

ENHANCING PRIMARY CARE IN BRAZIL:

*STRATEGIES UNDER
A DECENTRALISED
HEALTH SYSTEM*

POLICY QUESTION:

- How can states better support municipalities to improve primary health care delivery, considering the decentralized nature of SUS (Sistema Único de Saúde, or Unified Health System)?

THE ISSUE:

Brazil's universal, public national health system, known as the Unified Health System (SUS), was created in 1990 to operationalise the right to health, guaranteed by the 1988 Brazilian Constitution¹. SUS is characterized, among other things, by its universality, decentralised governance, and overall insufficient funding when compared to similar systems¹. Despite its challenges, SUS has led to positive results in several health indicators and includes a robust and internationally recognised primary health care (PHC) strategy^{2,3}.

Despite its relative success, the Brazilian PHC strategy still faces many challenges, including: unwarranted variation in service provision, excessive number of people under the responsibility of each medical team, shortage of health professionals, poor quality of training, high turnover of professionals (reducing the power of longitudinal care), especially of doctors, undervaluation of these professionals (in terms of their social standing and remuneration), elevating the standard of both management and working relations, and technological and infrastructural deficiencies⁴⁻⁶.

During the first 30 years of SUS, the municipal health departments stood out by implementing health policies in Brazil under a guideline of decentralisation, and especially the national primary care policy, with support coming almost exclusively from the central government. State health departments struggled to support the municipalities during that period. However, SUS is now facing challenges that require a new way of operating the federative pact, which invites a rethinking of the possible avenues for states to support primary care implementation.

SUMMARY OF THE POLICY OPTIONS:

There are strong arguments to suggest that the role of the state health secretariats (SES) in the SUS would benefit from robust reforms. This policy brief suggests that the relative prominence attributed to the municipalities during the early years of the SUS could now be partly transferred to Brazil's states, and that SESs would be a strategic actor in enabling a new version of interfederative management⁷. States would be playing a new, enhanced role, achieved through a process that will require great technical and political effort⁸.

This new role of the SES would be operationalised by strengthening institutions on two levels: first, the regional management structures within state governments, and second, the existing regional commissions where management is carried out in a collegiate manner, between states and municipalities. This brief suggests that this process should encompass not only institutional strengthening but broadening the agenda in both these spaces to more prominently include primary health care issues that are currently neglected and seen as the exclusive domain of municipalities.

The three main changes suggested by this brief are summarised below:

- States have been somewhat sidelined in the institutional architecture of the SUS, an issue which contributes to the weakness of the regionalisation process. Strengthening the regional management branches of the state health secretariats, by providing them with more resources and more professional management, could contribute to a new, more productive balance in the SUS.
- Regional intergovernmental commissions, which gather state and municipal managers in each health region, are not fulfilling their stated goal of facilitating coordination and regionalisation. One potential area of improvement, then, would be reforming the practices of these commissions, so that they engage more fully in planning, and in negotiations with other relevant health stakeholders in the region, including providers.
- Primary health care in Brazil is mainly a matter of municipal responsibility, though municipalities have historically counted on extensive federal financial and technical support. A more effective primary care system, with enhanced financial and technical support by the states, has the potential to improve outcomes across all levels of care. Therefore, this brief encourages the inclusion of primary health care issues and challenges (for example: hiring doctors for long-term contracts, running secure and quality tenders, improving infrastructure and professionalising working relations) on the agenda of both state governments and the shared regional commissions.

This brief explains the rationale for these recommendations and proposes how state health secretariats and stakeholders in the SUS can contribute to the implementation of these changes

HEALTH IN BRAZIL

SUS is one of the largest health systems in the world, providing health care access to more than 200 million people. It encompasses health promotion, disease prevention, diagnosis, treatment, and rehabilitation¹. Brazil's total health expenditure accounts for 9.5% of GDP, though less than half (4% of GDP) relates to public spending, which is low when compared to public spending in other countries with universal health systems⁹. As a point of comparison, in 2018, the average public expenditure on health in OECD countries was 7.3% of GDP⁹.

