

## Previne Brasil, the Agency for the Development of Primary Healthcare, and the Services Portfolio: radicalization of privatization policy in basic healthcare?

Previne Brasil, Agência de Desenvolvimento da Atenção Primária e Carteira de Serviços: radicalização da política de privatização da atenção básica?

Previne Brasil, Agencia de Desarrollo de la Atención Primaria y Cartera de Servicios: ¿radicalización de la política de privatización de la atención básica?

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### Abstract

*The essay analyzes documents produced by the Brazilian Ministry of Health in 2019 and 2020 for the reorganization of basic healthcare: the new financing policy (Previne Brasil), the Agency for the Development of Primary Healthcare (Law n. 13,958), the Services Portfolio, and complementary provisions. The objective was to understand how the projected changes in management roles and the healthcare model contribute to strengthening the public policy's mercantile logic. As parameters for the analysis, we used the management responsibilities and the principles and guidelines of the Brazilian Unified National Health System (SUS) and basic healthcare oriented according to the social determination of the health-disease process, the expanded definition of health, territorially organized care, community focus, and coordination of care in an integrated network. Changes in the allocation of public resources, the establishment of new possibilities for relations between the State and private companies, and adjustment of the healthcare model to market management characteristics reveal the privatizing orientation of these measures. The policy assumes an individualizing focus in the model of care and financing, undercutting the territorial perspective, community work, and comprehensive and multidisciplinary care. This accelerates the reconfiguration of the SUS as a system in which public or private agents can participate indistinguishably, exacerbating the break with the constitutional commitment to health as a duty of the State.*

*Health Management; Health Policy; Family Health Strategy; Unified Health System; Primary Health Care*

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## Introduction

Since Brazilian Unified National Health System (SUS, in Portuguese) was created, the system's development has included growth of the private sector, which was originally meant to have a complementary and supplementary role in the country's healthcare <sup>1,2</sup>. Under the hegemony of neoliberal rationality, the privatizing logic has forced the expansion of the private sector's presence in the SUS, gradually becoming part of the system's fabric. This trend incorporated ideas consistent with market relations in policy design and management processes, placing constraints on the universal right to health, the expanded concept of health, and the social security financing base.

Basic healthcare, the principal area for the expansion of the right to health under the SUS, was also affected by this circuitous development. Rationalization of resources and productivity were proposed, consistent with a managerialist logic. Measures were taken by which the State transferred part of the funds and roles to the private sector, as in the case of management contracts signed between municipal governments and the so-called "Social Organizations" (OS, in Portuguese) to supply and administer the healthcare services and workforce <sup>3,4</sup>.

This process did not occur without resistance. The SUS has maintained the principles of universal and comprehensive care with equity, disputing the system's direction and defending a more just and egalitarian perspective. However, since 2016, an even more favorable context has been established for the privatizing agenda that has materialized in counter-reforms triggered on various fronts in social policies, and specifically in health. The discourses and measures that were adopted reveal the market perspective's hegemony in health sector policymaking <sup>5,6</sup>, with basic healthcare as a prime target.

Important changes were made in 2017, with *Ruling n. 2,436*, which established the new National Policy for Basic Healthcare (PNAB, in Portuguese) <sup>7</sup>, in a restructuring process that includes guidelines, forms of services organization, composition of the healthcare teams, work processes, and scope of practices, with impacts on the healthcare model and the right to health. Universal care became less certain, with coverage of 100% of the population only recommended in areas with major population dispersion and areas at risk or with social vulnerability; segmented care was designed with the supply of different standards of service (basic versus expanded); the Family Health Strategy (ESF, in Portuguese) was shifted from its central position to the organization of basic healthcare, allowing compositions of teams and workweeks that resume so-called "traditional basic healthcare" <sup>8</sup>.

Since 2019, the reconfiguration of the SUS via basic healthcare was intensified through a set of measures that reveal the establishment of a new policy, broader than the changes introduced by the PNAB. This consists of changes that include nomenclature, organizational restructuring, and the production of rules and regulations.

Basic healthcare began to appear in documents by the Brazilian Ministry of Health under the term "primary healthcare" (PHC). The international nomenclature was thus resumed, namely PHC, overlooking the effort to distinguish between the two concepts, affirming basic healthcare as a field committed to universal and comprehensive care <sup>9</sup>, in keeping with the principles of the SUS and as opposed to the hegemonic restrictive and selective orientation at the global level, currently associated with the notion of "universal coverage" <sup>10,11</sup>.

In May 2019, the Brazilian Ministry of Health adopted a new organizational structure, eliminating and rearranging Secretariats (i.e., departments or divisions). The Healthcare Secretariat (SAS, in Portuguese) was dismembered into three, the Primary Healthcare Secretariat (SAPS, in Portuguese), Specialized Healthcare Secretariat (SAES, in Portuguese), and Special Healthcare Secretariat for Indigenous Peoples (SESAI, in Portuguese). Having been promoted to "secretariat" *status*, PHC has become the object of intense production of rules and regulations.

In the second half of 2019, three lines of restructuring were presented for basic healthcare: financing, regulation, and services provision. In the restructuring measures, we identify criticisms aimed at the proposals' process and content, highlighting the characteristics that jointly promoted a commodified management and healthcare model.

In relation to financing, the proposal began to circulate in July 2019 in presentations by policymakers from the SAPS of the Brazilian Ministry of Health. The first presentation was at the Brazilian Congress of Family and Community Medicine and continued in state meetings, linked with the National Council of State Health Secretaries (CONASS, in Portuguese). No official document was

presented for debate, and the methodology for calculation was not made available until the meeting of the Tripartite Inter-Managerial Commission (CIT, in Portuguese) on October 31, the date of its approval. This process hindered the organization of forums for analysis of the new model, ignoring requests by the National Health Council (CNS, in Portuguese) and other organizations for a more detailed explanation and in-depth discussion.

The new financing proposal, called the *Programa Previne Brasil* <sup>12</sup>, structurally alters the inductive logic of health policy organization and makes three main changes to basic healthcare: it eliminates the fixed and variable minimums (hereinafter PAB, as in the original Portuguese); introduces the transfer of federal funds according to the number of persons enrolled; and establishes a new form of payment for performance.

