Historical process of changes in public health until the implementation of the national primary care policy

Processo histórico de mudanças na saúde pública até a implantação da política nacional de atenção básica

Proceso histórico de cambios en salud pública hasta la aplicación de la política nacional de atención primaria

RESUMO

Objetivo: refletir teoricamente sobre o processo histórico de mudanças na saúde pública até a implantação da Política Nacional de Atenção Básica no Brasil. Métodos: estudo reflexivo, embasado na formulação discursiva sobre o histórico de mudanças da atenção básica no contexto da saúde pública. A pesquisa foi realizada no período de outubro a dezembro de 2021. Resultados: a atenção básica, atua na integralidade das ações com a busca da promoção, proteção e recuperação, além das atividades preventivas, redução de danos ou sofrimentos é desenvolvida com nível elevado de descentralização, visando atender maior parte da demanda da população. A política nacional de atenção básica foi criada com o objetivo de estabelecer as diretrizes organizacionais visando expandir a atenção básica no Brasil. Conclusão: com as novas atribuições propostas pela Política Nacional de Atenção Básica de 2017, as mudanças propostas caminham para a comercialização da prestação de serviços.

DESCRITORES: Saúde Pública; Estratégia de Saúde da Família; Atenção Primária à Saúde.

ABSTRACT

Objective: to theoretically reflect on the historical process of changes in public health until the implementation of the National Primary Care Policy in Brazil. Methods: reflective study, based on the discursive formulation on the history of changes in primary care in the context of public health. The research was carried out from October to December 2021. Results: primary care operates in the integrality of actions with the search for promotion, protection and recovery, in addition to preventive activities, reduction of harm or suffering is developed with a high level of decentralization, aiming to meet most of the population's demand. The national primary care policy was created with the objective of establishing organizational guidelines to expand primary care in Brazil. Conclusion: with the new attributions proposed by the National Primary Care Policy of 2017, the proposed changes move towards the commercialization of the provision of services.

DESCRIPTORS: Public Health; Family Health Strategy; Primary Health Care.

RESUMEN

Objetivo: reflexionar teóricamente sobre el proceso histórico de cambios en la salud pública hasta la implementación de la Política Nacional de Atención Primaria en Brasil. Métodos: estudio reflexivo, a partir de la formulación discursiva sobre la historia de los cambios en la atención primaria en el contexto de la salud pública. La investigación se realizó de octubre a diciembre de 2021. Resultados: la atención primaria opera en la integralidad de acciones con la búsqueda de promoción, protección y recuperación, además de las actividades preventivas, la reducción del daño o sufrimiento se desarrolla con un alto nivel de descentralización , con el objetivo de satisfacer la mayor parte de la demanda de la población. La política nacional de atención primaria fue creada con el objetivo de establecer pautas organizativas para ampliar la atención primaria en Brasil. Conclusión: con las nuevas atribuciones propuestas por el Política Nacional de Atención Primaria de 2017, los cambios propuestos avanzan hacia la comercialización de la prestación de servicios

DESCRIPTORES: Salud Pública; Estrategia de Salud Familiar; Atención Primaria de Salud.

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INTRODUCTION

The paradigm shift in Brazil provided the construction of the current care model that opposed the biomedical model, and had its origins in the past. Political and health changes guided reform movements, seeking the right and expansion of access to health. The hospital-centered model was criticized in the late 1970s, to the detriment of the high costs generated and the dubious resolvability of health problems, requiring a new organization of services, creating PHC as the central point of the system. [1]

In the historical context, since the 20th century, Primary Health Care has been structured worldwide. In 1922, Dawson's report served as the basis for the implementation of a health system based on services centered on primary centers with regional authority. [2,3]

In 1978, promoted by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), the International Conference on Primary Health Care took place, developed in Alma-Ata, whose strategy was to reduce disparities between central and third world countries, user participation and PHC as an important factor in achieving the goal of "Health for All by the Year 2000". Among the discussions at the conference, the criticism of the hegemonic medical model and the fight against endemic diseases stand out. [4]

This Alma-Ata declaration, which served as the basis for health reform movements in Brazil, encouraged primary care as the main focus of health care. [2,3] The sanitary movement in Brazil used the term Primary Care (AB) which refers to Primary Health Care, since it brings a broader integral meaning, which differs from the Selective Primary Care proposal. [5]

At the national level, health as a fundamental human right and a duty of the State was recognized from the promulgation of the Federal Constitution of 1988, in article 196, which starts to recognize as something inherent to citizenship. It is reformulated from Law 8080 of 1990. [2]

