MEDICINA
USP

Primary healthcare system in Brazil

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Assistant Professor of General Practice – USP (Brazil)
Wonca International Classification Committee member

Informe Dawson (Inglaterra, 1920)

INFORME DAWSON

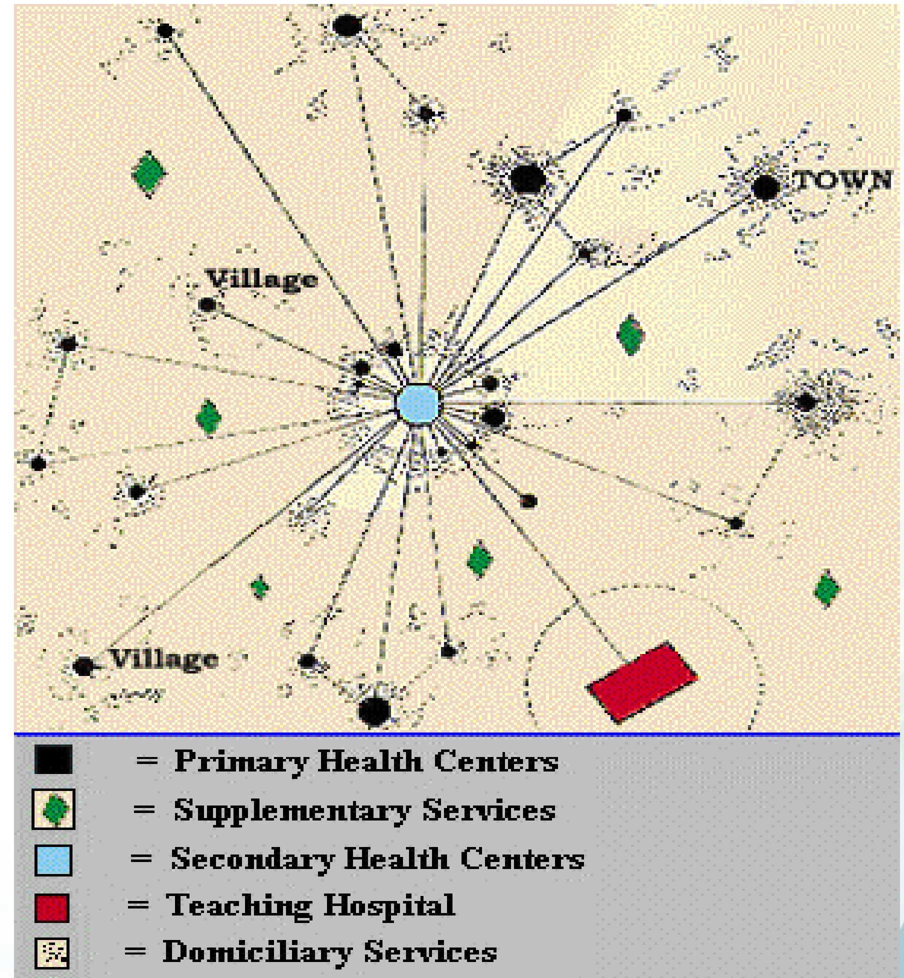
sobre

EL FUTURO DE LOS SERVICIOS MEDICOS Y AFINES

1920

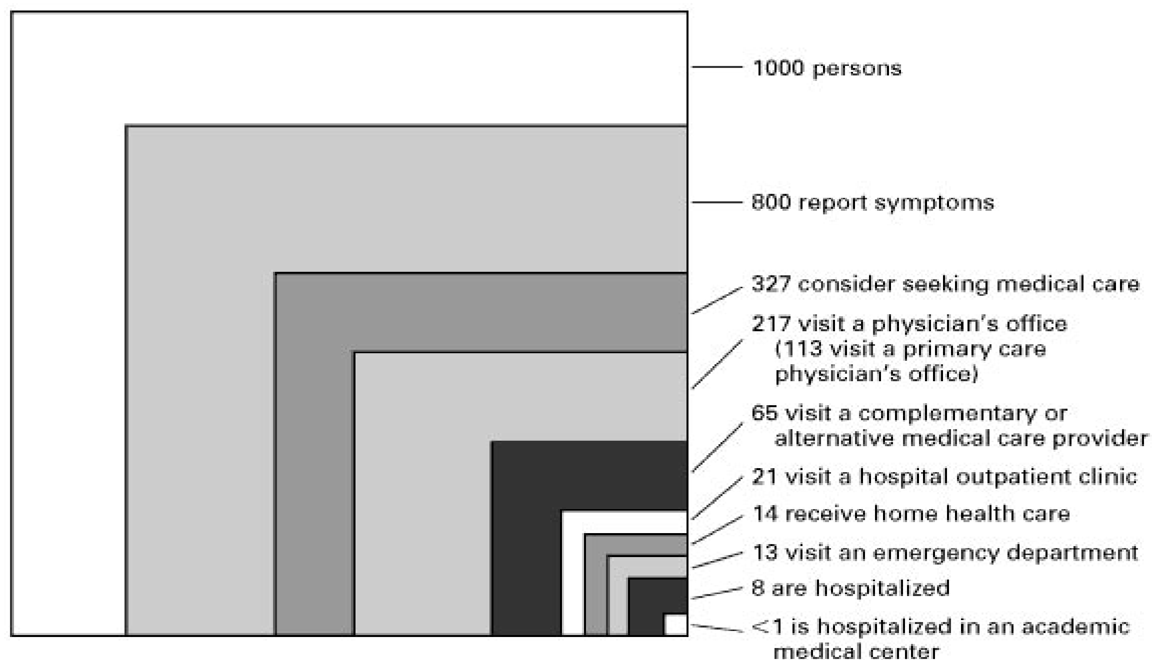
Informe provisional presentado al Ministerio de Salud de la Gran Bretaña en 1920 por el Consejo Consultivo de Servicios Médicos y Afines