Concerning the system's regulation, in August that same year, the Brazilian Ministry of Health submitted *Executive Order n. 890* <sup>13</sup> to the National Congress, converted in December into *Law n. 13,958* <sup>14</sup>, which created the Doctors for Brazil Program (PMB, in Portuguese) and authorized the creation of the Agency for the Development of Primary Healthcare (ADAPS), a privately incorporated institution with a quasi-State modality (called an "Autonomous Social Service").

As for services provision, also in August, the Brazilian Ministry of Health presented the proposal for a Services Portfolio for PHC <sup>15</sup> (CaSAPS, in Portuguese), establishing the list of services to be supplied by basic healthcare. In this case, the Ministry of Health held a public hearing that lasted one week, and four months later the Ministry of Health published the consolidated document <sup>16</sup>.

The political strategy has been to submit proposals at different moments, announced separately and with short discussion times. The proposals were drafted simultaneously with the preparatory debates for the 16th National Health Conference, but were not presented at the congress. Likewise, the CNS and the state and municipal councils were virtually excluded from this process.

The CNS's influence, namely societal control and strengthening of the managers' forums, especially the CIT, has been steadily undermined since the 1990s <sup>17</sup>. Health policy issues are excluded from the participatory setting, limiting them to the arena of negotiation of agreements between managers, shifting to the condition of management problems, the solutions to which are drafted in technical and administrative settings, disguising the political interests mobilized in the process.

This set of measures deepens the changes established by the PNAB 2017 and makes a significant change to the political and institutional framework of basic healthcare. The *Programa Previne Brasil* <sup>12</sup>, ADAPS <sup>14</sup>, and CaSAPS <sup>16</sup>, combined synergistically, expand the possibilities for privatization of health and are part of a new process of accumulation, further broadened by the sector's opening to foreign capital in 2015 <sup>18</sup>. Complementary rulings <sup>19,20,21,22,23</sup> were announced by the Brazilian Ministry of Health, ratifying the measures and filling occasional gaps. The linkage between their contents and the speed with which these documents became official suggest that the new policy's framework for basic healthcare has been produced with definite vested interests.

As a potential niche for capital accumulation, basic healthcare needs to be converted into a space that provides diverse opportunities for commodification, which requires the combination of maneuvers for expropriation of the public sector and appropriation by the private sector. The process is similar to what David Harvey <sup>24</sup> described as "accumulation by dispossession", in which the State impose such measures as alteration or creation of regulatory provisions, turning the clock back to private domination and market relations for rights that had been won by the working class.

This essay analyzes documents produced by the Brazilian Ministry of Health in 2019 and 2020 for reorganization of basic healthcare, namely the *Programa Previne Brasil*, *Law n. 13,958*, which established the ADAPS, CaSAPS, and complementary rulings (Box 1). The objective was to understand how such mechanisms combined to introduce changes in the management roles of the SUS and in the healthcare model, thereby strengthening the mercantile logic in public policy. To analyze the mechanisms, we returned to the management attributes (planning, financing, regulation, execution of services) and the principles and guidelines of the SUS (universal care, comprehensiveness, decentralization, and social participation) <sup>25</sup>, updated by the debate on a basic healthcare oriented by the social determination of the health-disease process, the expanded definition of health, territorialization, community focus, and coordination of care in an integrated network <sup>26</sup>.

**Box 1**

Legal provisions and rulings for changes in Brazil's basic healthcare, published by the Ministry of Health from August 2019 to January 2020.

Legal provisions and rulings	Objective	Highlights	Main remarks
<p><b>Law n. 13,958<sup>14</sup> of December 18th, 2019 – converted from Executive Order n. 890<sup>13</sup> of August 1st, 2019</b></p>	<p>Establishes the Doctors for Brazil Program (PMB) in the primary healthcare setting in the Brazilian Unified National Health System (SUS) and authorizes the Executive Branch to establish an autonomous social service called the Agency for the Development of Primary Healthcare (ADAPS).</p>	<p>The PMB will be executed by the ADAPS. The model for the ADAPS is the “Autonomous Social Service”, a privately incorporated non-profit organization.</p> <p>The institutional structure for the ADAPS provides for an Advisory Board, Executive Board, and Fiscal Board.</p> <p>Attributions of the ADAPS: primary healthcare (PHC) services provision, professional training and qualification, research and extension, incorporation of healthcare and management technologies, monitoring and assessment of healthcare activities, and execution of the PMB.</p> <p>ADAPS can sign services provision contracts with physical or legal persons.</p> <p>The Federal Executive Branch can provide technical support to the projects and programs developed by ADAPS, through cooperative agreements, contracts, or similar arrangements.</p> <p>Revenue sources for ADAPS: budget funds from the Federal government, additional credits, transfers, revenues from fees for services provided to legal persons, public or private; funds from contracts and agreements with Brazilian and international organizations, public or private; revenues from financial investments by the ADAPS; donations, endowments, and similar funds from physical or legal persons, public or private; and revenues from other sources.</p>	<p>Allows an important transfer of administrative responsibilities from the Brazilian Ministry of Health to the ADAPS. Makes basic healthcare a space for direct action by private healthcare companies, with access to public, stable, and large sources of funding.</p>

(continues)