Despite its underfunding, SUS has achieved robust results in terms of improved access to health services, particularly primary health care, emergency and urgent care, as well as in health promotion and disease prevention policies. This has resulted in increased user satisfaction with the health system and significant improvements in health indexes, such as infant mortality, avoidable hospitalisation and mortality, as well as racial equality health outcomes^{1,10}.

SUS is based on three fundamental principles that reflect the values of Brazilian society: universality, equity, and the impact of social determinants in the disease process (referred to as "integrality" in the Constitution)¹¹. To ensure that these principles are put into practice, the system is built around the following organisational guidelines: decentralisation, regionalisation, comprehensiveness (providing complete care to meet all assistance needs), organisation through different levels of care (primary care, secondary, and tertiary care), social control and complementarity with the private health care system¹¹.

The decentralisation principle in health gives municipalities the ultimate responsibility for guaranteeing health care for their citizens, even if the care is not provided in the municipality itself¹¹. Accordingly, the regionalisation principle aims to make it easier for municipalities to organise themselves into health regions so that they can provide the comprehensive care required by law, from health promotion to rehabilitation¹¹. Next, this brief will explore the role of municipalities in the SUS and the challenges that they face.

MUNICIPALITIES IN SUS:

Brazil is a federation with three levels of entities: the central government, the 26 states plus a Federal District, and 5,570 municipalities. The 1988 Constitution transferred responsibility for implementing social policy, including health, to the municipalities. The main objective of decentralisation is to ensure that public policies are implemented and decided at the local level, in order to: (1) make governments more

accountable; (2) facilitate social control; and (3) promote better adaptation to local contexts¹². This responsibility was accompanied by granting municipalities administrative, political, and financial autonomy¹².

Brazil is one of the few countries in the world with a universal health care system that has decided to decentralise most health care prerogatives to the local level (the municipalities). Some countries maintain some level of centralised management, such as the United Kingdom, while others have decentralised health care to an intermediate level of management, like the provinces, such as Australia and Canada¹³⁻¹⁵.

Brazil faces many challenges associated with this decentralised process for policy implementation¹². A comparison between the population profiles of municipalities in the country demonstrates that decentralisation takes place in a context of extreme heterogeneity^{12,16}, as shown in the Appendix. 70% of municipalities have up to 20,000 inhabitants (Table 1), i.e. they are small, with little infrastructure and low administrative and managerial capacity¹⁷. Its fragile economies are financially dependent on other federal entities, and face many difficulties in finding qualified labour^{12,17}.

CHALLENGES IN MUNICIPAL MANAGEMENT

There are several and varied challenges associated with municipal management of health policy in Brazil, which can be roughly grouped into three macro dimensions¹²:

1. Human resources;
2. Financial management; and
3. Administrative and planning management.

1. Human resources

Municipalities face many challenges in recruiting doctors, managing different employment contracts, and providing training for local professionals. Brazil currently has 2.6 doctors per 1000 inhabitants, which is lower than the average of 3.36 for the countries evaluated by the OECD. Compared to some of the BRICS countries – South Africa (0.79) and India (0.90) – Brazil has a much higher density, being closer to Japan (2.60), South Korea (2.51), the United States (2.64), and Canada (2.77). Germany (4.46), Australia (3.83), Austria (5.32), Norway (5.18), Spain (4.58), and Denmark (4.25) have densities above the OECD average¹⁸.

There is also considerable heterogeneity among the five regions of the country, as well as between rural and urban areas. The North of Brazil has 1.45 doctors per 1,000 inhabitants and the Northeast has 1.93, both below the national average. The Southeast (3.39), Centre-West (3.10) and South (2.95) of the country have densities above the national average. In Brazilian state capitals, the density of doctors is 6.13 per 1,000 inhabitants, much higher than in rural areas, where it is 1.84 per 1,000 inhabitants¹⁸.

The problem is so widespread that it has led to a major national policy to address it: the "More Doctors" programme, launched by the federal government in 2013, which has undergone minor reformulations but whose core remains in place today¹⁹. In other words, there is a federal policy aimed at providing doctors to municipalities on an "emergency" basis, but which has been in place for 10 years.