Linked to these proposals, the Family Health Program (PSF - Programa de Saúde da Família) emerges with the objective of collaborating in the organization of the SUS, especially in the process of municipalization, community participation, comprehensive care and reorganizing health care practices. [6] Given the need for expansion, as a strategy to change the hegemonic care model, the PSF was redefined in the Family Health Strategy (FHS), making it an alternative and priority model for the organization of Primary Care (PC), characterized by combining the practice of individual and collective care, as a means of strengthening and consolidating the principles and guidelines of the SUS. [7]

However, several actions demanded the creation of a policy to reorganize PHC, in view of this need, the first National Primary Care Policy (PNAB) was created in 2006. In this regard, the following question guides the study carried out: how did the historical process of changes in public health take place until the implementation of the National Primary Care Policy and what impacts? In view of these concerns, a reflection is proposed on issues related to the historical process of changes in public health until the implementation of the National Primary Care Policy in Brazil.

METHODS

This is a reflection study based on the discursive formulation on the history of changes in primary care in the context of public health. The research was carried out from October to December 2021. The text was organized into three parts, with an approach to the themes: "Occurrences in the historical framework of health and the influence on Brazilian public health", "theoretical framework for primary health care" and "emergence of the PNAB and its implications for the consolidation of primary care."

RESULTS AND DISCUSSION

Occurrences in the historical framework of health and the influence on brazilian public health

Since the period of colonization with the commercial monopoly by Portugal, the health actions were through the creation of Santa Casas de Misericórdia, a philanthropic entity, with the aim of treating the sick, whose challenge was to control pestilential diseases, in addition to an incipient health organization. In the Imperial period, the impact of the opening of the ports in 1808, brought a minimum health structure focu-

sed on the sanitary police, where the great endemics prevailed, being necessary the adoption of sanitary surveillance measures of the ports. [8]

Health care breaks out in social security systems, in the old Republic, with the enactment of the Eloy Chaves Law in 1923, the Retirement and Pension Funds - CAPS were created, initially to railroad workers, expanding to other professional categories, which were also responsible for providing health care to salaried workers, initially the boxes were linked to companies. [9]

In the context of public health, there was a predominance of rural endemics and major public health campaigns aimed at combating epidemics. It is worth mentioning the unification of CAP, which became the Retirement and Pension Institute (IAP - Instituto de Aposentadoria e Pensão), conferred by the State administration, allowing the cost of social security assistance in its budget, covering professional categories, extending social security to most urban workers. [9,10]

Social security assistance continued in a fragmented and restricted way, within the scope of public health, major events were fundamental to the evolutionary process of the health situation, with the first milestone occurring in 1949, during the second Vargas administration, when the Emergency Home Medical Assistance Service (SAMDU) was created, another important milestone was the separation from the Ministry of Education and Health, giving rise to the Ministry of Health (MH) in 1953. [11]

In the authoritarian period in Brazil in 1964, the political and civil rights of citizens were suppressed until 1985, at that historical moment, it was marked by the expansion of the IAPs to the National Social Security Institute (INPS - Instituto Nacional de Previdência Social), aggregating all the IAPs, in addition to the privatization of healthcare, and the capitalization of the healthcare sector, which led to a major crisis in the healthcare system. Health care was restricted to workers who performed paid activities, leaving most of the population unassisted, focused on disease and procedures. [10]

Aiming at expanding coverage, INPS merged to create the National Institute of Social Security Medical Assistance (INAMPS - Instituto Nacional da Assistência Médica da Previdência Social). The institutes were responsible for providing health care only to the population that contributed to social security. The health structure of the time, for the poor was made by philanthropic entities and the church, and for the working class, by INAMPS. [12]

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Faced with these repercussions of social security medicine in Brazil, influenced by ideals exposed by the Alma-Ata Declaration, in the same period, the Brazilian Sanitary Reform (RSB - Reforma Sanitária Brasileira) came in the fight against the dictatorial period, with the theme Health and Democracy. According to Arouca (2003) [12] the idea of the RSB appears as an initial thought linked to the criticism made to the ideological movement of preventive medicine and, on the other hand, to the search for alternatives to the health crisis during the military dictatorship. To face the preventive dilemma, a theoretical practice capable of producing knowledge was necessary, as well as a political practice aimed at changing social relations.

Popular struggles were crucial for the struggle for rights and democracy, and also for popular participation in planning new measures for the national health system and demanding changes in the provision of health services. It is reiterated that these movements were motivated by rights that should be considered fundamental, such as health, education and culture.

