family health, and assistant or oral health technician may be part of the team.
Coverage parameter	Ordinance 2436/2017 (not in force, but with part of its content incorporated on PC 2) A team for 2,000 to 3,500 people Ordinance 2979/2019 (current) In urban municipality, one team for every 4000 people In adjacent municipality, one team for every 2750 people In remote municipality, one team for every 2000 people
Workload	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) 40 hours a week for all team members Ordinance 2979/2019 (current) 40 hours a week for all team members Ordinance 60/2020 (not in effect, revoked by Ordinance 32) In units that adhere to Saúde na Hora, they can have flexible workload (min 20h) for nurses, doctors and dentists
Community Health Agents	**Normative Acts**
Coverage parameter	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) One ACS for every 750 people in areas of great territorial dispersion, areas of risk and social vulnerability
Workload	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) 40 hours a week
Basic/primary care team	**Normative Acts**
Composition	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) eAB – physicians, preferably in the specialty of family and community medicine; nurse, preferably specialist in family health; nursing assistants and/or nursing technicians. They may add other professionals, such as dentists, oral health assistants and/or oral health technicians, community health agents and agents to combat endemic diseases. Ordinance 18/2019 (not in effect, revoked by Ordinance 37) Reaffirms the composition of the PNAB for eAB Ordinance 2539/2019 (current) Establishes the eAP, its composition being: Physicians, preferably specialists in family and community medicine; and nurses, preferably specialists in family health registered in the same Health Unit.
Coverage parameter	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) A team for 2,000 to 3,500 people Ordinance 2539/2019 (current) eAP Modality 1 (20h) – must cover 50% of the population covered by the eSF eAP Modality 2 (30h) – must cover 75% of the population covered by the eSF Ordinance 2979/2019 (current) For eAP modality 1 (20h), coverage in: Urban municipality – one team for every 2000 people Adjacent municipality – is one team for every 1375 people Remote municipality – one team for every 1000 people For eAP modality 2 (30h), coverage in: Urban municipality – one team for every 3000 people Adjacent municipality – is one team for every 2063 people Remote municipality – one team for every 1500 people

Box 1. Systematization of federal norms related to the configuration of PHC teams. Brazil, 2017 to 2021

Workload	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) Ten hours, with a maximum of 3 (three) professionals per category, with a minimum of 40 hours/week Ordinance 18/2019 (not in effect, revoked by Ordinance 37) Reaffirms the workload of the PNAB Ordinance 2539/2019 (current) Modality 1 - the minimum individual workload of professionals must be 20 (twenty) hours per week Modality 2 - the minimum individual workload of professionals must be 30 (thirty) hours per week Ordinance 2979/2019 (current) Type 1 – 20 hours a week Type 2 – 30 hours a week
Oral Health Team	**Normative Acts**
Composition	Ordinance 2437/2017 (not in force, but with part of its content incorporated in PC 2) Modality I: Dental surgeon and oral health assistant (ASB) or oral health technician (TSB) Modality II: Dental Surgeon, TSB and ASB, or other TSB Ordinance 18/2019 (not in effect, revoked by Ordinance 37) Reaffirms the composition of the PNAB
Coverage parameter	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) One team for every 2,000 to 3,500 people Ordinance 18/2019 (not in effect, revoked by Ordinance 37) 40h modality – a team must cover 100% of the population assigned to an eSF Ordinance 2539/2019 (current) 30h modality – must cover 75% of the population enrolled for an eSF 20h modality – must cover 50% of the population enrolled for an eSF
Workload	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) 40 hours a week Ordinance 18/2019 (not in effect, revoked by Ordinance 37) 40 hours a week Ordinance 2539/2019 (current) Modality 1 – 20h Modality 2 – 30h
NASF-AB team	**Normative Acts**
Composition	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) Acupuncturist Doctor; Social Worker; Physical Education Professional/Teacher; Pharmaceutical; Physiotherapist; speech therapist; Gynecologist/Obstetrician; Homeopathic Doctor; Nutritionist; Pediatrician; Psychologist; Psychiatric doctor; Occupational Therapist; Geriatrician Doctor; Internist (medical clinic), Occupational Physician, Veterinarian, professional with training in art and education (art educator); and sanitary health professional, that is, a professional graduated in the health area with a post-graduate degree in public or collective health or graduated directly in one of these areas according to current regulations.
Coverage parameter	Ordinance 3124/2012 (not in force, but with part of its content incorporated into PC2) Modality 1 – at least five and at most nine eSF or Primary Care teams for specific populations (Street Clinics, riverside and riverside teams). Modality 2 – at least three and at most four eSF and/or Primary Care teams for specific populations (Street Clinics, riverside and riverside teams). Modality 3 – at least one and at most two eSF and/or Primary Care teams for specific populations (Street Clinics, riverside and riverside teams), specifically adding to their work process, setting up as an expanded team.
Workload	Ordinance 3124/2012 (not in force, but with part of its content incorporated into PC2) Modality 1 - the sum of the weekly workloads of the team members must accumulate, at least, 200 (two hundred) weekly hours; no professional should have a weekly workload of less than 20 hours; each occupation, considered separately, must have a minimum of 20 hours and a maximum of 80 hours of weekly workload. Modality 2 – the sum of weekly workloads of team members must accumulate at least 120 hours per week; no professional should have a weekly workload of less than 20 hours; each occupation, considered separately, must have a minimum of 20 hours and a maximum of 40 hours of weekly workload. Modality 3 – the sum of weekly workloads of team members must accumulate at least 80 hours per week; no professional should have a weekly workload of less than 20 hours; each occupation, considered separately, must have a minimum of 20 hours and a maximum of 40 hours of weekly workload.