One of the lines of action of "More Doctors" is federal payment by the Ministry of Health for these professionals to be allocated to municipalities¹⁹. By broadly sidestepping the state level in terms of recruitment and allocation, however, it can be argued that Mais Médicos is a centralising policy that reproduces some of the distortions in interfederative relationships.

2. Financial management

The ability of municipalities to generate their own revenue is generally low in Brazil and decreases with the size of the local population. That means that smaller the municipality, the more dependent it is on state and federal funding, including in the health sector¹². In addition, there is low overall efficiency in health spending, which has a negative correlation with the size of the municipality: the smaller the municipality, the less efficient its health spending. This is true for primary care and especially secondary and tertiary care, which is related to gains of scale^{20,21}.

In terms of health financing, the last two decade has seen an increase in both health expenditure by the municipalities themselves, and dependence on external resources, especially for municipalities with fewer than 50,000 inhabitants²². This situation is aggravated by a decline in federal health funding²³. In 2000, federal spending accounted for more than half of total health spending in Brazil. 20 years later, the federal share of health spending has fallen to 43% percent (2019 numbers). Municipalities currently respond for 32% of total public health spending while states account for 25%. This is despite the federal level remaining the largest player in terms of raising tax revenue, although a broad system of interfederative transfers is also in place.

3. Administrative and planning management

According to the 2021 Survey of Basic Municipal Information, 91% of municipalities have secretariats exclusively responsible for managing municipal health policy, but only 37.4% of health managers in the country have any kind of training in the field, and 19% have no university training at all²⁴. In short, policy

management in health is not properly professionalised. In addition to poor training in health management, there is a high turnover of both municipal managers and technical teams. There are various initiatives to improve the quality of training for municipal managers, many of them organised by the National Council of Municipal Health Secretariats (CONASEMS), but with little practical impact.

Almost all municipalities (98.5%) have made their health plans official through management tools. The Municipal Health Plan (PMS) is a document that defines and guides the implementation of a municipality's health policies and services during a four-year period. It is a central instrument for managing SUS, and as such must set clear goals, indicators, and targets, based on a situational analysis of the community and the health needs of the population.

However, not all plans comply with all national guidelines²⁴, in turn impacting the possibility of addressing certain issues, including equity. For example, 55.5% of the Brazilian population identifies as black or brown, but only 32% of municipal plans included a plan of actions with a specific focus on the black population, as recommended by the federal guidelines of the National Comprehensive Health Policy for the Black Population²⁴.

Another important fact is that 228 of municipalities still don't have a municipal health fund. These funds are important because it is through them that the municipalities receive specific health funding from the other federal entities. In addition to operationalising health spending, monitoring the financial flow of these funds allows managers and researchers to assess the health spending of different municipalities²⁴. At the end of the 1990s and beginning of the 2000s, an analysis of health expenditure from municipal funds revealed that some health expenditure was being spent on policies not directly related to health (e.g. sanitation, school meals), and this observation led to a change in the law governing health financing in the country^{25,26}.

Municipalities also often struggle to provide the infrastructure and services needed for health care provision in their territories, and consequently, citizens must travel excessively for treatment. According to the Municipal Basic Information Survey, 40% of municipalities refer patients to another municipality, and often just for simple tests. There is great variation, with the number of referrals reaching 58.6% in those municipalities with up to 5,000 inhabitants, and dropping to less than 20% in the most populous municipalities (>50,000 inhabitants)²⁴.

A recent study by health think tank IEPS shows that there has been a general increase in the proportion of hospital admissions outside the health regions where patients live, and that this proportion is highest in the Northeast of the country²⁷. Overall, the main takeaway is that, even though health funding from

the federal government in Brazil is organised at the level of transfers to states and individual municipalities, there is in practice a relationship of interdependence between municipalities of different sizes, in order to provide what citizens need, as well as between municipalities and states.

- Interfederative relationships

This brief suggests, then, that the challenge of municipal provision in health care incorporates an additional fourth dimension, which is **interfederative relationships**. This means that the quality of the relationships between different municipalities, and between municipalities and the states, is to be seen as essential for health care provision, since municipalities – and particularly small municipalities – lack the scope and scale necessary for effectively providing comprehensive care on their own.