In 1979, the creation of the SUS was proposed, resumed and expanded at the 8th National Health Conference. Supporting this idea, the RSB involved cultural ideologies and policies, the sanitary movement also known as the movement for the democratization of health. Part of the formalization of this project is found in the Constitution of 1988 and the Organic Health Law of 1990. [13]

The 8th National Health Conference came with the prerogative of access to universal, integral and equitable health, in addition, it defended health promotion and PHC. The formalization of the right to health in Brazil took place in 1988 when the Federal Constitution was enshrined, making health actions and services a citizenship right, creating the Unified Health System, directing articles 196 to 200 to the health section, with universal and equal access as its main priority.

In 1988, the Federal Constitution institutionalized the SUS, which provides for decentralization in its guidelines, bringing important responsibilities and autonomy to municipalities, on the other hand, decentralization did not come together with the strengthening of federal spheres, state and municipal authorities to promote cooperation between municipalities. [14]

The regulation of the SUS came in 1990 with Law 8080, reinforcing the equality of care, without prejudice or privileges of any kind as a right, still guaranteeing free care, preventing access made difficult by economic barriers in addition to the existing ones, such as distance from services, waiting time, opening hours, negative expectations regarding reception, in addition to educational and cultural factors. [15]

In the same year, Law 8,140, Law 8,142 was enacted on community participation resources in the management of the SUS and as intergovernmental transfers, established in the Financial Conferences, established in the Financial Conferences as collegiate instances of the SUS; This fact led to the creation of various mechanisms of participation and social control over public policies and the articulation between spheres of government. [16]

From the 1990s onwards, the creation of the Community Health Agents Program (PACS - Programa Agentes Comunitários de Saúde), was initially characterized by hierarchical and vertical programs with the aim of controlling certain diseases, achieving a "sanitary" character. Subsequently, the Family Health Program (PSF) was a model that reorganized care practice in PHC. [7]

Theoretical framework of primary health care

In the early 1980s, a new surge in the expansion of the basic network took place as a result of the country's redemocratization process. In a context of crisis in the social security model, it led to major measures to rationalize health expenditures, favoring PHC, measures supported by the Alma-Ata Conference. [2]

The actions involving the basic network grew with the implementation of new units in low-income communities. It is clear that, even with impasses and gaps, the essential policies were aimed at strengthening PHC, and that most collaborated with the implementation of SUS principles and guidelines in Brazil. [6]

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It is considered that the historical impacts marked by the hegemonic and health care models were important for the consolidation of Primary Health Care. During the process of implementing the SUS, the PHC actions became known as Primary Health Care (PHC), which assumes important roles within the SUS, as a preferential gateway, the integrality of care and the expansion of access to health services.

Among the SUS implementation processes, efforts to build a new care model in PHC materialized in 1991, with the implementation of PACS, which aimed to organize the practice of health care and worked with the family as a unit of programmatic action. Initially with coverage of the North and Northeast in peripheral and rural areas focusing on high risk situations for malnutrition and infectious diseases. [17]

The Ministry of Health (MH) created the PSF in 1994, having as its main antecedent, the PACS. With the positive results of the PACS, especially in the reduction of infant mortality, it sought its expansion to other Brazilian territories through the PSF and a greater resolution of actions and, from January 1994, the first Family Health teams began to be formed. [18]

Nationally, PC starts to act in its singularity, in the integrality of actions with the search for promotion, protection and recovery, in addition to preventive activities, reduction of damage or suffering, sociocultural insertion, it is developed with a high level of decentralization, municipalization, capillarity and its complexity of care, aiming to meet most of the population's demand. PHC in Brazil started to work through the PSF and PACS, which later, in 1996, the PSF was expanded and replaced by the ESF. This strategy induces greater coverage of Primary Health Care in Brazil.

Thus, until 2006, PHC was regulated by several norms and ordinances created by the Ministry of Health, where the publication in 1996 of the Basic Operational Norm (NOB/SUS/96) stands out, which determined the implementation of FHS teams, changing the logic of funding, enabling the greatest change in the care model so far. [19-20]

The creation of the Basic Care Floor (PAB - Piso de Atenção Básica), established

by the NOB-96, fixed and variable, operated by the fund-to-fund financial transfer, crucial in the implementation of the ESF, overcoming the logic of funding by procedures (production) or agreements. The PAB has a redistributive and broad character, through the fixed PAB (per capita/year) and the Variable PAB (by adherence to FHS components). [3]

In the processes of strengthening, restructuring and rationalization of public health systems, a role of great importance has been reserved for PHC, as the care offered by the wide network of basic services has been consolidated. [21] This strategy begins to advance and be recognized as an important means of action, with a view to reorganizing the SUS. In this prerogative, these actions demanded the creation of a policy that reorganized the PHC, aiming to regulate this strategy, the first PNAB was approved in 2006 that reviews the guidelines and norms for the organization of PHC. [22]

In the same year, the Pact for Health was created in Brazil, consisting of three pacts: Pact for life, Pact in Defense of SUS and Management Pact, which redefined the responsibilities of managers, through the adhesion of municipalities, states and the Union. In the years 2007 and 2008, the priorities of the Pact for Health were based on strengthening the ABS through the ESF, outlining objective indicators and targets for monitoring the health situation of Brazilians.