Source: Own elaboration.

Changes related to the composition, the coverage parameter and the workload of the members of the teams that work in the PHC can be observed in the federal regulation of the SUS (*box 1*). The eSF, which coverage parameters ranged from 2,000 to 3,500 people, began to be differentiated according to the geographic classification of municipalities by the Brazilian Institute of Geography and Statistics (IBGE). With the publication of the Prevent Brazil Program (PPB), in 2019, – a program that defines new federal funding rules for PHC actions and services in Brazil – the following were advocated: one team per 2000 inhabitants in remote intermediate and remote rural municipalities, and one team per 4000 inhabitants in urban municipalities. Regarding the workload, all team members must work 40 hours a week, with the exception of units that have joined the Saúde na Hora program. Saúde na Hora is a program that aims to extend the opening hours of health units.

In 2017, the coverage of the ACS, which was 750 people, became more flexible with the publication of a new version of the PNAB, with this parameter being recommended only in areas of great territorial dispersion, areas of risk and social vulnerability. There were also changes in eAP coverage from Prevent Brazil. If, before, the eAP modality I (20 hours a week) covered 50% of the population served by the eSF, now, coverage is established according to the municipality typology defined by IBGE. The same occurred with eAP modality II (30 hours per week).

As for the eSB, modalities I (composed of a dental surgeon, a technician or an oral health assistant) and II (consisting of three members, including the dental surgeon, two technicians or a technician and a health assistant) were maintained. However, with changes in coverage parameters determined by the workload of professionals. From the creation of the 20h and 30h modality, the required coverage became, respectively, 50% and 75% of the population assigned to an eSF. Regarding the NASF-AB team, there were no changes regarding the configuration.

Box 2. Systematization of federal norms related to the funding of PHC teams. Brazil, 2017 to 2021

Family health team	Normative acts
Incentive value	Ordinance 978/2012 (not in force, but with part of its content incorporated in PC 2) Modality 1 teams: BRL 10,695.00/month. Modality 1 teams are all teams deployed in municipalities: a) with a population of up to 50,000 inhabitants in the states of the Legal Amazon, or b) with a population of up to 30,000 inhabitants and a Human Development Index (HDI) equal to or less than 0.7, in the other states of the country; or c) who are already entitled to receive a 50% increase in the value of the incentives referring to the total eSF and eSB they implement; It is The eSF implemented in municipalities not included in the provisions of paragraph I and that serve the remaining population of quilombos and/or residents in settlements of at least 70 (seventy) people, respecting the maximum number of teams per municipality, published in a specific ordinance. Type 2 teams: BRL 7,130.00/month Ordinance 2979/2019 (current) The value is included in the weighted capitation value Ordinance 169/2020 (current) Updates the per capita amount by BRL 50.50/month
Incentive source	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) Variable basic care floor Ordinance 2979/2019 (current) Weighted capitation

Box 2. Systematization of federal norms related to the funding of PHC teams. Brazil, 2017 to 2021

Community Health Agent	**Normative acts**
Incentive value	Original Ordinance 1024 and 1962/2015 (not in force, but with part of its content incorporated in PC 6) Defines the transfer of funds from the Union's Supplementary Financial Assistance (AFC) to comply with the national professional salary floor for Community Health Agents (ACS) Ordinance 201/2019 (not in effect) Establishes the transfer of BRL 1,250.00 per ACS/month Ordinance 3317/2020 (current) Establishes the transfer of BRL 1,550.00 per ACS/month
Incentive source	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) Variable basic care floor Ordinance 2979/2019 (current) If included in the eSF, incentive by weighted funding If included in the ACS strategy, incentive for adherence to strategic actions
Primary care team	**Normative acts**
Incentive value	Ordinance 1808/2018 (current) eAB – the amount corresponds to 30% of the monthly cost of the eSF (BRL 2,139.00/month) Ordinance 2539/2019 (current) Modality I (20h) – BRL 3,565.00/month Modality II (30h) – BRL 5,347.00/month Ordinance 2979/2019 (current) The value is included in the weighted capitation value as the eSF Ordinance 3883/2019 (current) Modality I (20h): monthly transfer equivalent to 50% of the financial incentive related to the eSF Modality II (30h): monthly transfer equivalent to 75% of the financial incentive related to the eSF. Ordinance 169/2020 (current) Updates the per capita amount to R$ 50.50/month
Incentive source	From Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) Variable basic care floor Ordinance 2979/2019 (current) Weighted capitation
Oral health team	**Normative acts**
Incentive value	Original Ordinance 978/2012 (not in force, but with part of its content incorporated in PC6) Modality I 40h (with two professionals) BRL 2,230.00/month Modality II 40h (with three professionals): BRL 2,980.01/month Ordinance 2539/2019 (current) It makes the workload of the teams more flexible to: Modality I (20h): BRL 1,115.00 per team; Modality I (30h): BRL 1,672.50 per team. Ordinance 2305/2020 (current) Modality I - BRL 2,453.00/month Modality II - BRL 3,278.00/month Modality I – (20h): BRL 1,226.50/month Modality I – (30h): BRL 1,839.75/month
Incentive source	Ordinance 2436/2017 (not in force, but with part of its content incorporated in PC 2) Variable basic care floor Ordinance 2979/2019 (current) Incentive for adherence to strategic actions