Interfederative relationships in health in Brazil are currently managed with the assistance of commissions, known as CIR - Regional Intergovernmental Commissions (Conselho Intergestores Regionais). These commissions are characterised by the presence of the state manager and the municipal managers of the region and are responsible for agreeing and coordinating health policies in the regions²⁴, although they do not hold strong management prerogatives. 92% of municipalities already participate in these commissions, which provides a useful starting point for potential improvements both in the way they operate and the potential outcomes that they can contribute to²⁴.

These broader challenges of municipal management in health under the Brazilian decentralised system take various forms, particularly when addressing primary health care – one of the most crucial aspects of any health system. These challenges will be outlined in more detail below.

PRIMARY HEALTH CARE IN SUS

Brazil has had a National Primary Health Care (PHC) Policy since 2006, which outlines how PHC teams should be set up, and the responsibilities for this level of care in the national health system. This policy is aligned with the best available evidence on the impact of PHC on health indicators and on improving the effectiveness and equity of health systems²⁸.

Despite the development and enforcement of national policies and guidelines, SUS's management remains decentralised. As a result, there is great heterogeneity in the way health access and care is provided, as well as its impact on health outcomes, depending on the region or municipality. In short, establishing national policies has not been sufficient to ensure that citizens everywhere enjoy a minimum level of access to and quality of care²⁹.

Brazil's PHC organisational model is called the Family Health Strategy (Estratégia Saúde da Família, or ESF), a term which will be used interchangeably with PHC. This program was set up at the early 1990s, and today, Family Health Teams are the main gateway to the Brazilian health system, providing comprehensive (integral) care that is nationally and internationally recognised^{2,3}. Family health teams are based on a team consisting of a doctor and a nurse, one or two nursing technicians, and four to six community health workers. This team is responsible for the care of up to 3,500 people. Initially, this team was responsible for focused care in six priority areas: antenatal care, childcare, care for people with hypertension, diabetes, tuberculosis, and leprosy. Currently, the team's work responsibilities also encompass health promotion, disease prevention, treatment, and rehabilitation, as well as health surveillance, community and intersectoral interventions. The main sources of funding for PHC are the federal government and municipalities, with only few state governments having specific funding sources for PHC.

This model of PHC has produced robust results over the years, including a reduction in infant and adult mortality for some PHC-sensitive health conditions³. These are conditions for which effective primary care can help reduce the risk of people being admitted to hospital³⁰.

Other positive results that can be at least partly attributable to PHC policy in Brazil include improved equity in access to health care, improved control of some communicable diseases, access to dental care, a reduction in hospitalisations, and synergy with other social programs (e.g. Bolsa Familia) to amplify impact on health outcomes³.

Despite great progress, municipalities have faced challenges in enhancing the quality of PHC provision for several years. Below, this brief describes the three areas of main challenges^{22,31,32}.

CHALLENGES IN PRIMARY HEALTH CARE PROVISION

1. Workforce

a. Shortage of specialised personnel:

There are currently around [48,000 PHC teams in Brazil](#). The expansion was highly concentrated in the late 1990s and early 2000s, and now there is a shortage of specialised professionals for this level of care (more on that later). The training of professionals, especially doctors, has also not followed at the necessary pace¹⁸. In addition to hiring and training more people, it is also necessary to provide continuous training for those already working in PHC teams, to guarantee not only access but also quality of care^{33,34}.

b. Workforce management:

The recruitment of PHC professionals, as well as their working relationships, are fragile and precarious³³. There is no national standard, for example, regulating recruitment methods or establishing a base salary, and states have been mostly absent from this debate. It is worth considering that very different groups of professionals are involved in PHC, including community health workers, nursing technicians, nurses, doctors and other health professionals³⁵. Each of these groups has different characteristics in terms of recruitment, working hours, and pay. However, in general doctors remain the most challenging professionals to recruit and retain.

c. Teamwork overload and loss of longitudinality:

Another major issue is that PHC teams are often responsible for a very large number of people, an average of 3,500 people per team, much higher than in other countries with consolidated PHC programs (e.g. Spain, England, Canada), who work with around 2,000 people per general practitioner³⁶⁻³⁸.

