Original research

Pan American Journal of Public Health

National primary health care policy in Brazil: an analysis of the review process (2015–2017)*

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Suggested citation (original manuscript) Almeida ER, Sousa ANA, Brandão CC, Carvalho FFB, Tavares G, Silva KC. Política Nacional de Atenção Básica no Brasil: uma análise do processo de revisão (2015–2017). Rev Panam Salud Publica. 2018;42:e180. https://doi.org/10.26633/RPSP.2018.180

ABSTRACT

Objective. *To describe and discuss events associated with the latest review of the national primary health care (PHC) policy in Brazil (Política Nacional de Atenção Básica, PNAB) so as to highlight narratives that may contribute to future analyses focusing on the formulation, implementation, and assessment of this policy.*

Method. *Participant observation report of the PNAB review process, based on content and document analyses.*

Results. *The review process of PNAB, which took place between 2015 and 2017, was strongly marked by technical and political dispute between the Ministry of Health and authorities representing municipal and state health departments. The main changes introduced by the new version of PNAB are the financing of other PHC organizational models in addition to the Family Health Strategy; attribution of additional responsibilities to community health agents; introduction of a national set of core and extended PHC services and actions; and introduction of a manager role on PHC teams.*

Conclusions. *Implementation of the revised PNAB, which was the result of interfederation dispute, will depend on the convergence of interests towards PHC that is accessible and effective, strengthening the Unified Health System. This will require substantial societal engagement and leadership in the fight for the right to health in Brazil.*

Keywords Health policy; primary health care; Family Health Strategy; health evaluation; Brazil.

Since Alma-Ata, primary health care (PHC) has been understood as the delivery of essential primary care, based on appropriate, evidence-based, and socially acceptable technologies and methods. This care should be offered where people live and work, or as near as possible to those places. It should be universally available to individuals and families in the community, enabling them to fully participate in every phase of its delivery at an affordable cost to the community and country, in the spirit of self-reliance and self-determination (1, 2).

In developing countries, PHC was originally selective and focused on a few high-impact interventions aimed at combatting the most prevalent causes of infant mortality and certain infectious diseases (3). As time went by, comprehensive initiatives based on the

* Official English translation from the original Portuguese manuscript made by the Pan American Health Organization. In case of discrepancy, the original version (Portuguese) shall prevail.

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recommendations of the Declaration of Alma-Ata were introduced (4).

In the 1980s, changes in the demographic and epidemiological profile of the world population, coupled with economic contraction and higher health expenditure from the unfettered introduction of costly technologies, not to mention inefficient poor-quality services and changes in the role of the State, led to organizational reforms in the health systems of a number of countries in the Americas and the European Union (4, 5). These reforms were aimed at optimizing health expenditure and coordination among levels of care by strengthening PHC and improving quality and efficiency (5).

In South America, health system reform usually occurred in conjunction with democratization processes embedded in broader economic, social, legal/constitutional changes that established health as a basic human right to be guaranteed in public policies that emphasized social equity and participatory democracy. The biopsychosocial and intercultural health models underlying these reforms also implied greater emphasis on the family, the community, service delivery, intersectoral policies, and social participation (6).

In 2007, the Pan American Health Organization/World Health Organization (PAHO/WHO) laid the foundations for a movement to renew PHC in the Americas, stimulating discussions on the implementation of appropriate policies grounded in the principles and values defended in Alma-Ata and promoting new reforms to organize and strengthen PHC-based national health systems, including the Brazilian health system (4).

In Brazil, during the roll out of the Unified Health System (SUS), PHC practices, which came to be known as "basic care," were implemented as government policy. Primary care is the point of entry to the SUS and the first level of care in a hierarchical network organized by levels of increasing complexity. It is comprehensive and includes health promotion and protection; injury, risk, and disease prevention; and the diagnosis, treatment, and restoration of health (7). This concept is enshrined in Brazil's Federal Constitution of 1988 and the regulations governing the SUS.

The time line of PHC development in Brazil shows that the first primary care initiatives date back to the Carlos Chagas Reform, with the creation of rural prophylaxis stations in 1920 to fight endemic diseases and epidemics of the priority diseases of the era (8). Until the creation of the SUS in the 1980s, centralized health promotion models were the standard, with activities aimed at controlling major endemic diseases–models that were considered "poor medicine for the poor" and that involved a curative social welfare approach (9–11).