Box 2. Systematization of federal norms related to the funding of PHC teams. Brazil, 2017 to 2021

NASF-AB team	Normative acts
Valor do incentivo	Ordinance 548/2013 (not in force, but with part of its content incorporated into PC2) NASF Modality 1 – BRL 20,000.00/month NASF Modality 2 – BRL 12,000.00/month NASF Modality 3 – BRL 8,000.00/month Ordinance 2979/2019 (current) No funding
Fonte do incentivo	Ordinance 2436/2017 (not in force, but with part of its content incorporated into PC2) Variable basic care floor Ordinance 2979/2019 (current) No source of incentive

Source: Own elaboration.

In the financing axis, there are rules that privilege the expansion of the eAP, for which the financial incentives were updated and expanded several times during the period. As for the eSF, there was no change in the value of the incentive defined in 2012. In addition, there is the end of funding for the NASF-AB team by the PPB and changes in the ways of transferring federal transfers to finance the PHC – especially by replacing the per capita modality with weighted capitation. Unlike the per capita transfer, the weighted capitation is based on the transfer of resources only to users registered by the PHC teams. With the end of the variable PAB, the main form of transfer for financing the eSB is through adherence to strategic actions. The ACS can be funded by two different forms of transfer: through weighted capitation, by joining the ESF, or by joining this specific strategic action.

The systematization of the team's accreditation and approval process also provides clues as to how the APS model has been shaping up. Regarding accreditation rules (*box 3*), the year 2019 concentrated the largest number of regulations.

Box 3. Systematization of federal norms related to the accreditation process of PHC teams. Brazil, 2017 to 2021

THEMATIC AXES	NORMATIVE ACTS	VALIDITY
Accreditation Flow	Ordinance 2436/2017 Determines that the accreditation flow must go through the elaboration of the project by the municipality; be forwarded to the SES; be approved by the CIB, which resolution is forwarded to the MS, which publishes the accreditation ordinance. From then on, the municipality has up to four months to register with the CNES.	No, but part of its content is incorporated in consolidation ordinance n. 2
	Ordinance 1710/2019 Changes the previous stream. Reduces bureaucracy in the team accreditation process. The project comes from the municipality, which sends it directly to MS. A letter is sent to the other instances (CMS, SES, CIB), for knowledge.	Yes
Registration at CNES	Ordinance 18/2019 Creates the national team identifier (INE) for the eAB and eAB oral health modalities I and II.	No, revoked by ordinance 37/2021
	Ordinance 99/2020 Unification of several INEs. The following codes are included: 70 – eSF 71 – eSB	No, revoked by ordinance 37/2021

Box 3. Systematization of federal norms related to the accreditation process of PHC teams. Brazil, 2017 to 2021

THEMATIC AXES	NORMATIVE ACTS	VALIDITY
	72 – eNasf-AB, 76 – eAP – Primary Care Team	
	Ordinance 60/2020 Defines the criteria for the municipality to be able to validate the teams in the CNES.	No, revoked by ordinance 32/2021
	Ordinance 801/2020 Makes automatic accreditation in eAP for teams certified in the 3rd Cycle of PMAQ-AB and those registered in SCNES under team type codes 16, 17, 18, 19, 20 and 21 at the time of certification.	Yes
	Ordinance 32/2021 Defines the criteria for the municipality to be able to validate the teams in the CNES, changing the text of Ordinance 60 in some aspects.	No, its content was incorporated into APS Consolidated Ordinance 1
	Ordinance 37/2021 Defines new INEs. It differs from Ordinance 99/2019 by proposing eSF (code 70) with and without oral health. The same applies to eAP (code 76).	Yes
	Ordinance 1037/2021 Defines the exclusion and priority criteria for analyzing team accreditation requests.	Yes
Team's fixation	Ordinance 3566/2019 Sets the amount of eSF and eSB of municipalities. For the definition of the quantitative, the teams considered were those accredited, registered in the National Health Establishment Registration System (SCNES) and that received federal financial incentives until the financial competence of October 2019. Teams that are transitional can choose to migrate to eSF or eAP. If there is no relocation of the physician's HC, the transitional teams will be automatically converted into eAP.	Yes
Follow-up, monitoring and evaluation	Ordinance 47/2019 Determines that this process will occur through codes referring to the National Team Identification (INE) and the National Health Establishment Register (CNES) of the Primary Health Care teams or services. The INE code will be considered for the following types of teams: I - Family Health team (eSF) and Riverside Family Health team (eSFR); II - Oral Health team (eSB); III - Street Office team (eCR); IV - Prison Primary Care team (eABP); and V - Primary Care team (eAP).	Yes