These targeted populations are not only large, but often highly vulnerable. This leads to an excessive work overload for the professionals³⁹ and, as a result, diminished health access for the population. These factors contribute to another challenge, which is the high turnover of health professionals, especially doctors. This leads, in turn, to a loss of continuity of care, which is a key factor for the positive outcomes attributable to PHC in health systems^{28,40}. Policies that increase professional retention in primary health thus have a key role in contributing to better health outcomes in the SUS.

2. Infrastructure, supplies and information technology

a. Poor infrastructure:

PHC infrastructure can be defined as the set of physical structures and medical equipment required to allow the level of responsiveness that each system expects from their primary health care provision. These include but are not limited to: facilities to provide effective and quality services with reliable water, sanitation, waste disposal or recycling, telecommunication connectivity, power supply, information system, health equipment and transport systems that can connect patients to other care providers. There is no single standard for this infrastructure, and it changes depending on the expected resolution from the service.

There has been no primary care services census in Brazil since 2012. That data, however, showed that infrastructure was far below the minimum standard expected for the provision of a quality and effective PHC service⁴¹. The federal government had a financial incentive program for municipalities focusing solely

on the renovation and construction of PHC services, which has now become the subject of unstable and varying sources and models of financing. Under this program, however, the municipality was the one responsible for carrying out the work, a task requiring some level of administrative capacity for tendering, contracting, and monitoring. The available data shows that only 73% of the works were completed, highlighting the challenges faced by the municipalities³⁴. These forms of federal incentives thus can be inadequate, both in terms of ensuring continuity (since the funding of the program fluctuates greatly) and in terms of providing operational support. Practitioners generally agree that there have likely been only small overall improvements in the situation since. To summarise, even though municipalities do receive assistance, sometimes they have little capacity on their own to translate it into operational benefits.

b. Information technology (information systems/software, equipment/hardware and network infrastructure):

Access to equipment and the internet has improved considerably in recent years: 97% of primary care services now have access to computers and to the internet, and 92% have some kind of system for recording patients' clinical data. However, access is still not sufficient or in everyday use: for example, 44% of prescriptions in PHCs are still handwritten, and only 14% of GP surgeries offer online appointment booking⁴². Despite progress in terms of connectivity, only 17% of public facilities have speed bands above 100Mbps, and these tend to be concentrated in hospital services⁴². Only 49% of primary care managers state that the internet speed is sufficient for their work⁴².

In addition to technology access, only 25% of PHC services have information security policies, a key privacy issue⁴². The Ministry of Health provides free information systems (softwares) specifically for PHC, but one of the challenges is the interoperability of these systems with those chosen by municipalities, which are not obliged to use the centralised systems – in fact, many end up opting for private, costly solutions.

3. Medication and consumables

Despite the fact that Brazil has a universal system that includes access to free medications at the point of use, medication accounts for the largest direct out-of-pocket health expenditure for Brazilians, at around 40%⁴³. The main survey on access to medications in the SUS shows that the availability of medication in PHC services is low and varies widely between regions with only around 40% of people having access to all the medications they need in the SUS^{44,45}.

This issue is, again, linked to the difficulty, particularly for small municipalities, of organising the purchase and distribution of the national minimum list of medications and consumables. In recent years, however, access to medication has improved as a result of national access policies based on public-private partnerships. This policy has allowed free access to priority medications (such as contraceptives, antihypertensives, hypoglycaemics, and bronchodilators) in private pharmacies at no cost to the patient at the time of request.

In addition to the issue of medication, there are often shortages of supplies for primary care in the country. This scenario has been mitigated in recent years, especially in priority areas such as family planning, maternal and childcare, and care for people with hypertension and diabetes⁴⁶. However, it is still far from ideal in terms of the capacity to perform minor surgery, bandaging, and some tests such as electrocardiograms and imaging tests^{41,47}.