Since then, activities to organize primary care have been conducted throughout the country and have served as precursors for government action and programs established by the Brazilian government, inspired by the PHC models of countries such as Canada, Cuba, Sweden, and England. The early 1990s marked the introduction of the Community Health Agents Program (PACS) and the Family Health Program (PSF), which became the Family Health Strategy (ESF) in 2006 (12–15). These programs were the framework for a new national PHC initiative and part of a government strategy for restructuring the SUS system and model of care (16, 17). Table 1 presents the principal strategies, activities, and programs established during the consolidation of primary care in Brazil since the introduction of PACS and the ESF.

With the introduction and implementation of these activities, the government

TABLE 1. Principal strategies, activities, and programs established during the consolidation of primary care, Brazil, 1991–2017

Year	Strategies/activities/programs
1991	Creation of the Community Health Agents Program (PACS).
1994	Creation of the Family Health Program.
1998	Establishment of the Basic Health Care Package (*Piso da Atenção Básica* (PAB): amount of federal financial resources allocated for primary care activities in the municipalities, replacing payment for services delivered); creation of the Primary Care Information System.
1999	Publication of the National Food and Nutrition Policy.
2001	Inclusion of oral health in the Family Health Program.
2003	Family Health Expansion and Consolidation Project I; Creation of the *Bolsa Família* Program.
2004	Creation of the National Oral Health Policy.
2005	Introduction of self-evaluation to improve primary care accessibility and quality.
2006	Regulation of the professional category of community health agents; publication of the National Primary Health Care Policy, the National Integrative and Complementary Health Practices Policy, and the National Health Promotion Policy; Family Health Program becomes the Family Health Strategy.
2007	Creation of the School Health Program.
2008	Creation of Family Health Support Centers; inclusion of microscopists under the Family Health Strategy.
2009	Family Health Expansion and Consolidation Project II.
2010	Creation of the health teams for river families and the financing of primary care units for river communities.
2011	Reformulation of the National Primary Health Care Policy; creation of the National Program for the Improvement of Primary Care Accessibility and Quality, the Program for Upgrading of Primary Care Units, the Better at Home Program, the Health Academy Program, the Streetside Medical Clinic teams, the Brazil Telehealth Networks, and the Smiling Indigenous Brazil program; and the review of the National Food and Nutrition Policy.
2012	Creation of the Program to Upgrade the Skills of Primary Care Professionals.
2013	Creation of the *Mais Médicos* program and replacement of the Primary Care Information System with the e-SUS Primary Care Strategy.
2014	Publication of the National Policy on Comprehensive Health Care for Persons Deprived of Liberty; review of the National Health Promotion Policy.
2017	Reformulation and publication of the new National Primary Health Care Policy.

recognized the need for a national policy that not only grouped the different initiatives but overhauled many of them, with a view to setting priorities and optimizing public expenditure. In 2003, the Ministry of Health formed a working group that produced the National Basic Health Care Policy (PNAB), published in March 2006 (14, 18).

Even though many militant proponents of health sector reform joined the Ministry of Health's management staff (14, 19) in 2003, the political climate during the drafting of the PNAB was rather stormy, creating serious institutional insecurity. Much of this was caused by the ministerial reform introduced during the period (14) and the failure to implement some of the policy's structural activities, such as regulation of the professional category of community health worker (known by the Portuguese acronym ACS), which took place only in October of that year.

In an attempt to preserve the key role of family health teams and consolidate robust PHC, the PNAB was initially reviewed and amended in 2011. The new text retained the essence of the 2006 policy and introduced major innovations aimed at increasing the accessibility, coverage, and effectiveness of primary care, with emphasis on flexibility in the number of hours physicians worked and the introduction of new team arrangements and the National Program for the Improvement of Primary Care Accessibility and Quality (PMAQ-AB) (20). These activities have been a feature of the policy since then, in counterpoint to a national scenario of economic and political instability.

Since publication of the PNAB 2011, a series of programs and activities have been modified or introduced in primary care, among them the *Mais Médicos* program, activities and tools for consolidating the integration of teaching-service, and regulatory activities linked to the Brazil Telehealth Networks. A second PNAB review was launched in 2015 with a view to including these activities in the policy.

For more than 20 years, the social sciences have described the formulation and review of public policies as a cyclical process. According to Faria (21), in Western democracies in general and Latin America in particular, the 1990s were marked by efforts to strengthen the "evaluation function" in public administration with the implementation public policy evaluation systems, with the rationale of "modernizing" public administration through State reforms. Thus, understanding the policy implementation process can be important for improving government action (22, 23).

Based on the premise of evaluation as a component of health administration and in order to support decision-making in health systems, this article describes and discusses events linked with the review of the PNAB concluded in 2017. Our aim is to introduce narratives that can contribute to future studies on the formulation, implementation, and evaluation of this policy.