Source: Own elaboration.

A movement to simplify the process stands out, mainly due to the withdrawal of the Bipartite Intermanagers Commission (CIB) as a deliberation body on team accreditation. Along the same lines, there was the unification of several National Team Identifier (INE) codes. In the same year, an ordinance was published setting the number of eSF and eAP teams and describing the process for follow-up, monitoring and evaluation of registered teams. It is noteworthy that there is no mention of the NASF-AB team in this process, even though it is still possible to register in the system. In 2020, emphasis should be placed on the automatic accreditation of teams for the condition of eAP, and, in 2021, the creation of criteria for validating teams in the CNES.

Evolution of the composition of the teams that work in the PHC

Table 1 presents an overview of the approved teams, nationally and by macro-region, and the percentage variation of each one of them, from 2017 to 2021.

Table 1. Distribution of homologated teams and percentage variation according to macro-regions. Brazil, 2017 to 2021

Region	Team Modalities	2017	2018	2019	2020	2021	Variation in the period
		N	N	N	N	N	%
Brazil	Family Health Team	42388	44190	44334	48850	49989	17.93
	Basic/primary care team	488	535	524	2704	4497	821.52
	Oral Health Team	26369	27817	28083	30597	34579	31.14
	Community Health Agent	270867	271982	269217	282917	283104	4.52
	Family Health Support Center/ Primary Care	4904	5665	5863	5652	5467	11.48
North	Family Health Team	3427	3628	3628	4391	4593	34.02
	Basic/primary care team	42	42	7	142	316	652.38
	Oral Health Team	2004	2150	2178	2577	2917	45.56
	Community Health Agent	32874	32586	32700	33099	33081	0.63
	Family Health Support Center/ Primary Care	365	464	493	473	443	21.37
North-east	Family Health Team	15619	16046	16045	17479	17710	13.39
	Basic/primary care team	11	12	13	139	331	2909.09
	Oral Health Team	11802	12397	12614	12988	14138	19.79
	Community Health Agent	106508	106336	105996	106651	107028	0.49
	Family Health Support Center/ Primary Care	2029	2235	2287	2201	2055	1.28
Center-West	Family Health Team	2970	3201	3371	3764	3856	29.83
	Basic/primary care team	9	6	5	66	141	1466.67
	Oral Health Team	2137	2331	2348	2454	2788	29.49
	Community Health Agent	20183	20209	19922	20047	19910	-1.35
	Family Health Support Center/ Primary Care	359	410	443	426	403	12.26
South-east	Family Health Team	14229	14872	14887	16217	16695	17.33
	Basic/primary care team	318	377	402	1637	2625	725.47
	Oral Health Team	7225	7681	7736	8464	10190	44.42
	Community Health Agent	87904	89041	88345	88734	89123	1.39
	Family Health Support Center/ Primary Care	1441	1726	1782	1757	1769	22.76
South	Family Health Team	6143	6443	6443	6999	7135	16.15
	Basic/primary care team	108	98	97	720	1084	903.70
	Oral Health Team	3321	3180	3338	4114	4546	35.54
	Community Health Agent	35874	35079	34216	34386	33962	-5.33
	Family Health Support Center/ Primary Care	710	830	858	795	797	12.25

Source: CNES[34].

At the national level, the team with the highest growth rate was the eAP, with 821.52%, while the eSF had 17.93%. This disparity was maintained in all regions of the country, even in those with populations that are more dependent on the SUS.

The ACS was the one that presented the lowest growth rate (4.52%), especially in the South and Center-West regions, where there was a drop in the growth of this type of professional. The eSB showed growth (national average of 31.14%), although with variations between the regions of the country, being the lowest in the Northeast (19.79%) and the highest in the North (45.56%).

With regard to the NASF-AB team, there has been a drop in approvals from 2019 onwards, with a 6.75% decrease in registrations in 2021, compared to 2019. The drop was observed in all regions, with the lowest growth rate observed in the Northeast (1.28%).

Discussion

The ESF gradually consolidated itself as the main reference for organizing PHC in the SUS. Despite the existence of important limits and challenges, several studies indicate the advances resulting from the strengthening of the ESF. In addition, the policies directed towards PHC were the ones that most favored the implementation of SUS' principles and guidelines[35].