THE ROLE OF THE FEDERAL GOVERNMENT

The Ministry of Health has been a significant presence in primary care policy for the past 25 years, and several financial incentives were included in federal programs aimed at supporting municipalities in strengthening the family health strategy.

Examples include: (i) the financing of dental care teams and family health support centres, which expanded the scope of PHC teams; (ii) the UBS Qualification Program, which aimed to help municipalities improve the physical and technological infrastructure of basic health units (UBS); (iii) the Access and Quality Improvement Program; (iv) *Previne Brasil*, which aimed to qualify the work of teams; (v) the eSUS - AB program, which focuses on providing and expanding the use of information systems at this level of care; and (vi) *Mais Médicos* (More Doctors) and *Médicos pelo Brasil* (Doctors for Brazil), programs which aimed to help municipalities address the major challenge of attracting and retaining health professionals^{6,48}.

All these efforts have strengthened the relationship between the federal and the municipal level, but this has not happened to the same extent in the relationship between the states and the municipalities¹⁶. Few state secretariats have had ongoing programs or policies to support municipalities, both in terms of funding and technical-administrative support¹⁶. There is also insufficient knowledge available on the way that state health secretariats operate in general.

The current model and the several federal policies that support municipalities in the implementation of health policies show clear signs of exhaustion. Considering that Brazil has three federal levels, that the management of the SUS is decentralised, and that policies are agreed on a tripartite model (meaning, in agreement and cooperation between the national, state,

and municipal entities), one vital area for improving health management, including in primary care, is focusing on the quality of interfederative relationships.

In this scenario, this brief argues that the state governments, through their health secretariats, have the potential to play a leading role in changing the PHC management model with the goal of bringing new strategies for the SUS and to overcome existing PHC challenges. The following section outlines possible avenues that state secretariats could use to enact this change.

POLICY RECOMMENDATIONS

The recommendations put forward in this brief can either be developed independently or concomitantly; they do not necessarily have to follow a specific order of implementation. It should be up to each state manager to assess the local context of regionalisation in their state, as well as the functioning of the different bureaucratic bodies in the health regions, and then decide which strategies are most appropriate for their reality at each time, and the process through which they could be implemented.

This brief recommends that this process is led by the state secretariats with the support of CONASS, the National Council of State Health Secretaries. In addition to the leadership of the state health managers, it is key that the federal government provides technical and political support to the states, including by revising the laws that describe the responsibilities of the states and municipalities, and funding reforms aimed at better structuring the state secretariats.

In addition to support from the federal government, it is essential that the Council of Municipal Health Managers (CONASEMS) and the municipal secretaries are also engaged in this discussion and open to reviewing relationships as well as their responsibilities, or reforms are likely to face extra obstacles.

1. Strengthening the regional management branches of state health departments

One key action would be to turn the existing (but somewhat precarious and ineffective) regional management branches of the state health secretariats into more effective players in supporting municipalities and operationalising regionalisation. This would require expanding the technical capacity of their bureaucratic staff, which provides institutional support to the municipalities.

The goal is for this group of professionals to work side by side with the municipalities, building relationships based on trust and notions of shared management, so that together they can assess health needs, monitor policies and health outcomes, formulate solutions tailored to each specific context, and develop manuals and procedures to support the municipal secretariats in their tasks.

To fulfil this mission, states are encouraged to explore ways of reorganising existing teams or recruiting new professionals. In addition to available staff, it is vital to ensure that the organisational charts of health secretariats include a specific department responsible for supporting the municipalities, something which few states currently have.

Additionally, these departments will require the necessary institutional and political backing, as well as financial and budget capacity, to play their role. Finally, it is important that this support is provided on the ground and not just at a distance, so that professionals from the state secretariat can get to know the realities of the municipalities they are responsible for.

Another productive approach could be for state health government departments to propose typologies of municipalities based on their characteristics and needs in the previously mentioned dimensions that are relevant to health: human resources, financial management, and administrative and planning management.

Smaller, poorer municipalities can be presumed to have a diminished capacity in all these dimensions, for example, relative to large municipalities. Instead of a “one size fits all” approach, the use of a typology would allow state governments to tailor support according to need. Another possibility would be to offer programs for the joint purchase of equipment and infrastructure improvements.