TEIA



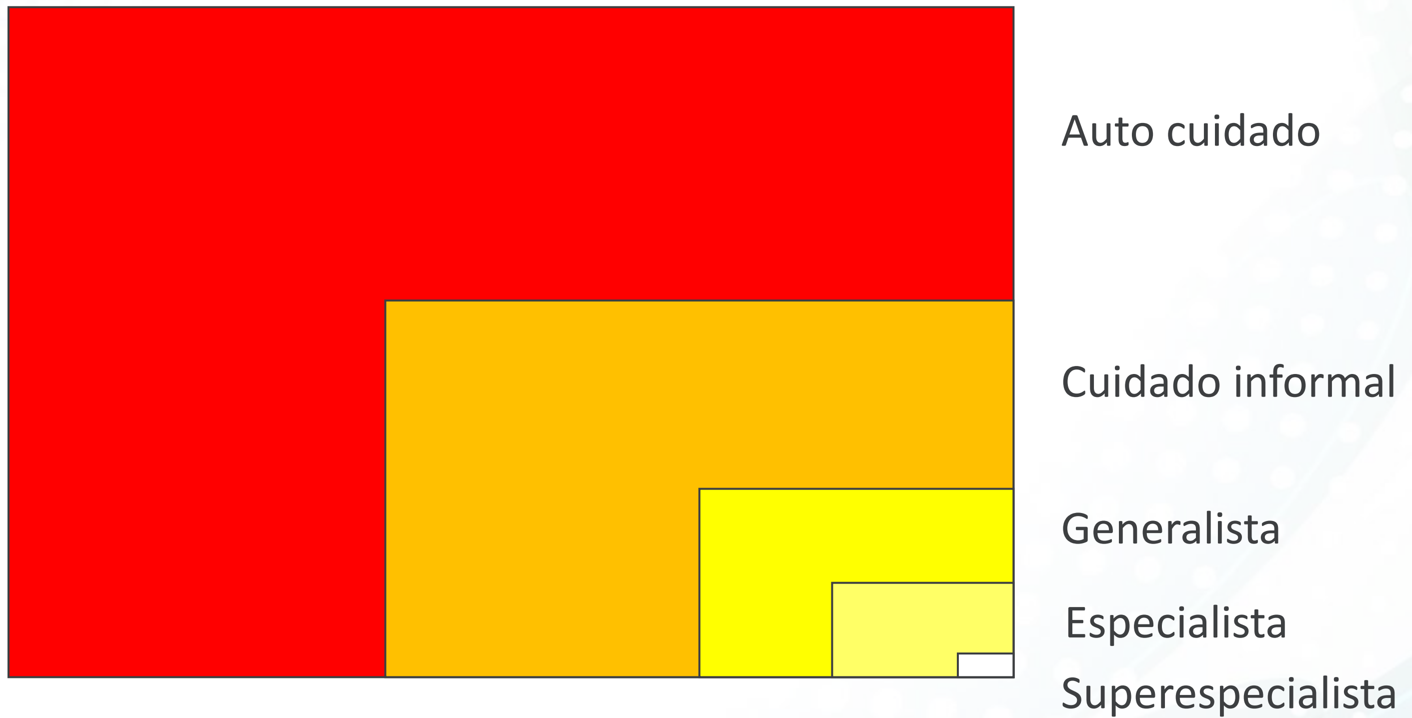
The Ecology of Medical Care*

Reprinted from
The New England Journal of Medicine
265:885–892, 1961

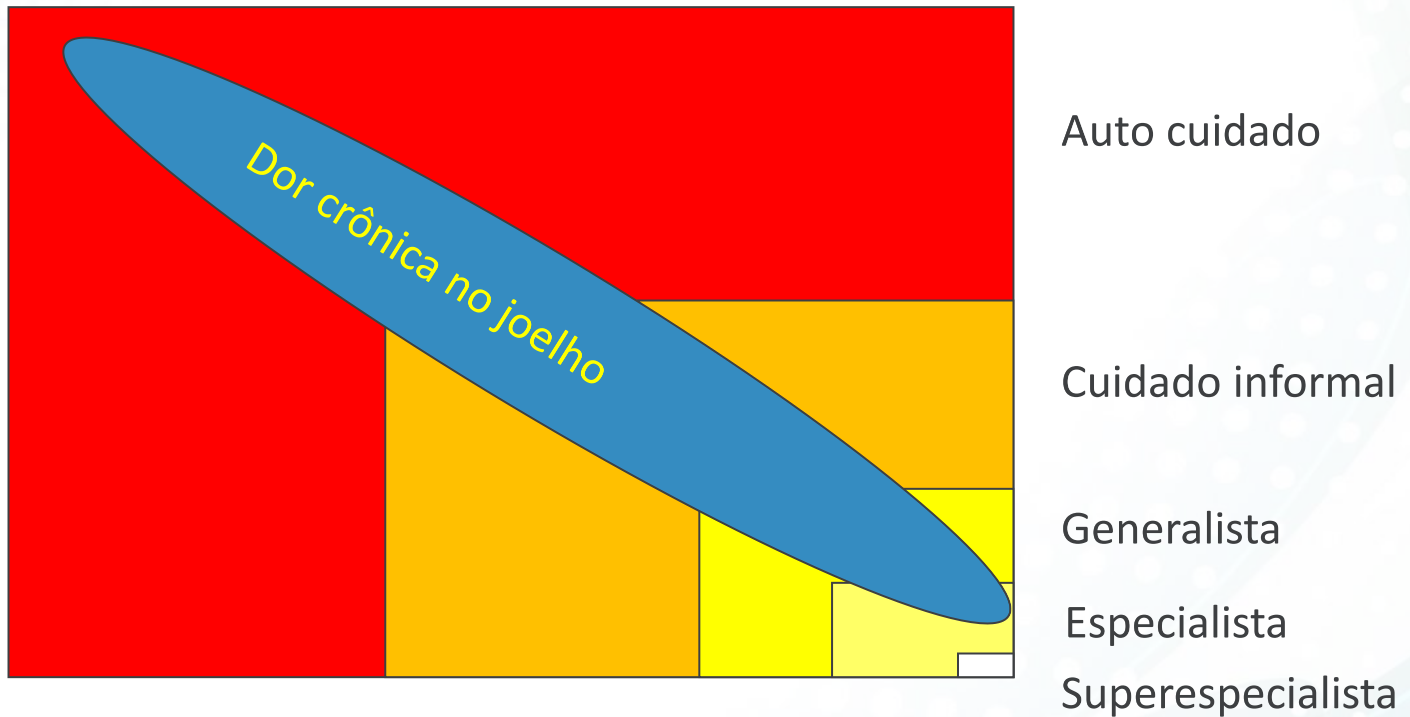


N Engl J Med, Vol. 344, No. 26 · June 28, 2001

Ecology



Ecology



1808 - 1988

- 1808 – 1917:
  - centralized vs descentralized movements
  - health assitance vs health surveillance
- 1923: insurances from companies (Bismarckian Model)
- 1930: insurances from type of job (for example: Rail Industry Worker) (Bismarckian model)
- 1953 – 1988: (Bismarckian model)
  - Ministry of Health: health surveillance
  - Ministry of Work and Social Security: health assistance
- 1964: INPS: social security and health assistance - for all employee
  - **Bismarckian model**: special taxes for employees and employers finances the system
- 1977: INAMPS health assistance - for all employee (Bismarckian model)

1988 - 2017