MATERIALS AND METHODS

This article describes the experience of a group of federal primary care managers who participated in the review of the PNAB during the period 2015–2017, accompanied by a documentary analysis. Information sources including documents and personal records of meetings, encounters, and workshops on the PNAB review process, as well as management reports and official technical and regulatory documents.

Triangulating sources and data, a content analysis was prepared (24). The authors first found materials to support the analysis, selecting them and obtaining a general impression of the subject. They then selected part of the material and grouped it in a manner similar to that described in the documents studied, using clippings and extracting the most important ideas to determine the topics.

By reading and re-reading the material considered important, they grouped the information by topic, creating three categories for analysis and discussion: the PNAB 2017 review process; the principal changes and innovations introduced in the PNAB; and interests and basic elements of the changes and innovations in the PNAB.

Despite the effort to critically analyze the systematized material, it is important to that the bulk of the conversations and involvement presented here is from the authors' personal accounts and records. It is also clear that this is just one of the possible ways of understanding the process and that there may be other points of view that may or may not coincide what those presented here. In other words, the authors embrace the Bourdieusian view (25) of the absence of neutrality in the scientific truth presented in this manuscript.

RESULTS AND DISCUSSION

PNAB 2017 review process: arena of debate

Since the publication of the first PNAB in 2006, significant progress has been made in expanding the population's access to primary health care, as seen in Figure 1. From 2007 to 2017, population coverage by family health teams rose from 48% to 64%; likewise, that of oral health teams, which rose from 29.9% to 41.2%. There was also a 25.3% increase in the number of ACS, which steadily grew, except in the last biennium, when it declined by 0.7%.

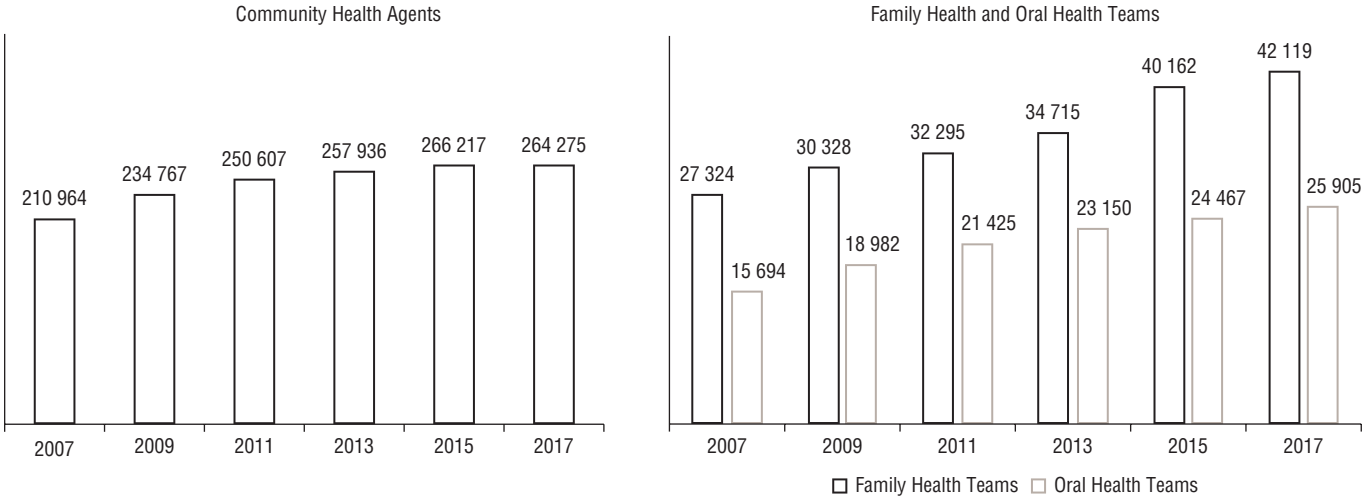
In addition, a series of programs and strategies were introduced to expand access to primary care and make it more comprehensive. Nevertheless, there remains the persistent challenge of the services' limited effectiveness (26, 27).

Faced with this scenario, municipal and state health administrators, through the National Council of Municipal Health Secretariats (CONASEMS) and the National Council of Health Secretaries (CONASS), expressed an interest in reviewing the most recent version of the PNAB; a major topic discussed was the expansion of federal financing for other organizational models of primary care and the possibility of changes in the composition of family health teams. Concomitantly, the report of the 15th National Health Conference of 2015 proposed that the PNAB review process be guaranteed in order to discuss the composition of family health teams and the number of hours professionals worked, along with the criteria for determining the population covered by each team.

In 2015, the Ministry of Health's Department of Primary Health Care (DAB) held a series of meetings, workshops, and forums attended by workers, managers, users, and researchers to obtain input aimed at developing strategies to strengthen primary care in the coming years and to amend the PNAB.

