

Does Brazil's Decentralized System Improve Primary Care with the Family Health Program?

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Abstract:

The health sector in Brazil has undergone important changes, particularly with the development of the *Sistema Único de Saúde* or Unified Health System (SUS). Decentralization is an important principle of SUS and advances have been made in transferring responsibilities and resources to the local government units, known as *municípios*. The decentralized SUS system has fostered progress in several aspects and areas of healthcare system, especially with the implementation of the

Family Health Program (PSF). With the implementation and growth of the decentralized program, The Family Health Program (PSF) has resulted in substantial benefits to the healthcare system, but research shows it does not necessarily improve the primary care services delivered in Brazil.

Introduction

Brazil is the largest country in South America; it covers 8.5 million square kilometers which is nearly half of the South American continent. In 2010, Brazil had an estimated population of 190,732,694 with most of the population living in urban areas. Brazil is the world's fifth most populous country and functions as a federal republic with 26 states, a federal district and 5,563 municipalities. Brazil was once a colony of Portugal from the year 1500 onward and gained political independence in 1822 and became a republic in 1889. Brazil has undergone major political, economic, demographic and social changes in the past 40 years which shaped the healthcare system in the country.

Federative Republic of Brazil has made major changes to its healthcare system with the development of the *Sistema Único de Saúde* or Unified Health System (SUS). From 1964 to 1985 Brazil was ruled by military dictatorship. The health system during this time period of military rule was riddled with inequality in accessing healthcare services. The wealthy had much better healthcare than the poor; the unemployed had very limited access to care. A civil-society movement to restore democracy began in the 1970s, which led to the development of a major health reform movement. An economic recession in the early 1980s brought with it the downfall of the military dictatorship and a transition to democracy. After the downfall of the military dictatorship, the *Sistema Único de Saúde* was put into place when the 1988 Constitution was signed; recognizing health as a citizen's right and a duty of the state.

Background on Brazil's Healthcare System

The *Sistema Único de Saúde* was created to provide universal healthcare access to all of the citizens of the country of Brazil. The SUS aims to provide comprehensive, universal preventive; curative care through decentralized management and provision of health services; promote; community participation at all administrative levels. The *Sistema Único de Saúde* is composed of three parts: (1) services funded and provided by SUS itself; (2) private healthcare services, made up of for-profit and not-for-profit organizations and providers, from which the SUS and the private insurance system contract services; (3) a private insurance system, the Supplementary Health System which includes over 1,500 private insurers, and which supports the purchase of services by the insured from either SUS providers or private providers.

One of the primary purposes of the *Sistema Único de Saúde* was to decentralize health policy down to the state and municipality level where they are responsible for managing and providing primary care services. According to Merriam-Webster Dictionary, decentralization has two meanings which include the dispersion or distribution of functions and powers; secondly, the delegation of power from a central authority to regional and local authorities. The Brazilian health system's challenges include reforming its financial structure to ensure universality, equity, and long term sustainability; renegotiating public and private roles; reshaping the model of care to cater to Brazil's rapid demographic and epidemiological changes; lack of human resources,

especially doctors; assuring quality of care and the safety of patients. Brazil also has to overcome a political challenge of strengthened political support so that financing can be restructured and the roles of both the public and private sector can be redefined.

In 1996, Brazil implemented a decentralized primary care program called The Family Health Program (known as PSF). The Family Health Program is designed to provide accessible, comprehensive care for the whole person at the community level. PSF provides and coordinates care and health promotion in clinics, patients' homes and in the community. A Family Health Program team is made up of a Doctor, Nurse, Nurse Assistant and four to six community health workers/agents. Each team is assigned to a geographic area defined by 600-1,000 families. In 2008, Oral Health Workers became part of the Family Health Program teams.

Outcomes

The Family Health Program (PSF) grew rapidly since its implementation which means coverage from the program has also grown rapidly. The PSF is the world's largest community-based primary care program. In 1999, the Family Health Program had 4,114 teams to provide care. In 2010, Brazil had about 33,000 Family Health Program teams. About 70% of Brazil's population is covered by the Family Health Program (PSF). Despite the fact that the Family Health Program has grown rapidly since its implementation, it needs to expand coverage to all of Brazil's population to better improve primary care in the country.

With the implementation and expansion of the Family Health Program, there has been an increased access to health services in Brazil. Family Health Program participants are generally more likely to have a usual source of care because of more

professional healthcare teams at the community level. In 1998, 54.6% of Brazilians had seen a doctor at least once in the past year; this percentage increased to 62.8% in 2003 and increased again to 67.8% in 2008. Between 1998 and 2008, the number of Brazilians who had access to yearly dental care also expanded from 33% to 40%. The Family Health Program gives access to primary care services to a significant portion of Brazil's population but access to these teams calls for improvement.