- 1988: Current constitution: “Constitution for all Citizen”
  - Changed to **Beveridgian Model**: general taxes finances the system
  - Sistema Único de Saúde (SUS): Unified Health System
  - Article 196: “Health is the right of everyone and the duty of the State”
  - Article 198: Principles of SUS: descentralized, integrality, community participation, equity, universality
  - Article 200: “Health care is free to private initiative”
- 1991: Health Community Agents Program: nurse and lay local workers
- 1994: Family Health Program: 6 health agents, 1 assistant nurse, 1 nurse, 1 doctor for 1000 families
- 1998: Family Health Strategy

1996-1998: Finance: per capita plus per team continuously

Prof. Dr. Adib Jatene

Dr. Gilson de Carrvalho

Capitation – Carr Hill formula

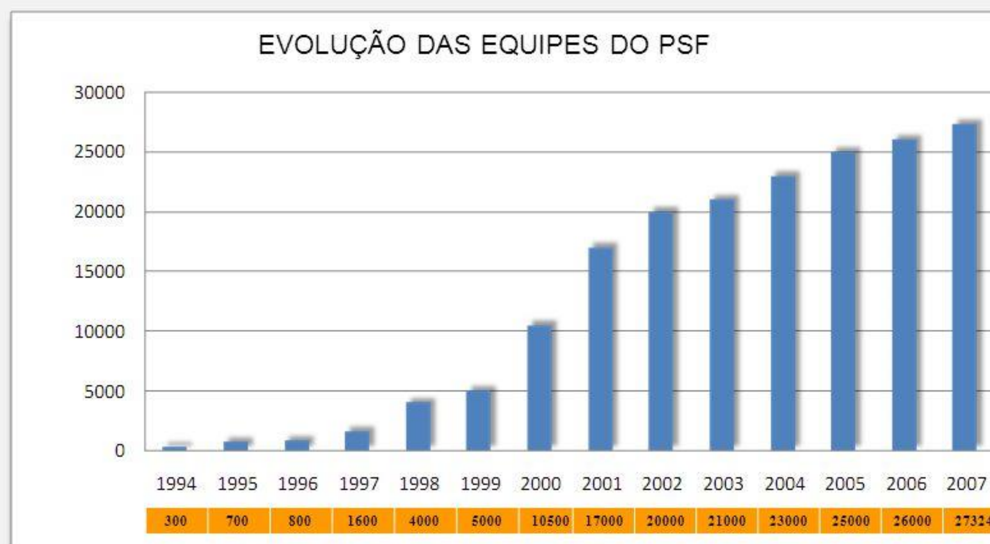
Idade/ Sexo	0-4	5-14	15-44	45-64	65-74	75-84	85+
Masculino	3.97	1	1.02	2.15	4.19	5.18	6.27
Feminino	3.64	1.04	2.19	3.36	4.9	6.56	6.72