## Box 1 (continued)

Legal provisions and rulings	Objective	Highlights	Main remarks
<b>Ruling n. 2,539</b> <sup>19</sup> , of September 26th 2019	Establishes primary healthcare teams (eAP) and rules on financing of oral healthcare teams (eSB).	Provides that the primary healthcare team (eAP) may consist of just a physician and nurse. Provides for flexible workweeks and enrollment of population with the eAP in: Modality I – 20h/week and population enrolled with the team corresponding to 50% of the assigned population; Modality II – 30h/week and population enrolled with the team corresponding to 75% of the assigned population. Allows participation by professionals from eAP and eSB (Modality I with differentiated workweek) in more than one team. Allows eSB in Modality I, under the following terms: Modality I – 20h: eSB consists of professionals with minimum 20-hour workweek in the same health unit, with population enrolled with the team corresponding to 50% of the assigned population for a family healthcare team or; Modality I – 30h: eSB consists of professionals with minimum 30-hour workweek and registered with the same health unit, with population enrolled with the team corresponding to 75% of the population assigned in a family healthcare team.	Allows and favors the creation of teams consisting only of physicians and nurses, with flexible workweeks and population coverage in relation to the family teams, further contributing to the biomedical focus and weakening the territorial perspective in basic healthcare.
<b>Ruling n. 2,979</b> <sup>12</sup> of November 12nd, 2019	Establishes the <i>Programa Previne Brasil</i> , which creates a new financing model for costs of primary healthcare (PHC) in the Brazilian Unified National Health System (SUS).	Federal financing of PHC will consist of: I – weighted capitation; II - payment for performance; and III – incentives for strategic activities. Calculation of the financial incentives for weighted capitation considers: I – the population assigned to the family health team (eSF) and the primary healthcare team (eAP) in the Information System on Basic Healthcare (SISAB); II - socioeconomic vulnerability of the population enrolled in the eSF and eAP; III - demographic profile by age bracket of the population enrolled in the eSF and eAP; and IV – geographic classification according to the Brazilian Institute of Geography and Statistics (IBGE). Calculation of the financial incentive for payment for performance will be based on the results of indicators achieved by the teams accredited in the SCNES. Calculation of the funds for incentives for strategic activities based on: I – health specificities and priorities; II – the teams’ structural characteristics; and III – production of strategic health activities.	Extinguishes the fixed PAB, eliminating the only mechanism for per capita transfer of funds. Capitation weighted by patient lists favors hiring of services in the private sector, undercutting the perspective of the universal right to health. The logic of payment for performance is no longer complementary and is consolidated as one of the central areas.

(continues)

## Box 1 (continued)

Legal provisions and rulings	Objective	Highlights	Main remarks
<b>Ruling n. 3.222</b> <sup>20</sup> <b>of December 10th, 2019</b>	Rules on the indicators for payment for performance of family healthcare teams in primary care, in the <i>Programa Previne Brasil</i> .	Only presents seven clinical and epidemiological indicators for “payment for performance”, pertaining to strategic activities in women’s health, prenatal care, children’s health, and hypertension and diabetes mellitus for 2020: I – proportion of pregnant women with at least six prenatal consultations, the first within the 20 <sup>th</sup> week of pregnancy; II – proportion of pregnant women tested for syphilis and HIV; III – proportion of pregnant women receiving dental treatment; IV – Pap smear coverage; V – coverage of polio and pentavalent vaccination; VI – percentage of hypertensive individuals with blood pressure measured every six months; and VII – percentage of diabetics with glycated hemoglobin test ordered. Defines the strategic activities for 2021 and 2022: I – multidisciplinary activities in primary care; II – postpartum care; III -child care (infants up to 12 months); IV – HIV; V – tuberculosis; VI – dental care; VII – hepatitis; VIII – mental healthcare; IX – breast cancer; X – overall indicators for assessment of quality of care and patients’ experience.	Adopts only a few indicators, although relevant, limited to the scope of traditional activities that do not extend beyond biomedically based prevention. Fails to contribute to valuing health promotion and comprehensive care.
<b>Portfolio of Services in Primary Healthcare (CaSAPS)</b> <sup>19</sup> , <b>of December 18th, 2019</b>	Describes, for the population, the system’s other levels, administrators, and professionals working in primary healthcare (PHC), the list of activities and clinical services and health surveillance supplied in Brazil’s PHC.	Defines the range of available services supplied by the PHC units, separated as follows: “Health Promotion”, “Healthcare for Adults and Elderly”, “Healthcare for Children and Adolescents”, “PHC Procedures”, and “Oral Healthcare”. Allows municipal administrators to add or remove items from the Services Portfolio.	The services portfolio is essential for pricing, a condition for hiring services from the private sector. The wording is indicative (suggestive), and the content converges on the idea of segmentation of care and the establishment of minimums, typical of selective PHC.
<b>Ruling n. 3,510</b> <sup>21</sup> <b>of December 18th, 2019</b>	Establishes financial incentives for additional monthly costs in municipalities with family health teams or oral health teams that serve as training fields for health professionals in primary healthcare (PHC).	Defines professional training in PHC as medical residency program in family and community medicine or single or multi-professional residency programs in PHC or family health for dentists and nurses.	In the dialogue between training and administration, the ruling reiterates the idea that physicians, nurses, and dentists are sufficient for comprising the multi-professional perspective in basic healthcare.

(continues)

## Box 1 (continued)

Legal provisions and rulings	Objective	Highlights	Main remarks
<b>Technical Note n. 3<sup>22</sup> of January 27th, 2020</b>	Presents the configuration of the Expanded Center for Family Health and Basic Healthcare (NASF-AB) and the <i>Programa Previne Brasil</i> .	Composition of multi-professional teams no longer linked to typologies of NASF-AB teams. The municipal administrator has the autonomy to organize the multi-professional teams, defining the professionals, workweek, and team arrangements. As of January 2020, the Brazilian Ministry of Health no longer performs accreditation for NASF-AB.	Makes explicit the renunciation of the NASF as the model for strengthening multi-professional and territorialized care, resulting from its defunding by the Brazilian Ministry of Health. Fails to present an alternative for understanding the multidimensionality of basic healthcare.
<b>Ruling n. 99<sup>23</sup> of February 7th, 2020</b>	Redefines the registration of Primary healthcare and mental healthcare teams in the National Registry of Healthcare Establishments (CNES).	Reformulates the classification of health teams. Presents the correlation between the previous and new classifications. Reformulates the information model – team module. Reformulates specialized primary healthcare services. Modifies the classification of Motive for Demobilization of Healthcare Teams. Transfers the rules of consistency related to composition of teams, work schedules, and other rules necessary for the management of Primary Healthcare and Mental Healthcare Teams, from the CNES to a management and monitoring system under the responsibility of the Primary Healthcare Secretariat (SAPS) of the Ministry of Health (SAPS).	Recreates the possibility of registering Expanded Center for Family Health (NASF) teams in the CNES. Introduces changes in the classification of teams and codes, with repercussions on data feeding procedures. This involves a new workload, which may lead to difficulties for the municipalities during the adaptation period, with implications for financing. The change in the responsibility for the rules of consistency – from the CNES to a system still not officially established – requires attention. The Brazilian National Program for Improvement in Access and Quality of Basic Healthcare (PMAQ) was also cancelled, the system that monitored basic healthcare.

Source: prepared by the authors.



### ***Previne Brasil: the induction of targeting***

Three arguments were presented to justify the new financing policy: to meet the demand for greater autonomy of municipal managers in the use of federal funds; to reach the most vulnerable groups; and to guarantee cost-effectiveness in the basic healthcare policy.