The eSF played a fundamental role in guaranteeing the first contact, longitudinality and coordination of care. By acting in defined geographic areas and with assigned populations, they allowed the construction of bonds and recognition of users' needs[20,36,37]. Studies indicate that the implementation and expansion of the ESF increased the population's access to health services[38], favored the reduction of infant mortality and hospitalizations due to conditions sensitive to PHC[16-21] and equity in health[23].

In the period 1994-2001, eSF growth was significant, registering 328 in 1994 and 10,788 in 2001. In the latter year, teams were present in 4,266 municipalities, providing assistance to 36 million Brazilians[38]. Federal regulation, based mainly on the issuing of ordinances linked to mechanisms for transferring financial resources from the Ministry of Health, was essential for adherence and implementation of the model by municipalities[15].

Thus, betting on policies that promote the sustainability of Family Health becomes essential to guarantee the progress achieved. But recent changes in federal rules on PHC and the evolution observed in the composition of teams do not point to this. On the contrary, they suggest a competition between the eSF and eAP team models. The eSF were financed exclusively until 2017, when the PNAB was revised and the eAP was instituted. Depending on which teams are strengthened, certain types of care are consolidated, producing direct effects on the services provided and, consequently, on the health of the population.

The analysis of the ministerial ordinances revealed a special attention to the eAP, marked by three characteristics: on several occasions, the amounts of federal transfers to finance the eAP were updated, unlike the eSF, which have not been readjusted since 2012; accreditation for eAP became automatic for some teams registered with CNES; and there was flexibility in the workload of professionals linked to this type of team. That is, the facilitation of hiring professionals can be seen in a model that prioritizes individual care and meeting spontaneous demand[39].

According to Morosini, Fonseca and Lima[27], the composition of the eAP may be more attractive, since they have fewer professionals than the ESF and, therefore, may have a lower cost; they are easier to organize, due to the flexibility of the workload; and are also financially supported. The results of this study corroborate the aspects of preference for eAP pointed out by the authors.

The eAP registration growth from 2017 to 2021 was 821.52%, against a growth of 17.93% for the eSF. These disparities persist in all regions of the country, even in those with poorer and more vulnerable populations. In the long term, if these rates are maintained, a large part of the Brazilian population will no longer have teams that have the presence of the ACS. This, in terms of the care model, can bring worrying results with regard, above all, to universal access. The growth of the eAP also tends to strengthen the presence of professionals whose training remains strongly oriented towards the control of individual risks[27].

With regard to eSB, despite the results pointing to a growth rate, a recent study showed a significant suppression in contracting the modality II of eSB[40]. Reis et al.[41] also identified a five times greater presence of eSB I compared to eSB II in the South and Southeast of Brazil. Although the present study did not perform the discrimination between modalities I and II, considering the regulations that make the workload more flexible and guarantee the transfer of federal resources to the modalities I teams, it is possible that the observed increase occurs only in these conformations that have a smaller number of professionals.

Thus, the advances achieved from the National Oral Health Policy (PNSB), implemented in 2004 and which covers health promotion, disease prevention, diagnosis, treatment and rehabilitation[42], may be compromised with this new configuration of eSB with fewer professionals[43]. The same is pointed out by Probst et al.[44], who emphasize that the actions proposed by the PNSB to invert the model of oral health care have been discontinued, mainly due to the precariousness of the service and the lack of investments.

The new PNAB also made the ACS coverage parameter more flexible. Currently, it is possible to accredit a team that has only one ACS, contrary to what happened in the previous PNAB, which recommended a minimum of four agents per eSF. That is, even with the MS stating that the eSF are a priority strategy, they are gradually constituting teams with smaller numbers of ACSs. The study by Gomes, Gutiérrez and Soranz[45] has already detected that, even with the increase in the eSF registration, there was, in the period from 2017 to 2019, a reduction in the number of ACSs in the country.

In this study, it was found that the ACS were those who showed the lowest growth rate (4.52%), and in some regions (South and Center-West), there was a decrease. It is noteworthy that stopping this trend of reducing ACS in the teams seems unlikely, since there was a process of simplifying the accreditation of the teams. This means that other instances, such as the CIB, which participated in the process of approving accredited teams, currently no longer participate in this process.

In addition, there is a damming up by the federal government regarding requests for validation from teams. That is, in addition to being currently the only entity to deliberate on the action of accreditation of teams, it demonstrates slowness in the development of this process, calling into question how much agility the 'debureaucratization' really brough to the process of implantation of teams.

Does the current tendency to configure PHC with a smaller number of ACS shift us towards a model capable of providing sustainability for Family Health? For Giovanella et al.[46], the absence of the ACS in the team affects one of the pillars of the care model that characterizes the ESF in its community and health promotion component, guided by the conception of the social determination of the health-disease process and the expanded clinic.