- patient age and gender (used to reflect frequency of home and surgery visits)
- Standardised Mortality Ratio
- Standardised Long-Standing Illness for patients under the age of 65 years
- number of newly registered patients (generate 40% of work in 1st year)
- rurality
- costs of living in some area (ie South East - Higher staff costs)
- patient age/gender for nursing/residential
- consultations

1988 - 2017

- 1997: Family Health Strategy: financing from federal government to cities is not though project year by year as Family Health Program but **per capita plus per team continuously**

Números do SUS



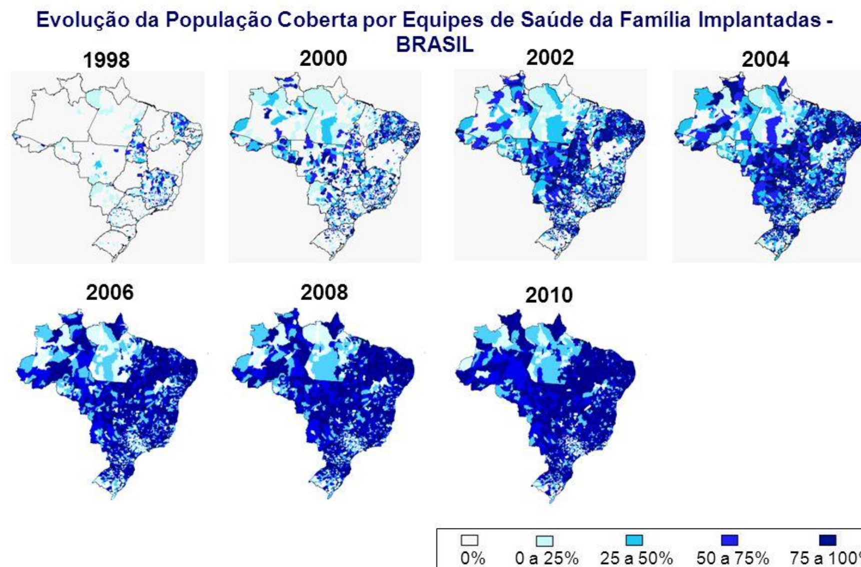
Fonte: DAB/MS

12

1988 - 2017

- 2006: National Policy of Primary Care:
  - 1 team with
    - 1 FTE doctor
    - 1 nurse
    - 1 assistant nurse
    - health Community agents

    for up to 4000 people (3000 recommended)
  - 1 Health Community Agent for 750 people



1988 - 2017

- 2017: Current Numbers - PHC

  - 270.417 Health Community Agents
  - 40.188 teams
  - 62% of all Brazilians covered (if the average was 3000 people/ team)

http://dab.saude.gov.br/dab/historico_cobertura_sf/historico_cobertura_sf_relatorio.php

http://www.brasil.gov.br/saude/2015/06/grandes-numeros-do-sus/view

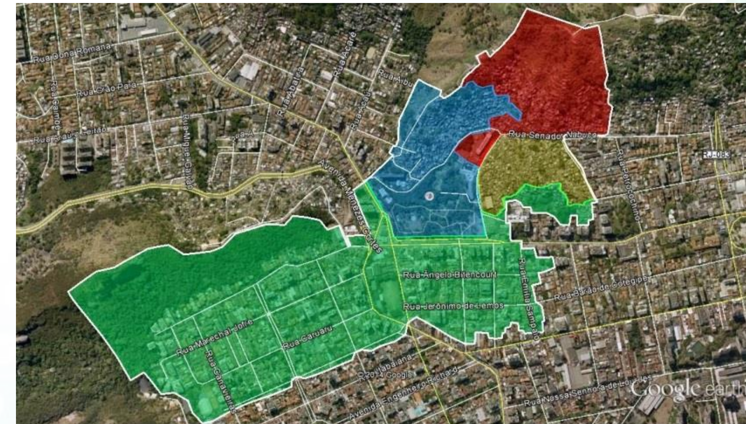
Case: Rio de Janeiro

Family Health Strategy

- 3% in 2009
- 50% in 2016

More than 100 new health units with EHR and good structure

Residency program in Family Medicine with more than 100 places (pays more)



1988 - 2017

- 2011 Numbers

	R$m (%)	% GDP
Taxes and social contributions	53 329 (39·05%)	3·14
Federal	27 181 (19·90%)	1·6
States	12 144 (8·89%)	0·7
Municipalities	14 003 (10·25%)	0·8
Private	83 230 (60·95%)	4·89
Family spending[66]*	65 325 (47·84%)	3·84
Employer company spending[60]†	17 905 (13·11%)	1·05
Total	136 559 (100%)‡	8·03

Data from references 6 and 7, unless otherwise stated. GDP=gross domestic product. *Estimated from the national household expense survey 2002–03 (corrected by the consumer-price inflation index). †Estimated from information on private health plan and insurance billing provided to the national health insurance regulatory agency. ‡GDP in 2006=R$1·7 trillion.