Emergence of pnab and its implications for the consolidation of primary care

In the early 2000s, the ESF underwent a major expansion in urban centers and the expansion of the Oral Health Teams (ESB), the creation and incorporation of the Family Health Support Centers (NASF). The NASF emerged with the purpose of expanding the problem-solving capacity, made up of a multidisciplinary team working in different areas of knowledge in partnership with the eSF professionals. Concomitantly, with the expansion, difficulties persisted, such as underfunding, care model, inadequate infrastructure, in addition to difficulties in the low demand for medical professionals. [3]

Until 2006, there was no policy responsible for organizing the role of PHC, as of 2006, with the objective of establishing organizational guidelines to expand the FHS, the Federal government published the first National Policy for Primary Health Care – PNAB.

The 2006 PNAB started important discussions, by bringing recommendations for guiding health services, for the work process, for the composition of teams, for the financing of the system, for the attributions of the professional categories, and crucial items for the implementation of family health teams (FHt) in basic health units.

It is reiterated that, in order to expand health actions so that the SUS can be more effective, the National Primary Care Policy is essential, since one of the main attributes of PHC is the first contact, in a comprehensive and holistic way, providing a greater capture of users and supplying their needs. [23]

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The Policy incorporated the PHC attributes defined by Starfield (2002) [22] the author brings aspects such as: integrality of care, longitudinality, first contact with the population, coordination and centrality in the family and its cultural competences. In addition, the multidisciplinary team responsible for up to 4,000 inhabitants is reported, with an average recommendation of 3,000 inhabitants, with 40 hours per week for all professionals and composed at least by a doctor, nurse, nursing technician or nursing assistant and ACS, and the number of CHAs is sufficient to cover 100% of the enrolled population, with up to 750 people per CHA and 12 CHAs per Family Health team. [24]

With the perspective of expansion, the PNAB was shaped through unique aspects of different realities. In 2011, the first review took place, with the aim of further improving the quality of care. The movement for changes in the PNAB began by reaffirming the guidelines proposed in the last edition, in addition to the flexibility of the average workload of 20 to 30 hours per week, this change aimed to supply the deficit of professionals in the teams. 25 This change brought negative impacts, such as the decrease in medical hours favored the higher turnover of these professionals, breaking with the idea of establishing a bond with the client, in addition to overloading the other team members.

The last amendment to the PNAB, Ordinance No. 2,436, in force to date, took

place in 2017, this new change consolidates the main ideas contained in previous versions. One of the main risk highlights is the mischaracterization of the CHA's performance, which strengthens inequalities of access and breaks the integrality of health care. In the past, in the framework of the multiprofessional team, there were setbacks in the face of FHS assistance in care policies, in the last update.

In addition to the mischaracterization of the role of the CHA, there was an intersection between the CHA and the nursing technician of a more curative nature, compared to the educational actions of their work, another negative factor is associated with the FHt with only one CHA and the Primary Care teams (PCt) without any. This prerogative reinforces the absence of one of the main pillars of the FHS, the component responsible for health promotion, based on the concept of social determination, on the expanded clinic and on the health-disease process. 6

Among the changes, it is worth mentioning, the minimum workload required of the medical professional, of ten hours per week, in PC, and the extinction and weakening of federal funding to the NASF, with the justification of greater autonomy for municipal managers. In this way, the multiprofessional component was weakened. These changes jeopardize the consolidation of PC in Brazil, weakening many popular achievements since its implementation.

CONCLUSION

Undoubtedly, the trajectory of primary health care in Brazil had positive impacts, collaborating in the consolidation of the principles and guidelines of the unified health system. In fact, the national primary care policy brought relevant aspects to the organization, but on the other hand, its third edition reveals important challenges that break the universal character of the unified health system and make it difficult to consolidate primary care.

Such challenges echo with the new attributions proposed by the 2017 national policy of primary care, the proposed changes move towards the commercialization of the provision of services in primary care. Primary health care is an important instrument used in the organization of health services. It is hoped that these interests can converge in the implementation of a more resolute and accessible primary health care, collaborating with the strengthening of the unified health system, rather than its dismantling.

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