For Morosini, Fonseca and Lima[27], this configuration expresses the deconstruction of a commitment to the expansion of the ESF and the public health system. In addition, there is a great risk of barriers to accessing health being restored, given that it is precisely the ACS that contributes to facilitating access

and providing a stable and continuous relationship between the population and the PHC services. The authors also point out that there will be a commitment to work processes, such as: listening to and perceiving problems and needs that could be invisible to the services, as well as identifying and creating possibilities for intervention, based on their knowledge of the dynamics of life in the territory.

Another outstanding issue is the end of funding for NASF-AB teams. The municipal manager has the autonomy to maintain this arrangement, but, with the absence of funding, it is likely that the multidisciplinary component will be weakened within the scope of PHC. Activities such as matrix support, continuing education, communication, joint planning, decisions, knowledge and shared responsibility, for greater care resolution, will probably be discontinued upon the concrete possibility of dismissal of these professionals[28,39].

The results revealed that there was growth in all regions (2017 to 2021), but if the records from 2019 are considered, the trend is downward. Furthermore, however much accreditation is maintained, this does not necessarily mean that the work logic of the NASF-AB teams is being preserved.

A recent study by Lopes[47] revealed that professionals were reassigned to other functions. The MS's lack of interest in NASF-AB is also expressed when it does not mention this type of team in the ordinance that establishes the monitoring, follow-up and evaluation process of the teams. Paulino et al.[48] warn that excluding one of the main PHC interprofessional strategies does not guarantee that the other teams will act in an integrated, interdisciplinary and multidisciplinary way.

Based on the above, we can see a strengthening of a new team arrangement, the dismantling of practices aimed at health promotion and prevention actions, in addition to the fragility in building a bond with the community and the territory. Everything indicates that the tendency to induce a more restrictive PHC, with characteristics of prioritizing spontaneous demand and individualized care, causes constraints for the support of PHC focused on the ESF.

Final considerations

Within the framework of a universal, resilient and sustainable system (economically and socially), PHC integrates the set of health actions and services dedicated to meeting the individual and collective needs of a given population, community or territory, involving multiprofessional care practices, articulations with specialized care services, relations between sector and with society.

The study aimed to identify the extent to which the new PHC organization rules have an impact on the composition of the teams, a fundamental aspect of the Family Health model. The results suggest that the incentives for other arrangements of health teams, the flexibility of the ACS coverage and the multidisciplinary action compromise the sustainability of the Family Health model in the SUS.

From the point of view of federal regulations, it was found that the rules tend to strengthen a less comprehensive PHC perspective. Some characteristics present in the model developed until 2017 seem to have lost priority, among them, a multidisciplinary work process, linked to the territory, with conditions for the expanded team to act towards the promotion of access and comprehensive actions. With regard to certification data, the composition of the teams shows the same trend, marked by the strong growth of the eAP, a trend towards a reduction in the number of ACSs and of teams that work in a multidisciplinary approach.

The federal government, as an entity with high power to induce and coordinate policies, assumes the defense of a PHC model quite different from what was observed in previous PHC policies. That said, it is worth asking: who, which groups and which sectors are

interested in building a new, more restrictive and less universal PHC model?

Collaborators

Mendonça FF (0000-0002-6490-1815)* contributed to the design, data collection, data analysis, writing and final revision of the manuscript. Lima LD (0000-0002-0640-8387)* contributed to the conception, writing and final review. Pereira AMM (0000-0002-2497-9861)* contributed to writing the final review. Martins CP (0000-0001-6217-4944)* contributed to data collection and final review. ■

References

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005; (83):457-502.

2. Organização Pan-Americana da Saúde. Renovação da atenção primária em saúde nas Américas: documento de posicionamento da Organização Pan-Americana da Saúde/Organização Mundial da Saúde (OPAS/OMS). Washington, DC: Organização Pan-Americana da Saúde; 2007. [acesso em 2022 mar 14]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/renovacao_atencao_primaria_saude_americas.pdf.

3. Lawn JE, Rohde J, Rifkin S, et al. Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. The Lancet. 2008; 372(9642):917-927.

4. Walley J, Lawn JE, Tinker A, et al. Primary health care: making Alma-Ata a reality. The Lancet. 2008; 372(9642):1001-1007.

5. Pereira AMM, Castro ALB, Oviedo RAM, et al. Atenção primária à saúde na América do Sul em perspectiva comparada: mudanças e tendências. Saúde debate. 2012; 36(94):482-499.

6. Giovanella L, Mendonça MHM. Atenção Primária. In: Giovanella L, Escorel S, Lobato LVC, et al. Políticas e sistemas de saúde no Brasil. 2. ed. Rio de Janeiro: Editora Fiocruz; 2012. p. 493-546.

7. Giovanella L. Atenção Primária à Saúde seletiva ou abrangente? Cad. Saúde Pública. 2008; 24(supl1):7-27.

8. Cueto M. The origins of primary health care and selective primary health care. Am J Public Health. 2004; (94):1864-1874.

9. Castro ALB, Machado CV. A política de atenção primária à saúde no Brasil: notas sobre a regulação e o financiamento federal. Cad. Saúde Pública. 2010; 26(4):693-705.