www.thelancet.com Vol 377 May 21, 2011

Problems

- Bismarckian (before 1988) vs Beveridge (after 1988) = poor vs rich system
- Municipality is in charge of PHC: more than 5000 mayors with autonomy
- Health Community is lay people: can´t measure blood pressure
- Team based on location: can´t choose your team
- Most doctors are not trained: just 5000 Family doctors in Brazil from more than 400.000

Problems

- Structure: 2016 data
  - 82% carry out all basic calendar vaccines
  - 60% carry out points withdrawal
  - 60% apply intramuscular injectable medications
  - 50% apply intravenous injectable medications
  - 50% apply penicillin (benzetacil)
  - 35% perform ear washing
  - 34% do wound drainage / abscess
  - 31% make wound sutures
  - 25% do nail removal

- Structure: 2016 data
  - 87.6% of the health professionals of the health units have a standardized medical chart with health information of the citizens.
  - 18% of healthcare professionals at health units work with Electronic Records.
  - 30% of the health units of the country has 1 office or more with computer connected to the internet.

http://dab.saude.gov.br/portaldab/cidadao_pmaq2.php?conteudo=resultado_avaliacaoFORM

Problems

- Process: verticalized programs and health surveillance beyond access
  - “headache is not role of Family Health Strategy” (nurse manager)
  - Hypertension, diabetes, child care, pregnant, tuberculosis and leprosy were priorities from 1994 to 2006
  - Access to PHC or to urgente care/ walk in?
- Mais Médicos (More Doctors): 14000 cubans doctors since 2013: doens´t pressure for more brazilians Family Doctors

Future

- Private system demanding Family Doctors
- Municipalization vs Decentralization?
- Socialized system with single payer (private services in a public system)?
- Residency program mandatory?

PROGRAMA SAÚDE DA FAMÍLIA

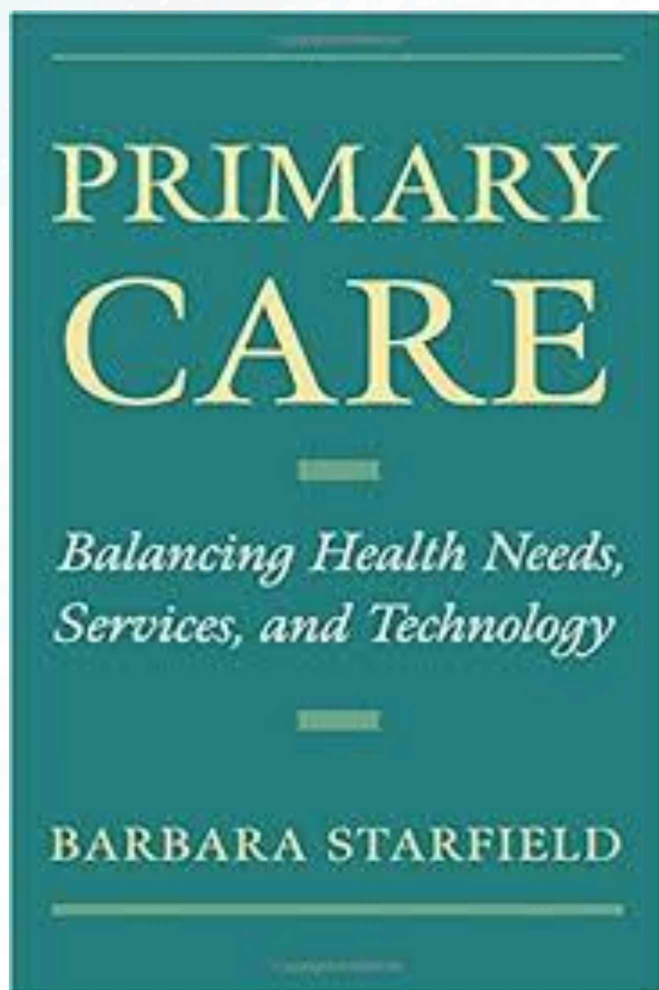
CENTRO DE SAÚDE
CÓRREGO GRANDE

Future?