This first set of proposals, in addition to enhancing the administrative capacity of the municipal secretariats, could reduce the impact of the high turnover of municipal health secretaries by providing municipalities with ongoing support, thus facilitating the creation of standards over time and promoting policy continuity.

Though there is no consolidated literature on this topic, health practitioners mention that there are existing efforts underway to strengthen regional administrative health structures in some states, including Ceará, Bahia, Minas Gerais, Pernambuco, and others.

2. Reforming the practices of regional intergovernmental commissions

The idea of a collegiate body for planning and decision-making by consensus among local managers in the regions has been in SUS documents since 2006, but it wasn't until 2011 that it became a formal SUS regulation.

That was the year when the Tripartite Management Commission (the official SUS collegiate forum for agreements, gathering national, state, and municipal managers) officially agreed on the creation a new structure, the CIR - Regional Intergovernmental Commission (Conselho Intergestores Regionais).

Unlike the bipartite and tripartite structures, the CIR have the clear objective of strengthening the regionalisation perspective and planning within the SUS.

The CIRs are consultative bodies composed of representatives of the state and all municipal health secretaries in each health region. The purpose of the CIR is to enable integrated regional planning of actions and services in a health region, and each region is required to have one.

These commissions work as spaces for liaison, planning, and agreement on regional health system management issues. Unfortunately, these management spaces are now undervalued and have a very bureaucratic working process, capable only of making procedural decisions at monthly meetings⁴⁹.

Despite these shortcomings, the CIRs remain a potentially privileged forum for putting into practice new, more collaborative and coordinated forms of shared management. One potential avenue to do this would be to increase the frequency of committee meetings, while pushing them to go beyond rubber-stamping of what has been previously decided towards becoming effective and dynamic management spaces, where the typical activities of public administration (such as planning, monitoring, and evaluation) are developed in conjunction with all relevant stakeholders^{8,50,51}. This is a great opportunity for the public bureaucrat to take on the role of changing the working process within the commission.

There is currently no formal institutional space, for example, where local managers can engage in joint negotiations with providers (be it service providers or individual professionals)⁷. These forms of individual negotiations complicate the health management process and diminish the power of local managers vis-à-vis these providers. Creating a space where members (state and municipalities) could engage with service providers in the region as a collective and not individually could facilitate, for example, demanding a minimum standard of quality and negotiating purchase prices on a regional level, without inciting competition between municipalities. There is no major barrier for this modification; at present, the rules governing the CIR do not prevent members other than local managers from being involved in the meetings of the committee at certain times.

Other actions that CIRs could facilitate include: (1) allowing opportunities for managers in the region to exchange experiences with the aim of increasing local management capacity; (2) drafting documents that objectively describe the responsibilities of the different federal entities for health actions and services in the region, including PHC; (3) formulating joint training plans, among others.

In a few words, shared management of the SUS remains a major challenge for the full implementation of the principles of SUS⁷, including comprehensiveness and regionalisation. State health secretariats could play a leading role in addressing this, by taking responsibility for changing the working process of the CIRs, and to the best of our knowledge, this would entail a mostly political and administrative process, not requiring major legislative changes.

3. Putting primary health care on the agenda of regional interfederative commissions and developing common strategies

Regionalisation is a constitutional, organisation principle of SUS that is often brought up by health managers as the necessary structural axis guiding health policy discussions in Brazil. However, the focus of these discussions is usually on specialised (secondary/tertiary) care, which requires a high level of coordination between municipalities, and between states and municipalities, to address the lack of scope and scale faced by smaller municipalities for making higher complexity procedures.

This brief argues that the challenge of regionalisation is also linked to the quality and effectiveness of PHC and the capacity of municipalities to guarantee it. The CIRs have the potential of going beyond working solely as spaces for the management and planning of specialised care, but also to encompass cooperative management responsibilities with the goal of improving PHC.

The inclusion of PHC-related themes in these commissions would enable the state secretariats to engage more closely with this agenda, including by supporting municipalities in tackling challenges that can't be solved by the municipal level alone.