10. Macinko J, Guanais FC, Fátima M, et al. Evaluation of the impact of the Family Health Program on infant

*Orcid (Open Researcher and Contributor ID).

mortality in Brazil, 1990-2002. J Epidemiol Community Health. 2006; 60(1):13-19.

11. Macinko J, Souza MFM, Guanais FC, et al. Going to scale with community-based primary care: An analysis of the family health program and infant mortality in Brazil, 1999-2004. Soc Sci Med. 2007; 65(10):2070-2080.

12. Aquino R, Oliveira NF. Impact of the Family Health Program on Infant Mortality in Brazilian Municipalities. Am J Public Heal. 2009; 99(1):87-93.

13. Guanais FC, Macinko J. Primary Care and Avoidable Hospitalizations: Evidence from Brazil. J Ambul Care Manag. 2009; 32(2):115-22.

14. Fausto MCR, Giovanella L, Mendonça MHM, et al. A posição da Estratégia Saúde da Família na rede de atenção à saúde na perspectiva das equipes e usuários participantes do PMAQ-AB. Saúde debate. 2014; 38(esp):13-33.

15. Facchini LA, Thumé E, Nunes BP, et al. Governance and Health System Performance: National and Municipal Challenges to the Brazilian Family Health Strategy. In: Reich MTK, editor. Governing Health Systems. Brookline: Lamprey & Lee; 2015. p. 203-36.

16. Arantes LJ, Shimizu HE, Merchán-Hamann E. Contribuições e desafios da Estratégia Saúde da Família na Atenção Primária à Saúde no Brasil: revisão da literatura. Ciênc. saúde coletiva. 2016; 21(5):1499-1510.

17. Malta DC, Santos MAS, Stopa SR, et al. A Cobertura da Estratégia de Saúde da Família (ESF) no Brasil, segundo a Pesquisa Nacional de Saúde, 2013. Ciênc. saúde coletiva. 2016; 21(2):327-338.

18. Ribeiro MDA, Bezerra EMA, Costa MS, et al. Avaliação da atuação do Núcleo de Apoio à Saúde da Família. Rev. Bras. Promoção Saúde. 2014; (2):224-231.

19. Silveira Filho AD. Potencial de efetividade das estratégias de promoção da saúde bucal na atenção primária à saúde: estudo comparativo entre capitais e regiões do Brasil. Rev. bras. Epidemiol. 2016; 19(4):851-865.

20. Alonso CMC, Béguin PD, Duarte FJCM. Trabalho dos agentes comunitários de saúde na Estratégia Saúde da Família: metassíntese. Rev. Saúde Pública. 2018 [acesso em 2022 mar 25]; (52):1-13. Disponível em: https://doi.org/10.11606/S1518-8787.2018052000395.

21. Organização Mundial da Saúde. Escritório Regional para o Pacífico Ocidental. Papel da atenção primária na resposta ao COVID-19. Escritório Regional da OMS para o Pacífico Ocidental. [acesso em 2021 abr 10]. Disponível em: https://apps.who.int/iris/handle/10665/331921.

22. Medina MG, Giovanella L, Bousquat A, et al. Atenção primária à saúde em tempos de COVID-19: o que fazer? Cad. Saúde Pública. 2020 [acesso em 2022 mar 25]; 36(8):e00149720. Disponível em: https://doi.org/10.1590/0102-311X00149720.

23. Prado NMBL, Rossi TRA, Chaves SCL, et al. The international response of primary health care to COVID-19: document analysis in selected countries. Cad. Saúde Pública. 2020 [acesso em 2022 mar 25]; 36(12):e00183820. Disponível em: https://doi.org/10.1590/0102-311X00183820.

24. Prado NMBL, Biscarde DGS, Pinto Junior EP, et al. Ações de vigilância à saúde integradas à Atenção Primária à Saúde diante da pandemia da COVID-19: contribuições para o debate. Ciênc. saúde coletiva. 2021 [acesso em 2022 mar 25]; 26(7):2843-2857. Disponível em: https://doi.org/10.1590/1413-81232021267.00582021.

25. Machado CV, Pereira AMM, Freitas CM. As Respostas dos Países à Pandemia em Perspectiva Comparada: semelhanças, diferenças, condicionantes e lições. In: Machado CV, Pereira AMM, Freitas CM, organizadores. Políticas e sistemas de saúde em tempos de pandemia: nove países, muitas lições. Rio de Janeiro: Observatório Covid-19 Fiocruz; Editora Fiocruz; 2022. p. 323-342.

26. Pereira AMM, Machado CV, Veny MB, et al. Governança e capacidade estatal frente à Covid-19 na Alemanha e Espanha: respostas nacionais e sistemas de saúde em perspectiva comparada. Ciênc. saúde co-

letiva. 2021 [acesso em 2022 mar 25]; 26(10):4425-4457. Disponível em: https://doi.org/10.1590/1413-812320212610.11312021.