- Private + Public systems: single payer?
- Residency mandatory
- Technology

Market - Demand

Education - Offer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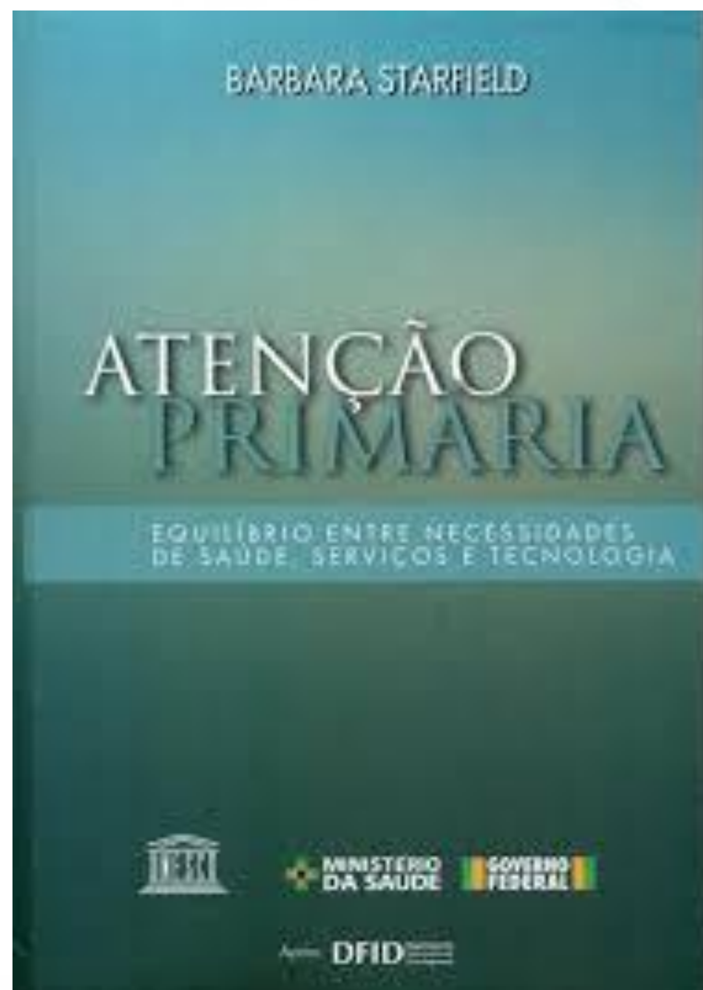
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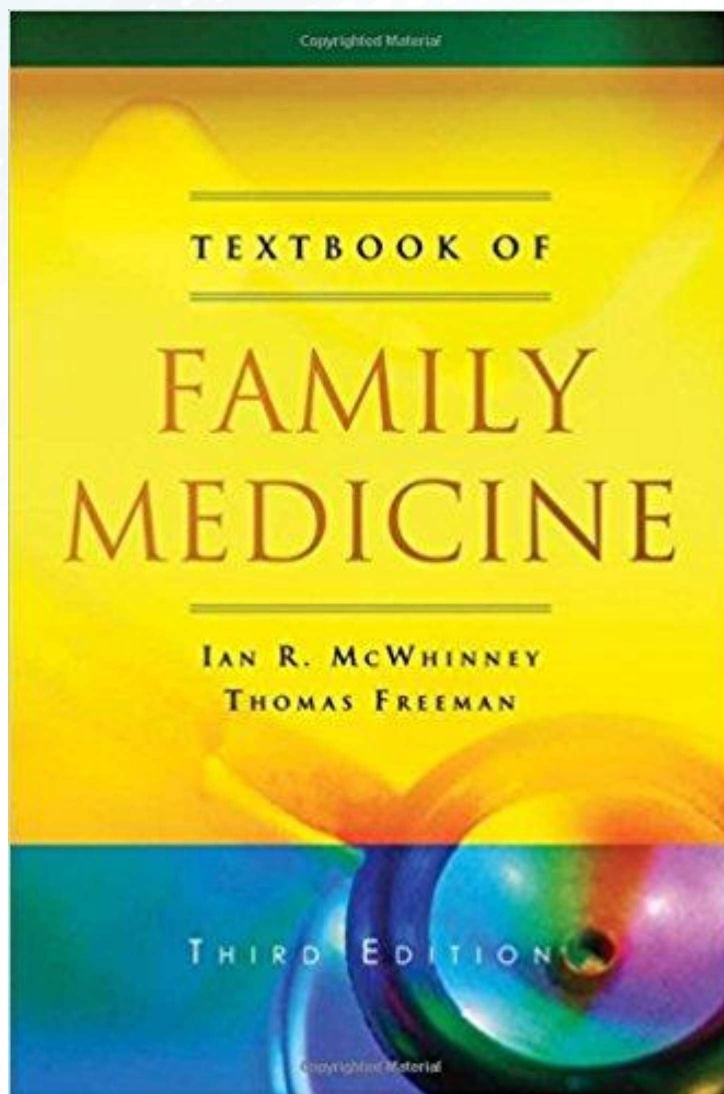
DFID