As for greater autonomy for municipal managers, *Previne Brasil* presents much more of a change in the object of the federal incentive and its purposes than a break with the inductive logic.

Since the Basic Operational Standard (NOB, in Portuguese) of 1996, the prevailing financing model was based on a mechanism for regular and automatic transfer of federal funds (“PABs” in Portuguese), using fund-to-fund transfers. Every municipality began to immediately receive per capita funds per year to cover the costs of basic health activities (the fixed PAB) and incentives for implementing programs recommended by the Brazilian Ministry of Health (the variable PAB), such as the Family Health Program (PSF, in Portuguese) and Community Health Agents Program (PACS, in Portuguese). The creation of the PABs allowed overcoming (in basic healthcare) the model based on payment for production of services and encouraged municipalities’ adherence to the ESF <sup>27</sup>.

Promoted to the status of priority strategy for reorienting the model, impelled by funds from the PAB, the ESF enjoyed important expansion. From 1998 to 2019, the change was from 25.7% of the municipalities (counties) with the PSF to 98.6% with the ESF <sup>28,29</sup>. One can infer that the Ministry of Health was successful in expanding the system’s coverage and organization at the local level. The same cannot be said for guaranteeing access to healthcare comprehensiveness, while acknowledging the effort at strengthening basic healthcare and the different incentives and measures for its improvement <sup>30,31,32</sup>.

By defining the financial incentive as the inductive factor for changing the organization of care, the federal administrator assumed the central role in orienting the policy at the local level, with limited autonomy for municipal managers in the use of federal funds. The financing model that was adopted, based on the so-called *caixinhas* (literally “little cash boxes”) <sup>33</sup>, was a source of tension between the federal and municipal administrators as the guideline for decentralization. The funds transferred by the Federal Government were “earmarked” according to the policies prioritized by the Brazilian Ministry of Health <sup>33</sup>. This model underwent various revisions from 1996 to 2019, without altering the healthcare model’s inductive logic based on federal transfers.

In the last revision of the financing model, in 2017 (*Projeto SUS Legal*) <sup>34</sup>, the change ultimately aimed to shift away from the inductive logic. Two major blocks were created, costs and investment, for transferring funds. The fixed and variable PABs were maintained in the costs block, with a list of specific incentives associated with the variable PAB.

*Previne Brasil* makes a radical change. It eliminates the fixed PAB, the only population-based intergovernmental transfer in health, which means the end of universal financing of basic healthcare, according to Massuda <sup>35</sup>. The criteria for determining the new financing model are: weighted capitation; payment for performance; and incentive for strategic activities <sup>12</sup>.

Since Brazil’s Organic Health Law, for the vast majority of the country’s municipalities, the logic of bottom-up territorially and population-based planning served as a mechanism for determining the fixed value of the transfers and the main guarantee for organization of the SUS at the local level. The population-based model allowed the administrator to determine the distribution of funds according to each territory’s profile, considering the inequalities. The defunding <sup>36</sup> created by *Constitutional Amendment n. 95* (EC 95, in Portuguese) <sup>37</sup> plus the threats of extinction of healthcare minimums and de-earmarking of funds pose a major risk to local systems’ maintenance. Even though the amount of the fixed PAB had been devalued over time <sup>27,33</sup>, its maintenance provided some guarantee of continued funding for the organization of basic healthcare.

The weighted capitation proposal in *Previne Brasil* is calculated according to the following: (1) the population enrolled with the family health team or primary care team; (2) the socioeconomic vulnerability of the enrolled population; (3) the demographic profile of the enrolled population according to age bracket; and (4) geographic classification by the Brazilian Institute of Geographic and Statistics (IBGE) <sup>12</sup>. The enrolled population corresponds to the “multiplication of the number of family health and PHC teams accredited and registered in the National Registry of Healthcare Establishment (SCNES) by the potential number of persons enrolled per team, not to exceed the total population according to the IBGE” <sup>12</sup>.



Theoretically, this combines two elements: emphasis on the enrolled persons and balancing by conditions of vulnerability.

Emphasis on the persons enrolled or treated<sup>22</sup> raises concern as to the focus on the individual, to the detriment of the community perspective and territorialization. It exacerbates the break with the principle of universal care, admitting that part of the population will not be treated in basic healthcare, and evokes the idea of universal coverage, shifting scarce resources to the poorer segments of the population, thereby promoting a model of targeted PHC.

By alluding to socioeconomic vulnerability, the age composition of the enrolled persons, and the geographic classification of the municipalities by the IBGE for weighting the capitation, the proposal purportedly connotes the idea of equity. However, the IBGE calls attention to the limits of this study, indicating that it is a “first approximation” that does not cover the territory’s various dimensions, which should be examined at other levels of analysis<sup>38</sup>. Perhaps that is why it is not possible to grasp the relations between this classification and the understanding of the phenomena in the health field.

Thus, the emphasis on the individual, overlooking the social and political process in the production of vulnerabilities, tends to make territorial problems less visible and to demobilize actions in the health field that transcend the biomedical clinic.

A study by the Rio de Janeiro State Council of Municipal Health Secretariats (COSEMS-RJ, in Portuguese) projected two scenarios for 2020 based only on analysis of the adoption of the weighted capitation component by the state’s municipalities. The first scenario, including the situation with the current enrollment, showed a 37.15% loss in total federal transfers to these municipalities. The second scenario simulated the maximum possible enrollment, considering the installed capacity and the established parameters, resulting in a final transfer with a reduction of 4.68%<sup>39</sup>. Thus, even if the municipalities were capable of meeting the enrollment target (an unlikely scenario for many of them), the result would be insufficient to maintain the amount of funds received in 2019.

Efforts such as those by the COSEMS-RJ faced difficulty created by the hasty debate and the Ministry of Health’s failure to disclose (in advance) the database and methodology for calculation.

A second issue in the new model is payment for performance, “*considering the results of the indicators achieved by the teams accredited and registered in the SCNES*”<sup>12</sup>. Payment for performance had already been practiced in basic healthcare since 2011, through the Brazilian National Program for Improvement in Access and Quality of Basic Healthcare (PMAQ, in Portuguese), which combined access to follow-up with discussion of indicators. It supplied new funding, added to the PAB, allowing investments in the renovation and expansion of health units<sup>40</sup>. *Previne Brasil* overlooks the lessons from PMAQ and introduces a different performance logic, emphasizing monitoring of procedures and the results of health activities, not including evaluation of work processes.