27. Morosini MVGC, Fonseca AF, Lima LD. Política Nacional de Atenção Básica 2017: retrocessos e riscos para o Sistema Único de Saúde. Saúde debate. 2018; 42(116):11-24.

28. Melo EA, Almeida PF, Lima LD, et al. Reflexões sobre as mudanças no modelo de financiamento federal da Atenção Básica à Saúde no Brasil. Saúde debate. 2019; 43(esp5):137-144.

29. 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.

30. Massuda A. Mudanças no financiamento da Atenção Primária à Saúde no Sistema de Saúde Brasileiro: avanço ou retrocesso? Ciênc. saúde coletiva. 2020; 25(4):1181-1188.

31. Mendes A, Melo AM, 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 [acesso em 2021 set 20]; 38(2):e00164621. Disponível em: https://doi.org/10.1590/0102-311X00164621.

32. Brasil. Ministério da Saúde. Sistema Saúde Legis. Sistema de Pesquisa de Legislação que reúne os atos normativos do Sistema Único de Saúde (SUS), no âmbito da esfera federal. [acesso em 2021 set 20]. Disponível em: http://saudelegis.saude.gov.br/saudelegis/secure/norma/listPublic.xhtml.

33. Bardin L. Análise de conteúdo. Lisboa: Editora Edições 70; 2020.

34. Brasil. Ministério da Saúde. Cadastro Nacional de Estabelecimentos de Saúde. Profissionais. [acesso em 2021 out 15]. Disponível em: http://cnes.datasus.gov.br/.

35. Carvalho BG, Cordoni Junior L, Souza RKT, et al. A organização do Sistema de Saúde no Brasil. In: Andrade SM, Cordoni Junior L, Carvalho BG, et al., organizadores. Bases de Saúde Coletiva. Eduel: Londrina; 2017. p. 70-136.

36. Brasil. Decreto Federal nº 7.508, de 28 de junho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde – SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Diário Oficial da União. 28 Jul 2011.

37. Brasil. Ministério da Saúde. Política Nacional de Atenção Básica. Brasília, DF: MS; 2011.

38. Marques RM, Mendes Á. A política de incentivos do Ministério da Saúde para a atenção básica: uma ameaça à autonomia dos gestores municipais e ao princípio da integralidade? Cad. Saúde Pública. 2002; 18(supl):163-171.

39. Giovanella L, Franco CM, Almeida PF. Política Nacional de Atenção Básica: para onde vamos? Ciênc. saúde coletiva. 2020; 25(4):1475-1482.

40. Martins CP. Repercussões do financiamento e da organização dos serviços de saúde bucal para o modelo de atenção odontológica na macrorregião norte do Paraná. [dissertação]. Londrina: Universidade Estadual de Londrina; 2022.

41. Reis PAM, Corrêa CP, Martins CB, et al. O técnico em saúde bucal: a atuação deste profissional no serviço público de saúde. RGSS. 2017; 6(3):293-305.

42. Lucena EHG, Pucca JRGA, Sousa MF. A Política Nacional de Saúde Bucal no Brasil no contexto do Sistema Único de Saúde. Tempus. 2011; 5(3):53-63.

43. Chaves SCL, Almeida AMFL, Reis CS, et al. Política de Saúde Bucal no Brasil: as transformações no período 2015-2017. Saúde debate. 2018; 42(esp2):76-91.

44. Probst LF, Pucca Junior GA, Pereira AC, et al. Impacto das crises financeiras sobre os indicadores de

saúde bucal: revisão integrativa da literatura. Ciênc. saúde coletiva. 2019; 24(12):4437-4448.

45. Gomes CBS, Gutiérrez AC, Soranz D. Política Nacional de Atenção Básica de 2017: análise da composição das equipes e cobertura nacional da Saúde da Família. Ciênc. saúde coletiva. 2020; 25(4):1327-1338.

46. Giovanella L, Bousquat A, Schenkman S, et al. Cobertura da Estratégia Saúde da Família no Brasil: o que nos mostram as Pesquisas Nacionais de Saúde 2013 e 2019. Ciênc. saúde coletiva. 2021; 26(supl1):2543-2556.

47. Lopes WP. Repercussões do contexto sócio-político, sanitário e normativo para a oferta e organização de serviços de Atenção Básica na Macrorregião Norte do Paraná. [dissertação]. Londrina: Universidade Estadual de Londrina; 2022.

48. Paulino KC, Silva FC, Barros APM, et al. Reflexões sobre o novo financiamento da atenção básica e as práticas multiprofissionais. BJD. 2021; 7(1):5362-5372.

Received on 07/28/2022
Approved on 01/30/2023
Conflict of interests: non-existent
Financial support: Strengthening Primary Health Care in Brazil – PMA 2019 (FIOCRUZ/VPPCB; process 25380.101539/2019-05). The publication received support from the Postgraduate Program in Collective Health at State University of Londrina. LDL is a research productivity fellow from CNPq and Cientista do Nosso Estado from FAPERJ