Primary Care

- Acess
- Coordination
- Compreehensiveness
- Longitudinality

- NOT Prevention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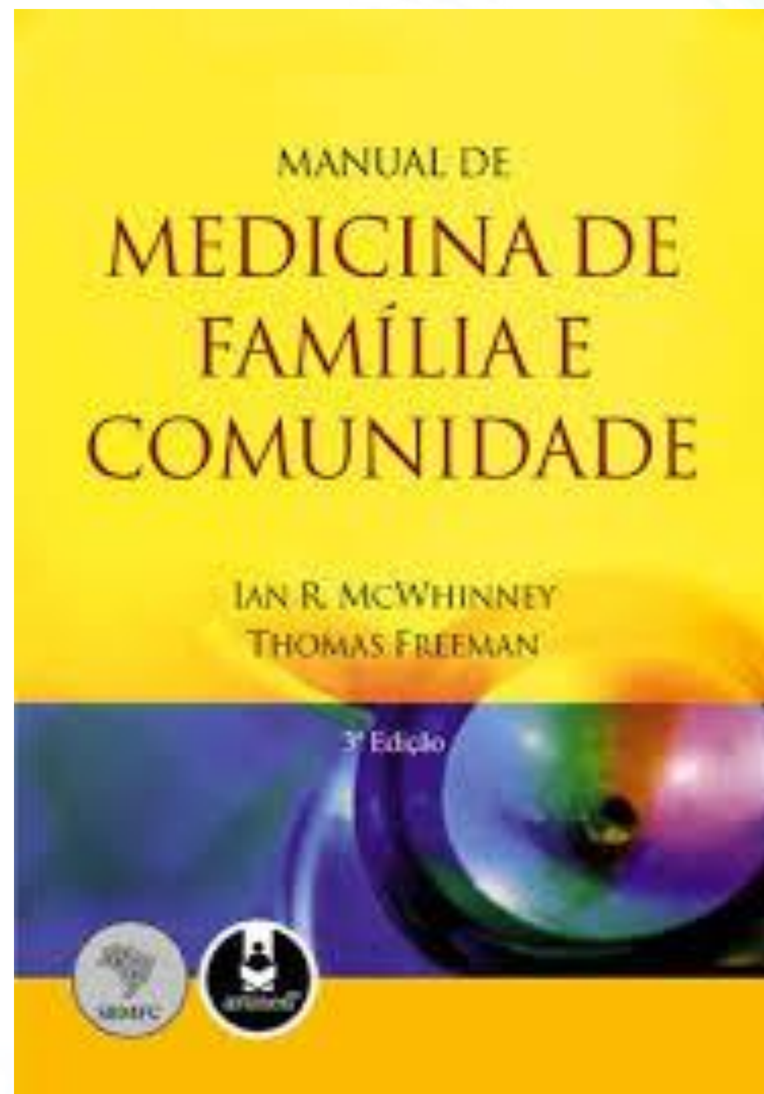
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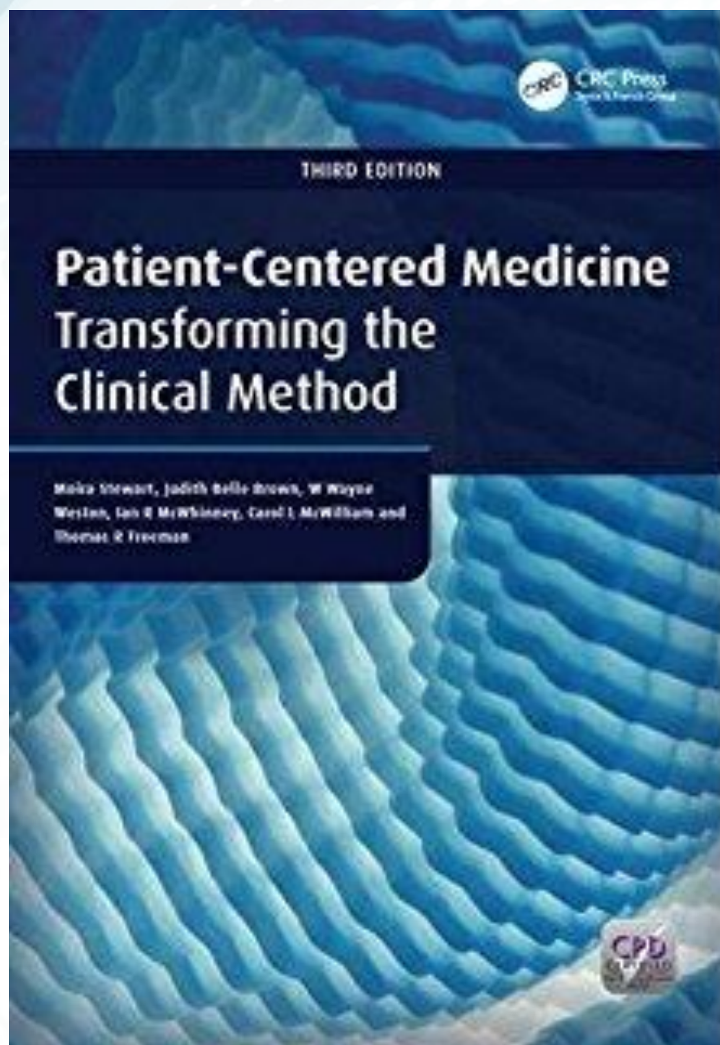