To regulate payment for performance, in November 2019, the CIT passed *Ruling n. 3,222*, defining only seven performance indicators for 2020<sup>20</sup>, related to some clinical services for women, children, hypertensives, and diabetics. The Ruling does not specify targets or parameters for payment for performance, thus requiring further regulation.

Unlike the United Kingdom (the main international experience used as a reference), *Previne Brasil* adopts capitation and performance criteria as the mechanism for calculating intergovernmental transfers, and not as the mechanism for remuneration of services. Massuda<sup>35</sup> calls attention to possible difficulties in the adoption of this new procedure and implications for the sustainability of basic healthcare in the municipalities. Mendes & Carnut<sup>36</sup> recall that the English model, before adopting this format, underwent various adjustments that were not considered in the Brazilian policy’s formulation. There are also important differences between the two national health systems and realities that need to be considered in the adoption of financing policies, notably the structural inequality marking Brazilian society.

Brazil’s social, territorial, and healthcare inequalities require a model that considers the existing difficulties and vulnerabilities, thus a model oriented by equity. Such a model must not lose sight of building equality of rights and universal care, commitments that should guide the management policies of the SUS and particularly federal funding’s redistributive role. Without this perspective, orientation by social vulnerabilities overlooks equity and is transmuted into targeting and curtailment of rights.

The third component is payment as an incentive for strategic actions, with 16 items that retain some components of the variable PAB, providing for the inclusion of other items based on subsequent rulings<sup>12</sup>. The component maintains the logic of induction with specific incentives, but eliminates the incentives that reinforced the model's orientation and the work's structuring according to the territorial and community logic, such as implementation of the family health teams, the Family Health Support Center (NASF, in Portuguese), and indigenous health. These modalities are reinserted as teams for registration in the SCNES in *Ruling n. 99*<sup>23</sup> of February 2020, but without recovering their status as strategies incentivized by the federal policy for financing basic healthcare.

Taking the NASF as the reference, an important strategy is eliminated for building comprehensiveness and territorialized expanded care. A significant share of its responsibilities consists of supporting and linking services and teams in the actions and practices to be adopted in the territory, working to integrate the community, the network of care, and policies from other sectors.

### **ADAPS: configuring the mechanisms for expansion of privatization**

*Law n. 13,958*<sup>14</sup> operates in two ways: it establishes the PMB in PHC and authorizes the creation of ADAPS, responsible for the Program's execution.

PMB was presented with the objective of increasing the provision of medical services in difficult-to-serve places or those with high vulnerability and promoting specialization in family and community medicine. It was announced as a counterproposal to replace the More Doctors Program (PMM, in Portuguese) in order to "*correct the distribution of vacancies previously defined by the Program*"<sup>41</sup>.

The ADAPS is an alternative proposal to public management that seeks to lend "*legal security to the policy's execution*" and "*economic sustainability for its implementation*"<sup>41</sup>. It is configured as an autonomous social service, a legal person "*under private law, non-profit, of collective interest and public utility*", whose purpose is to promote the execution of policies for the development of PHC at the national level<sup>41</sup>. Its attributions include: services provision, professional training and qualification, research and extension, incorporation of healthcare and management technologies, monitoring and evaluation of health activities, and execution of the PMB.

Its institutional structure provides for an Advisory Board, an Executive Board, and a Fiscal Board. The Advisory Board is presented as the "*top decision-making body of ADAPS*"<sup>14</sup>, consisting of 12 representatives: six from the Brazilian Ministry of Health; one from CONASS; one from the National Council of Municipal Health Secretaries (CONASEMS, in Portuguese); one from the Brazilian Medical Association; one from the Federal Board of Medicine; one from the Brazilian National Federation of Physicians; and one from the CNS.

The composition predominantly includes representative bodies from management, the Ministry of Health with the tiebreaking vote, CONASS, and CONASEMS, and medical bodies. The CNS and the medical bodies were not included in *Executive Order n. 890*, which included the private sector's representation. This new composition does not necessarily expand the public interest's representation in the management of the ADAPS, since social control only has one representative, and the three segments representing the medical profession are closely aligned with privatizing interests in health. According to Giovanella et al.<sup>42</sup>, more than 300 amendments were submitted to the Executive Order, but recommendations in favor of the SUS were not included in the report by the Special Commission that analyzed it, and its overall sense prevailed in the Law's wording. This is important for explaining the proposal's intentions and the counter-proposal's existence.

The establishment of the ADAPS creates the conditions for a private organization to take over the management of basic healthcare, including obtaining revenues from other sources. The justification is the need to support the PMB, but the scope of attributions significantly extrapolates this purpose, constituting a new and ample portal of entry for the private sector into the SUS. We agree with Giovanella et al.<sup>42</sup> when they identify the Executive Order's privatizing perspective and the risk of a dual outsourcing, which we characterize here as the transfer of management responsibilities for basic healthcare to the ADAPS and the possibility of the agency hiring services from public or private companies, a possibility highly celebrated by the private healthcare sector<sup>43</sup>.

The private sector is provided with access to and management of a stable and voluminous source of financing, constituting the predicted revenues for the ADAPS: funds transferred from the Federal Government, funds from services provided to public or private legal persons, and funds from contracts and agreements with Brazilian and international organizations, public or private, including teaching institutions, among others <sup>14</sup>. Notably, the SUS handles the Brazilian Federal Government's second largest budget, with more than 120 million persons depending on it and with guaranteed production of services by basic healthcare.

The SUS provided an important space, although still limited, for action by the private sector, still ordered by the rules of public administration. By situating itself as a mere hiring body, the States abdicates its role as the system's administrator and policy-maker. Various obligations become exposed to market interests, such as the responsibility for health, the commitment to the right to health and healthcare, results by the services system, and custody of users' data. The private sector now works in a monopsonic market, i.e., with a single buyer, in this case the State, from various sellers, with a place guaranteed for private health plans and open room for new arrangements. The private sector will count on control of all the management resources, including economic, technical, informational, labor (to hire and use public employees), educational, and scientific, thus enabled to define the rules of the game.