With the implementation of the Family Health Program (PSF), there was been significant reductions in Infant Mortality Rates and Post-neonatal Infant Mortality Rates. Infant Mortality Rate is defined as the number of deaths under one year of age per 1,000 live births among the population occurring in a specified geographical area during the same given year of the given geographical area. From 1996 to 2004, the infant mortality rate decreased from 24.1 to 16.1 per 1000 live births. Post-neonatal Mortality Rates defined the number of babies who die between 29 and 365 days of life per 1,000 live births. Between 1998 and 2006, Post-neonatal mortality fell to nearly half of its initial value due to the expansion of the Family Health Program; due to the increased number of ambulatory care facilities per capita; improvements in clean water supply; and lower illiteracy rates. Post-neonatal mortality rate per 1,000 live births went from 14.24 in 1998 to 6.92 in 2006.

Other outcomes from *Sistema Único de Saúde* and the Family Health Program include the under-5 mortality rate, decreasing from 55 per 1,000 live births in 1990 to 19 per 1,000 live births in 2010. The average life expectancy has increased from 67 in 1990 to 73 in 2010; maternal mortality has decreased from 120 per 100,000 live births in 1990 to 56 per 100,000 in 2010.

Does Brazil's Decentralized System Improve Primary Care?

Brazil's decentralized system doesn't necessarily improve primary care in the country because it was never associated with worst performance. With the expansion of the Family Health Program, substantial health benefits have resulted in a somewhat better delivery of healthcare. Going forward, Brazil has to address the overwhelming need to improve healthcare in the country, and to identify problems in access to and quality of care. Brazil also has to address issues and problems to further improve primary care in the country. It has to address issues/problems such as reforming its financial structure to ensure universality, equity, and long term sustainability; renegotiating public and private roles; reshaping the model of care to cater to Brazil's rapid demographic and epidemiological changes; with lack of human resources, especially Doctors, to assure the quality of care and the safety of patients. Also, since the Family Health Program (PSF) covers about 70 percent of the population in Brazil, the program needs to expand to reach 100 percent of the population especially in rural areas which need primary care services. These actions have the potential not only to improve the health system's efficiency but also to improve the quality of people's lives.

Comparison of Healthcare in India & Finland

India: Healthcare is one of India's largest services sectors. Under the Constitution in India, health is a state subject; each state has its own healthcare delivery system in which both public and private operate. The challenges its healthcare system faces include the need to reduce mortality rates; improve physical infrastructure; the necessity to provide health insurance, ensure the availability of trained medical personnel;

etc. There has been a rise in both communicable and non-communicable diseases. In 1982, the National Health Policy started. Within the campaign, a three-tier system of self-governance was established and comprised 900 villages (*panchayats*). During the NH Policy, primary health care centers and their referring sub-centers were brought under the jurisdiction of villages in order to engage more closely with the community to identify and implement effective changes to respond to local health need. The National Rural Health Mission (NRHM), launched in 2005, is the first health program to improve the health system and the health status of the people. One of the areas NRHM sought to increase was decentralization and to achieve district management of health program.

India has varying levels of success with having a decentralized system. Kerala, India, has been an outlier with better health outcomes in a number of areas compared to most states in India. The following are some examples of the outcomes: lower infant mortality rate of 12 per 1,000 live births in Kerala vs. 40 per 1,000 live births in India; lower maternal mortality ratio of 66 per 100,000 live births in Kerala vs. 178 per 100,000 live births in India. These outcomes can be attributed to factors such as strong emphasis from the state government on public health and primary healthcare; health infrastructure; decentralized governance; financial planning; girls' education; community participation; willingness to improve systems in response to identified gaps.

Finland: In Finland, the organization of healthcare services have been considered a public responsibility; municipalities being responsible for providing basic medical services. During the 1980s and 1990s, state regulation gradually decreased. After 1993, changes in legislation, planning and financial incentives were introduced which

increased decentralization in the system. Legislation eventually brought three major changes: redesign of the state subsidy system; relaxation of the rules on service provision; decentralization of detailed planning. There are some structures in the Finnish healthcare system which are perceived as problematic: the level of decentralization; poor steering capacity in the system; relatively weak position of primary care; a lack of cooperation between primary and secondary care; dual financing. Finland's decentralized system does not work in its favor to the following reasons: municipalities appeared to be too small to provide sustainable quality services for local needs and achieve advantages of economies of scale which means efficiency is decreasing; inequality in access and utilization of services increased between municipalities and is related to decentralization of healthcare to small units; planning and development capacity and knowledge are scarce in local municipalities, especially regarding secondary levels of care; municipalities' power position over

hospitals is low, leading to transfer of human and economic resources from primary health services to specialized healthcare and from rural areas to urban regions.

Conclusion

Brazil has undergone major political, economic, demographic and social changes in the past 40 years which have shaped the healthcare system in the country. The healthcare in Brazil has undergone important changes, particularly with the development of the *Sistema Único de Saúde* (Unified Health System (SUS)) in 1988. Decentralization is an important principle of SUS and advances have been made in transferring responsibilities and resources to the *municípios* or at the community level in Brazil. With the implementation and growth of the decentralized primary care program, The Family Health Program (PSF) has resulted in substantial benefits, but doesn't necessarily improve the primary care in Brazil. Brazil has to address its major issues and problems to further improve primary care.