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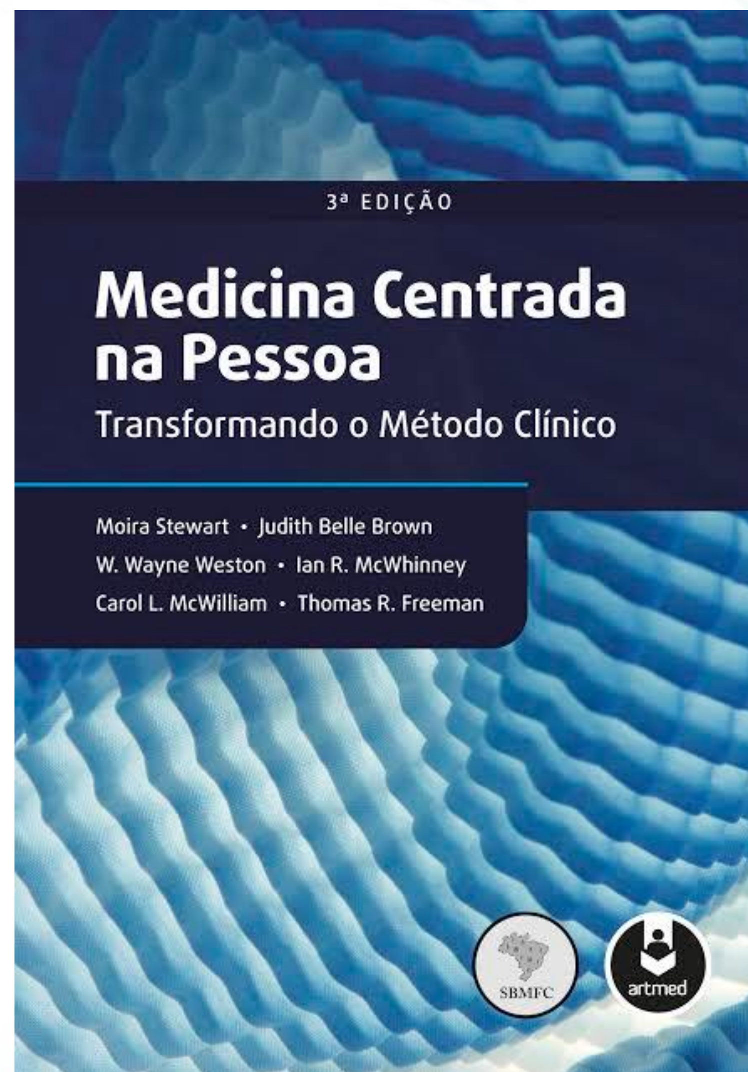
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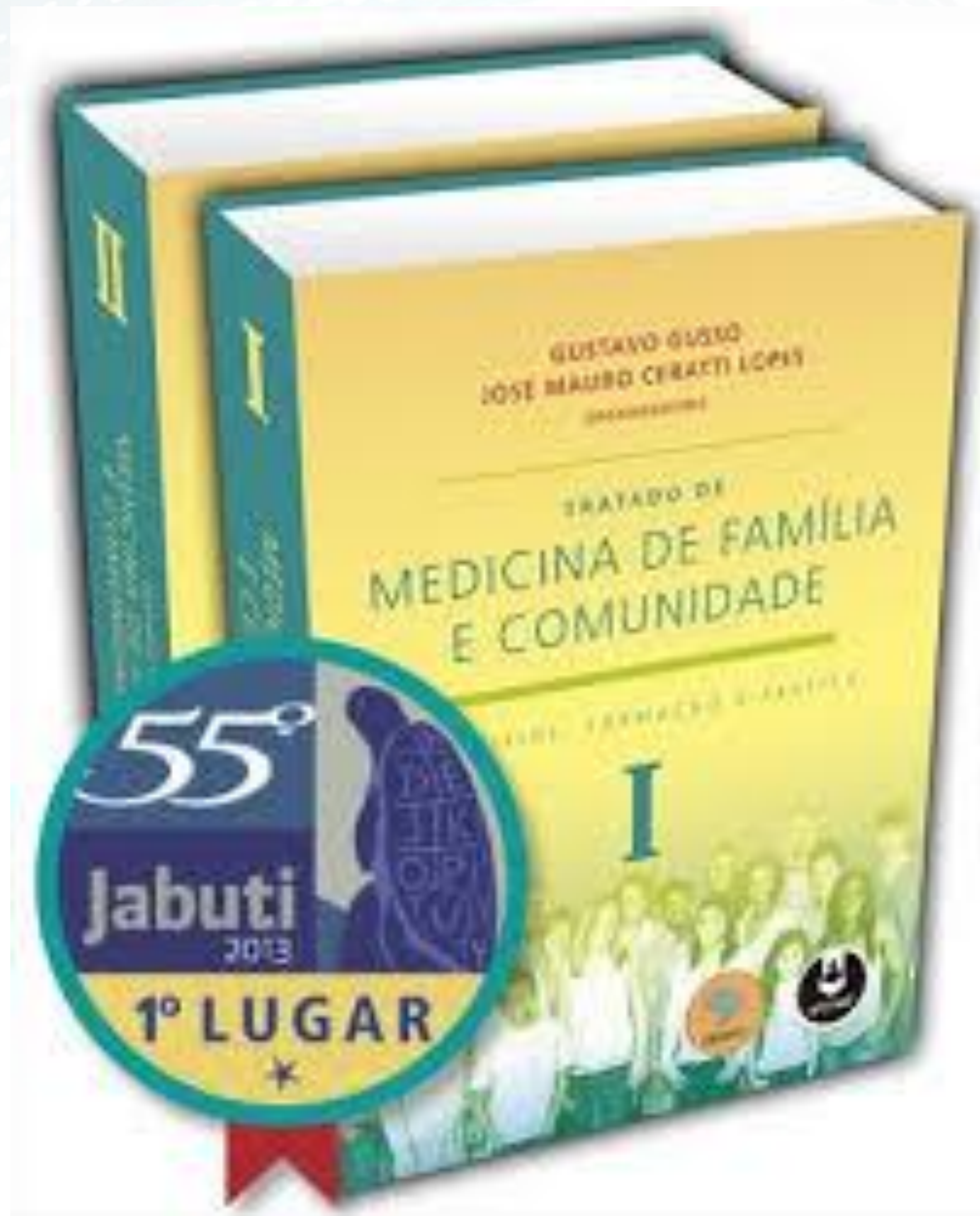
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