*Law n. 13,958* <sup>14</sup> contains control mechanisms for the work by ADAPS, such as: technical orientation and supervision by the Brazilian Ministry of Health on execution of the PMB; management contracts between the ADAPS and the Ministry of Health; submission of activities reports for review by the Ministry of Health and sent to the National Congress and the CNS; and inspection of management contracts by the Federal Accounts Court (TCU, in Portuguese). However, the only sanction for unjustified noncompliance with the management contract is dismissal of the Director of the ADAPS by the Advisory Board.

The justification for execution of the PMB via ADAPS is also the "*possibility of establishment of payment for performance and the requirement of minimum healthcare quality levels through the management contract*" <sup>41</sup>. Payment for performance and the establishment of minimum levels of healthcare quality relate to the complementary relationship between the logic of privatization promoted by *Law n. 13,958* and the content of CaSAPS.

### **CaSAPS: reducing and adapting healthcare to private management**

The Brazilian Ministry of Health published CaSAPS <sup>16</sup> in December 2019. In August, the SAPS/Ministry of Health had submitted a proposal for this Portfolio to a public consultation <sup>15</sup>. The objective at the time was "*to establish an 'optimum' scenario for the implementation and supply of clinical services in health units*" <sup>15</sup>. This first version generically introduced the underlying principles of PHC and established four lines for its organization: (1) access to first contact, (2) longitudinal care, (3) comprehensiveness and scope of care, and (4) clinical coordination/cooperation. Access to first contact was the only line addressed in depth, presenting what appeared to be the proposal's core content: to organize the work process and agenda and propose new teams, centered on physicians and nurses. The list of services was presented in the document's annex, with less emphasis, but revealing an important change, with a predominance of individual clinical actions and practices and an emphasis on diseases and procedures.

The reaction to the proposal was immediate. The Brazilian Society of Family and Community Medicine (SBMFC, in Portuguese) took a favorable stance, citing the need for greater case-resolution capacity, quality assessment, and efficiency of services <sup>44</sup>. The PHC Network <sup>45</sup> expressed concerns over the reduced scope of care, based on a clinical and individual model, and the disappearance of the family and community dimension. The network highlighted the functionality of the services portfolio for the pricing process and recalled that hiring providers implies the definition of the number of persons to be covered (capitation by list of patients) and the list of procedures to be provided.

The CNS and some professional societies and scientific institutions denounced the predominantly biomedical approach and the absence of the comprehensive health perspective. The challenges were quite extensive, including the proposal's arguments and contents and the way it was produced.

The final CaSAPS document <sup>16</sup> is quite different from the one submitted for consultation. It was published in three versions: one for the general population and two for health administrators and professionals – complete and abridged. A previous annex became a central part of the documents, and the entire discussion on the organization of the work process, agenda, and team modalities was excluded. The services and actions are organized in five groups: “Health Promotion”, “Healthcare for Adults and Elderly”, “Healthcare for Children and Adolescents”, “PHC Procedures”, and “Oral Healthcare” <sup>16</sup>. In the complete version, each item is associated with recommendations, material for consultation, and lists of inputs for implementation.

It is not possible to analyze the degree to which the contributions from the public consultation were incorporated, since these results were not made public. There is an evident attempt to dodge the criticisms for the first version. The definitive document became more refined in terms of arguments and theoretical basis and more complex in terms of the description and composition of the services. The document’s direction became more veiled, revealing itself by what it does not fail to include in terms of instituting or deconstructing.

The document is presented as a reference for administrators, with the possibility of expansion or elimination of services from the list, based on local specificities. Compared to the parameters that had oriented the expansion of the ESF, expressed especially in the *Basic Healthcare Notebooks* (CAB, in Portuguese), the CaSAPS represents a reduction in the scope of actions that had been promoted with federal resources (financial and technical). The Portfolio already starts from standards close to the minimum and reiterates the segmentation of care based on a differential supply, between essential (basic) and expanded (strategic) standards, indicated in the PNAB 2017. The CaSAPS provides for the assessment of its implementation in 2020, in order to back the definition of these standards. We believe this raises the following question: does the composition of the CaSAPS include services that can be eliminated without leading to lack of care or loss of case-resolution capacity?

We analyze the Portfolio based on four key aspects (territorialization, multidisciplinary, community work, and comprehensiveness of care), indicative of the orientation of basic healthcare according to the social determination of the health-disease process, the expanded definition of health, territorialization, community focus, and coordination of care in an integrated network <sup>26</sup>.

Territorialization entails understanding the historical processes that condition life and social relations in a given space, considering the specificities of environmental and population situations and health needs <sup>46</sup>. It is a mode of organization of health services and practices, centered on the territory and health responsibility. The word “territory” only appears twice in the CaSAPS, associated with the idea of “local environment”, and territorialization is used as a technique for collecting information. This reduced notion fails to refer to social determinants and inter-sector collaboration, reinforcing the biomedical perspective in understanding the health-disease process and the organization of care.

The depletion of the territorialization focus leads to weakening the notion of community – limited to a place or set of persons in a locality – losing the perspective of building relations between the teams and the people in different communities. The idea of “community orientation” is dissociated from popular participation, an expression that does not even appear in the CaSAPS.

CaSAPS, by ignoring popular participation, one of the historical guidelines of the ESF (in a direct relationship with the work of the community health agents), denies users the status of protagonists in the organization of care. Protagonist status refers to the notion of comprehensiveness, which involves understanding people in their various dimensions – their biopsychosocial nature – and acknowledgement of the social determination of the health-disease process. It is not a self-defined attribute. Evoking comprehensiveness necessarily means presenting the guidelines and measures for its materialization <sup>47</sup>. Such measures are not specified in the CaSAPS. It cites a well-established idea, but without committing to its materialization, which would require a network of complementary and interconnected services, the provision of inter-sector actions, and a multidisciplinary approach.

While inter-sector collaboration remained as a persistent challenge in Basic Healthcare, multidisciplinary work made some important strides with the incorporation of professionals from different fields. The structuring of the NASF contributed more systematically with knowledge and practices from nutrition, physical therapy, social work, psychology, occupational therapy, pharmacy, physical education, and collective health, interacting with the teams from the perspective of comprehensive care. However, the CaSAPS makes no reference to this form of organization of multidisciplinary

work, aggravating the insecurity plaguing the NASF teams since publication of the PNAB 2017, reinforced by its defunding in *Previne Brasil* and by Technical Note n. 3 of 2020<sup>22</sup>. This Note established the cancellation of new accreditations of NASF-AB, shelving the applications already submitted, and delinking the composition of multi-professional teams from the typologies of NASF-AB teams. Although *Ruling n. 99* of 2020 reincluded the NASF among the modalities for registration of teams in basic healthcare in the SCNES, the situation remains uncertain<sup>23</sup>.