For instance, commissions could assist with the joint development of strategies to address the challenge of attracting and retaining professionals and develop shared management tools, as well as regional health programs. Additionally, they could propose possible arrangements to make labour relations in health more professional and reduce regional competition. This would require involving the various professional bodies and organisations to discuss labour relations within the CIRs.

Other options include developing joint continuous education activities and supporting councils in developing professional training programs, such as regional medical and interdisciplinary residencies. Launching larger tenders through the CIRs also present potential to bring more legal certainty and better results. To the best of our knowledge, there is currently no legal impediment to changing the way that CIRs operate.

CONCLUSION

In the 30 years of the SUS, the decentralisation guideline has undoubtedly played an essential role in triggering the development of state capacity in the municipalities and allowing for the implementation of the national health system in all its capillarity, and especially in primary care policy.

On the other hand, it has laid bare the limitations of the SUS model in managing interfederative relations, especially when responsibilities are not well defined, and coordination is insufficient. Reviewing the policy choice of municipalisation and its prerogatives is a complex process, politically and technically, and in the current scenario of democratic and institutional fragility, it is simply not on the agenda.

This brief argues that one way to mitigate the most deleterious side effects of decentralisation is to strengthen the shared management spaces that are already a part of the SUS regulatory framework. This would make these spaces more effective and responsive to the country's context, which is currently very different than when the SUS was created.

This document recommends three paths for enacting these changes, with the ultimate goal of supporting the municipalities in overcoming their own challenges and improving the results of the national health system and the satisfaction of Brazilian citizens with it. Joint technical and political efforts are needed to bring about the necessary changes, which encompass the roles of each of the three entities⁸.

In the case of states, this brief argues that, among the several responsibilities held by their health secretariats, one of the most important now is to act as a strategic player in enabling a form of shared health management that is more collaborative and places the health regions as their preferred locus. This new model would require, then, a reworking of the interfederative pact of the SUS, with a shift in emphasis; the prominence that municipalities had in the first decades of the system would partly shift to the states and the SESs⁷.

In short, this brief argues that health service management in Brazil requires a clearer definition of responsibilities and roles, and a rethinking of the role of state health secretariats. This new role could help reduce regional inequalities, while regional development through SUS could bring benefits beyond health, in other areas that are important for the country's progress.

In addition to the suggestions above, focused on improving the shared management between federative units, this brief also argues that the state health secretariats have the power to support the development and implementation of PHC in several other ways, and most importantly by co-financing the current primary care policies and programs.

This includes guaranteeing the purchase of common and frequent supplies and medicines, helping to improve the infrastructure of primary care services (by supporting the purchase of equipment and defining contextualised engineering and architectural plans for the construction of primary care units) and implementing regionalised selection processes for the recruitment of health professionals, both for care and management.

During the writing of this document, we also identified a relevant gap in the available knowledge around the functioning of the state health secretariats, and an even larger one regarding the operation of CIRs. Thus, this brief concludes by highlighting the importance of investing and supporting in research in those areas. The results of these combined efforts will be essential if the country is to take the next steps necessary to consolidate the SUS.

APPENDIX

Table 1 - Municipalities in Brazil, by population group and by quantitative range, 2022

Number of inhabitants per municipality	Number of municipalities	Percentage (%)	Number of inhabitants	Percentage of the population of these municipalities in relation to the country's total population (%)
Less than 5,000	1,314	23.59	4,401,271	2.12
From 5,001 to 20,000	2,537	45.55	27,550,121	13.26
From 20,001 to 50,000	1,059	19.01	32,201,560	15.50
From 50,001 to 100,000	344	6.18	24,201,286	11.65
From 100,001 to 500,000	272	4.88	56,453,348	27.17
From 500,001 to 1,000,000	29	0.52	20,371,398	9.81
From 1,000,000 to 10,000,000	14	0.25	30,371,127	14.62
> 10,000,000	1	0.02	12,200,180	5.87
Brazil	5570	100.00	207,750,291	100.00

Source: Percentage of Brazilian municipalities by number of inhabitants, source IBGE 2022

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