Brazil's Primary Health Care Financing: Case study

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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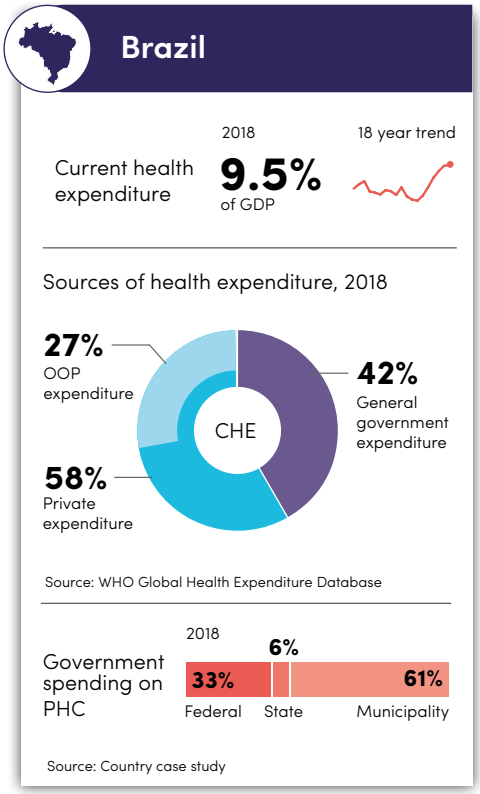
Since the restoration of democracy in the late 1980s, Brazil has developed one of the largest and most innovative Primary Health Care (PHC) systems in the world. The Family Health Strategy (FHS), which delivers PHC through the public health system, has expanded access to primary health services to more than 130 million people. To underpin the national scale up of the FHS, an innovative financing mechanism called the Floor for Basic Care (Piso da Atenção Básica – PAB) was established, channelling federal resources directly to municipalities to deliver services, ensuring a stable source of funding for PHC for more than 20 years. However, current proposed health financing reforms threaten the achievements of the FHS. Federal spending on health has been severely restricted and the Bolsonaro government has introduced a policy to replace the PAB arrangement with a risk-adjusted capitation mechanism. This paper investigates how the PAB contributed to the successful expansion of the FHS and shaped the PHC model in Brazil, with municipalities becoming responsible for both the organisation and financing of PHC. It also highlights the challenges in scaling up the FHS in a highly unequal country and the potential consequences of changing the funding mechanism at a time of crisis.



THE PAB – EXPANDING THE DELIVERY OF PHC

The PAB was established in 1998 as a source of financing for PHC from the federal Ministry of Health to municipalities, replacing the existing fee-for-service reimbursement mechanism to providers, which had previously concentrated resources in wealthier regions. The PAB is composed of two components: a fixed, population-based component channelled to municipal governments every month for the exclusive purpose of delivering PHC services; and a variable component, designed to encourage municipalities to adopt federal priority programmes for PHC and guidelines for PHC. The remit of the PAB-variable element has expanded over time to cover a broad range of incentives for PHC including specialised professionals (e.g., oral health teams) and models to reach specific populations (e.g., Riverine, Indigenous, and homeless populations).

The combination of the PAB fixed- and variable-components simultaneously encouraged the expansion of FHS coverage and shifted the model of care provided in Brazil. Between 1998 and 2020, the number of FHS teams, consisting of a doctor, a nurse, a nurse assistant, and community health workers, grew from 2,054 to 43,286, reaching 63.3% of the population. However, scale up has not been even across the country and, in 2020, the variation in FHS coverage between states ranged from 40.7% in São Paulo to 99.7% in Piaui.

CHALLENGES TO SCALING UP THE FHS

A significant challenge to scaling up the FHS is insufficient federal financing of the health system. Whilst states and municipalities have been required to apply minimum funding for health from their total revenue (12% and 15% respectively) since 2000, the contribution from the federal government was not indexed to the revenue as the other government spheres and has decreased relatively over time. As a result, municipalities have become increasingly responsible for financing PHC services, leading to considerable disparities in levels of expenditure between relatively rich and poor municipalities. Municipalities in less developed regions have experienced difficulties in attracting and retaining qualified health professionals, especially doctors. There are also differences in the technical and administrative capacities of municipalities and in their human resource management practices, creating distinct differences in PHC service delivery.

The government has taken some steps to address these challenges and reduce inequalities in funding and service provision. In 2011, a social inequality factor was introduced to the PAB-fixed component, whereby municipalities with lower GDP per-capita and higher rates of poverty received a higher per capita amount. However, the little difference in the per-capita values was not significant enough to produce a substantial change in financial inequalities. In 2013, the Mais Médicos (More

Doctors, MM) programme was created to address imbalances in the distribution of PHC doctors. Through the MM strategy, foreign and domestic physicians were recruited to serve in typically underserved communities. In addition of providing funding, the Ministry of Health directly placed 18,240 doctors in 4,058 municipalities.

FISCAL AUSTERITY AND TRANSITION FROM PAB TO RISK-ADJUSTED CAPITATION

Brazil's ongoing political and economic crisis has affected financing for the public health system. Long-term fiscal austerity policies were implemented in 2016. Federal financing blocks for PHC were merged with other health system funding blocks in 2017, making it difficult to monitor the share of PHC in federal transfers to states and municipalities. There is a risk that PHC could lose out on financing due to a strong political lobby for concentrating resources in specialized and hospital care.

Following the fiscal austerity measures, a new policy for PHC financing was introduced in 2019 called Prevent Brazil (Previne Brasil), replacing the PAB fixed and variable components with a capitation mechanism based on the number of people enrolled in FHS teams registered by municipalities, weighted by socioeconomic vulnerability criteria. Despite the need to improve financing arrangements to address PHC challenges, the substitution of PAB-transfers by capitation and performance assessment is risky. The PAB arrangement was crucial for creating a stable source of funds for PHC and losing it may provoke undesirable fluctuations in PHC financing. There are also challenges and costs associated with setting up a new capitation system.

Looking ahead, as a prolonged economic and political crisis unfolds in the country, dramatically exacerbated by the COVID-19 pandemic, replacing the successful PHC financing model by redirecting the existing resources according to new criteria may be unwise. In moments of crisis, the need for a consistent financing scheme for PHC is crucial. Capitation can be a valuable enhancement to the financing mechanisms for PHC in Brazil if it is integrated with the successful PAB scheme in a blended model.

LESSONS LEARNED

1. **Importance of political will in expanding primary health care.** The political will to provide universal and comprehensive healthcare was a major driver in creating the financial arrangements for scaling up a resilient FHS model. In contrast with many other low and middle income countries, PHC in Brazil was developed to be the basis of its public health system and not a vertical or separate programme.
2. **The importance of stable and predictable funding for PHC.** Population-based funding mechanisms, such as the PAB fixed component, are essential for a creating stable and predictable source of funding for public managers to invest in PHC.
3. **Local funding and responsibilities enhance support for PHC.** Establishing financial transfer to local managers, close to where people live and targeted at PHC, was a successful strategy for fostering political commitment to expanding PHC services at the municipal level.
4. **Addressing inequalities between municipalities in decentralised health systems.** Federal health budget constraints led to a disproportionate increase in municipal health financing, which in part relies on revenues from municipal taxes. That inequality in sources of funding exacerbates inequalities in the allocation of PHC resources across municipalities in Brazil. Auxiliary federal policies, such as the MM strategy, and equalizing federal transfers are necessary to mitigate inequalities in service provision.

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