The document refers indistinctly to multidisciplinary and multiprofessionalism, predominantly associated with specific conditions such as violence against women and palliative care. An important trait is its appearance in the document's introduction, where the objective of CaSAPS is stated as follows: "(...) it is a document that aims to orient health in Brazil's PHC with strong recognition of the multi-professional clinic"<sup>16</sup>. Multi-professional work here is diminished by limiting it to an exclusively clinical version, reiterated in *Rulings n. 2,539*<sup>19</sup> and *n. 3,510*<sup>21</sup> of 2019. The first establishes a team consisting only of physicians and nurses, while the second provides financial incentives for municipalities with teams that serve as field of practice for medical residency programs or that include dentists and nurses – powerful mechanisms for disseminating the limitation of multi-professional teams to these professions.

*Ruling n. 2,539*<sup>19</sup> includes changes with effects on continuity of care and universal access. By establishing the minimum composition – a physician and nurse – for the PHC team, the ruling provides for a more flexible workload and assigned population, allowing two modalities of PHC teams. For modality I, it establishes a minimum individual workweek of 20 hours and 50% of the population enrolled with a PHC team; for modality II, a 30-hour workweek and 75% of the population enrolled with a PHC team. Members of the teams are allowed to work in more than one PHC team or family health team.

These changes regulate the proposals of PNAB 2017<sup>7</sup>, which allowed support from the Brazilian Ministry of Health for other teams besides family health teams, with different workweeks and composition. This configuration may appeal to administrators and professionals due to the possibility of reconciling work with more than one team, but it is potentially harmful to establishing bonds between healthcare professionals and the population.

The virtual elimination of community health agents from the CaSAPS is another striking element in the deconstruction of the family health teams and community work and territorialization. Community health agents are mentioned only once, in the context of postpartum care. This radicalizes the orientation of the PNAB 2017<sup>7</sup>, which failed to provide for a minimum number of such workers in family health teams, allowing basic healthcare teams without community health agents.

What is the future of health when the work of community health agents is weakened in basic healthcare? In much of Brazil's reality, it is difficult to imagine territorialized care without the work of community health agents. This increases the distance between the reality of territories and health teams and services, further hindering people's access to healthcare. For example, the potential is lost for educational work produced in greater harmony with the dynamics of life in the communities<sup>8</sup>.

The CaSAPS creates another distance in relation to the territory by limiting home visits to individuals confined to home, such as newborns and bedridden individuals. Home visits are part of a set of important circumstances for the creation of bonds between health services and the community. Home visits are used to register persons, and updating the registry provides essential knowledge on the persons served and their living conditions. Through home visits, the services take a more active stance toward promotion of access. Home visits have also been an opportunity for subjective interaction, which allows observation of conditions of risk, vulnerability, and suffering that are not necessarily reported in the services' daily routine.

The CaSAPS distances itself from the perspective of territorialized, community-centered care, thereby jeopardizing attributes that the document itself cites in defining PHC, such as longitudinal care and coordination of care. Longitudinal care requires continuity of care and lasting bonds with users; it becomes unfeasible without a more collective understanding. Likewise, the idea of coordination of care loses an important basis for the establishment of a network of continuing care that transcends referral and counter-referral. The organization of care in network format, defined as sharing care and complementary responsibilities, structured according to the territory, with a continuous



flow of persons and information, requires a concept of expanded clinic, unlike the standard taxonomic features like the ones with which the CaSAPS intends to organize basic healthcare.

These documents clearly draw on the principles and guidelines of the SUS and of the so-called “strong PHC” merely as rhetorical props that fail to stand up to the procedural guidelines adopted by them.

The connection is completed here between the three lines of policy changes in Basic Healthcare. The construction of the means for extending the privatization of Basic Healthcare consists of the redefinition of financing mechanisms, featuring weighted capitation and payment for performance, combined with the list of procedures (with biomedical nomenclature), as the necessary devices for establishing contracts between public and private organizations. In order to allow direct participation by the private sector, especially “supplementary health” (private health plans and insurance) in the provision of basic healthcare services with public financing, the ADAPS was created as the legal and institutional format for the process, with effects on health administration, care, and training.

### Final remarks

Basic healthcare in Brazil had witnessed efforts to build a model of care associated with continuous expansion of access to services and improvement in the quality of care. More than a reality, it was a long-term wager that included an agenda for confrontations in the field of social policies and the SUS.

Financing of basic healthcare remained insufficient, with important limits and tensions in the relations between the federal and municipal administrators. Even so, significant strides were achieved in decentralization of administration and implementation of local care. With the ESF, there was an even more direct confrontation with the hospital-centered model, and although Brazil made less progress in overcoming the biomedical model, it was possible to produce multidisciplinary work processes. With the expanded composition of the family health teams and especially through integration with the NASF, innovative forms of interpreting and responding to health needs were achieved.

Still, the managerialist and productivist bias in the administration of healthcare services and work was consolidated, to the detriment of a more participatory teamwork process and a stronger and fairer connection to the health workforce, offering them job stability and better conditions for the teams to deal with policy changes. The effects were felt in the process of care itself, bolstering practices and actions amenable to measurement, undercutting the value of listening and subjective interaction, characteristics of health education that are equally indispensable to exercising the expanded clinic.

The set of changes for basic healthcare, drafted in the name of purported improvements in efficiency and efficacy in the application of resources and in case-resolution capacity, proved to be determined by financial rationality, which turns health into a commodity, adjustable to the private sector’s interests. The reconfiguration of the SUS is expanded, backed by the logic of universal coverage, which reinforces the idea of a health system that is less and less unified or single, in which more agents can participate indistinctly, whether public or private. Far from understanding health as a universal right, this quickly exacerbates the break with the Constitutional commitment to health as a duty of the State.

The accelerated conversion of basic healthcare to mercantile and privatizing interests in the SUS requires changes in the modalities of public resource allocation, the establishment of new possibilities for relations between the State and private companies, and adaptation of the model of care to the characteristics of private administration. The Federal Government has worked actively to produce provisions with formal backing and a legal basis for this operation. We identify in the PNAB 2017 the underlying framework for this process that materialized progressively with a set of measures produced from 2019 to early 2020.

The adherence to an individualizing orientation as the model of care and the work process plays an important role in the transition from a public basic healthcare to a privatized basic healthcare. The individualizing focus is mediated by strategies that weaken structural lines in the ESF: the territory perspective, multidisciplinary, community-based work, and comprehensive care. Such strategies consist of the composition of teams without community health agents, reinforcement of the idea of basic healthcare teams consisting mainly of physicians, nurses, and dentists, the debilitation of the

multi-professional perspective, and weakening of the community focus. Combined with the narrow definition of the clinic orienting the list of services in the CaSAPS, these changes consolidate the central position of the biomedical model, more consistent with the private sector's health practices.

Financing has the power to induce strategic changes, by the allocation, restriction, or withdrawal of funds. In *Previne Brasil*, the individualizing logic is driven by the elimination of the fixed PAB and the adoption of capitation based on enrolled persons and payment for performance, centered on a few clinical aspects. The universalization project thereby loses an important vector, based on solidarity and the Federal Government's redistributive role, while the horizon of comprehensiveness retreats even further. The privatization project gains, with capitation per enrolled person, plus the list of services determined in the CaSAPS, important instruments for pricing – conditions for payment of contracted-out services, especially hired from the private sector.

In parallel, the ADAPS was created as a privately incorporated organization with a broad range of powers to work in basic healthcare, including provision and hiring of services; training healthcare professionals; research; and the incorporation of technologies. Presented as an alternative to public administration, ADAPS lays bare the plans for privatization of basic healthcare.

This policy process was anchored in dialogue with the system managers' collegiate bodies, shifting the discussion away from the social control forums of the SUS and seeking legitimacy through supposedly participatory means, like the public consultation. This tool has been used frequently in the political setting as a means to gather opinions. Still, without providing accountability mechanisms on the opinions gathered, it hampers transparency and favors the selection and use of results that favor the political agenda of the managers that control it. It has also replaced direct and representative participation, jeopardizing the public debate and disguising the differences of positions.

Confronted with the limits placed on public policies by EC 95<sup>37</sup> and the harmful effects for the working class from the labor and social security counter-reforms, the arguments defending the need for (and positive results from) the package of measures do not take long to appear. Ripe with rhetoric, they are unable to hide from critical view the problems with the policy's direction and implementation.

The nature of the proposals and the way they are presented and justified evokes the image of the Trojan Horse, the Greek gift to the Trojans that contained and carried in the means for conquering the city. Gift-wrapped, the changes contained in such measures are presented as a means to solve the problems of local management autonomy, case-resolution capacity, access, efficiency, and efficacy in basic healthcare. Unwrapped, they reveal the potential to accelerate and deepen privatization and the renunciation of the SUS principles, which jointly determined the main battle front: the universal and equal right to health, promoted with equity, comprehensiveness of care, and the people's participation.



## Contributors

All the authors contributed to the study's conception, data analysis, and writing of the paper.

## Additional informations

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## Resumo

O ensaio analisa documentos produzidos pelo Ministério da Saúde entre 2019 e 2020 para a reorganização da atenção básica: a nova política de financiamento (Previne Brasil), a Agência de Desenvolvimento da Atenção Primária à Saúde (Lei nº 13.958), a Carteira de Serviços e normatizações complementares. Buscou-se compreender como as mudanças projetadas nas funções gestoras e no modelo de atenção à saúde contribuem para o fortalecimento da lógica mercantil na política pública. Tomamos como parâmetros de análise as atribuições gestoras e os princípios e diretrizes do Sistema Único de Saúde (SUS) e de uma atenção básica orientada pela determinação social do processo saúde/doença, a concepção ampliada de saúde, o cuidado territorializado, o enfoque comunitário e a coordenação do cuidado numa rede integrada. As mudanças na alocação dos recursos públicos, a instituição de novas possibilidades de relação entre o Estado e empresas privadas e a adequação do modelo de atenção às particularidades da gestão de mercado revelam o sentido privatizante dessas medidas. A política assume um enfoque individualizante no que tange ao modelo de atenção e financiamento, enfraquecendo a perspectiva do território, o trabalho comunitário, o cuidado integral e multidisciplinar. Acelera-se a reconfiguração do SUS no sentido de um sistema no qual agentes públicos ou privados podem participar, indiferenciadamente, aprofundando a ruptura com o compromisso constitucional da saúde como dever do Estado.

Gestão em Saúde; Política de Saúde; Estratégia Saúde da Família; Sistema Único de Saúde; Atenção Primária à Saúde

## Resumen

El ensayo analiza documentos producidos por el Ministerio de Salud entre 2019 y 2020 para la reorganización de la atención básica: la nueva política de financiación (Previne Brasil), la Agencia de Desarrollo de la Atención Primaria a la Salud (Ley nº 13.958), la Cartera de Servicios y normativas complementarias. Se buscó comprender de qué forma los cambios proyectados en las funciones gestoras y en el modelo de atención en salud contribuyen al fortalecimiento de la lógica mercantil en la política pública. Tomamos como parámetros de análisis las atribuciones gestoras y los principios y directrices del Sistema Único de Salud (SUS) y de una atención básica orientada por la determinación social del proceso salud/enfermedad, la concepción ampliada de salud, el cuidado territorializado, el enfoque comunitario y la coordinación del cuidado en una red integrada. Los cambios en la asignación de los recursos públicos, el establecimiento de nuevas posibilidades de relación entre el Estado y empresas privadas, así como la adecuación del modelo de atención a las particularidades de la gestión de mercado, revelan el sentido privatizador de estas medidas. La política asume un enfoque individualizador, en lo que atañe al modelo de atención y financiación, debilitando la perspectiva del territorio, el trabajo comunitario, el cuidado integral y multidisciplinario. Se acelera la reconfiguración del SUS como sistema en el que agentes públicos o privados pueden participar, indistintamente, profundizando la ruptura con el compromiso constitucional de la salud como deber de Estado.

Gestión en Salud; Política de Salud; Estrategia de Salud Familiar; Sistema Único de Salud; Atención Primaria de Salud

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