The initial objective of the review was to affirm the principles and strategic guidelines of the PNAB, giving priority to strengthening family health teams for the expansion and consolidation of primary care. A second objective was to

FIGURE 1. Number of community health agents, family health teams, and oral health teams, Brazil, 2007–2017



Source: Department of Primary Health Care, Ministry of Health, Brazil.

introduce changes aimed at increasing access to primary care and to make the services "friendlier" and more effective, while respecting cultural differences.

However, the review was interrupted by the political events that rocked the nation in 2015 and resulted in dramatic changes in the federal Executive Branch. The ministerial reforms introduced by the administration of President Dilma Rousseff led to a change in management at the Ministry of Health, with the ouster of Minister Arthur Chioro and his replacement by Deputy Marcelo Castro. Although the purpose of this change was to shore up the Rousseff administration politically, especially in the National Congress (28), the process culminated in the President's impeachment in August 2016 and the elevation of then Vice President of the Republic Michel Temer to the presidency.

It should be noted that during this time of political and institutional instability, ministerial decrees 958 and 959 of 10 May 2016 were published, authorizing the creation of family health teams without ACS, who could be replaced by nurse technicians. The publication of these decrees sparked outrage among the ACS, who mobilized for the abrogation of these regulations. At the same time, the decrees partially met the CONASEMS demand for changes in the composition of the teams and represented efforts by the federal Executive Branch to seek a wider base of support among federal entities.

Thereafter, significant changes were introduced in the government, including the naming of a new Minister of Health, Deputy Ricardo Barros, who brought in new political appointees, opening a window of opportunity for institutions like CONASEMS and CONASS that were urging the Ministry of Health to resume the PNAB review so that they could return to their main agendas areas of work, this time more incisively, and align them more closely with the new components of the ministerial agenda.

It should be noted that one of the first acts of the Ministry's new management in relation to primary care was the abrogation of administrative rules 958 and 959 on 9 June 2016 (decree GM/MS 1 132), in a conciliatory effort by the new administration to satisfy the organizations representing the ACS. This measure was also the result of an agreement with CONASEMS on the ministerial commitment to resume the PNAB review.

At the same time, there were fierce disputes in the legislative and judicial sphere. Two projects to benefit the ACS and the health workers who fight endemic diseases stand out: one on their duties and the other on an increase in the minimum wage. There was also a preliminary injunction prohibiting nurses from ordering tests in primary care, stemming from a motion filed by the Federal Board of Medicine. The decision by the municipal government of Rio de Janeiro to shut down primary care services dates back to this period, an action that was mistakenly attributed to the PNAB review process.

Motivated by political alignment among the senior officials of the agencies of the Tripartite Interagency Commission (CIT), the review process was given priority on the government agenda, even though there was no consensus among technical personnel about its time frame. This situation—both succinctly presented and complex—clearly created tension throughout the review process, since new issues were constantly emerging and important ones were forgotten in the disputes. Thus, the process was subject to changes in the organizational model established up to that point in the policy on primary health care, and projects parallel to those historically defended in public health were now on the negotiating table.

In short, in the alignment of forces, the CONASS and CONASEMS agendas enjoyed greater political backing among CIT decisionmakers than did those supported by DAB technical personnel, who sought to defend the principles and guidelines of primary care, advocating for the priority of family health teams, retention of the elements debated between 2011 and 2016, and a participatory and pluralistic review process that considered the expectations of SUS workers and users.

Despite this effort, throughout 2017 the process was conducted largely by managers of the three entities, an action that was questioned even by the National Health Council. In response, the CIT proposed a public consultation. For 15 days, 8,901 proposals for changes to

the text under consideration were received and some were incorporated. On 31 August 2017, the CIT reached agreement on the final text.

It should be noted that throughout the process in 2017, the PNAB review was questioned by social movements, researchers, and SUS workers. Their concerns ranged from questioning the rationale for a review at a time of political, economic, and social instability to criticism of the proposals under consideration (29, 30). Nonetheless, the review was completed, with the publication of decree No. 2 436 of 21 September 2017, republished seven days later in Annex XXII of consolidation decree No. 02 (7).

PNAB 2017: principal changes and innovations

Table 2 presents a summary of the principal changes and innovations introduced in the PNAB in 2017. The new PNAB published in 2017 financially recognized primary care organizational models other than the family health team. The family health team retains its priority for the expansion and consolidation of primary care in Brazil, with lower amounts of financing allocated for the new primary care teams (eAB). Nevertheless, some studies have expressed concern that this measure could lead to a weakening of the primary care organizational model and the probable loss of resources for other models in a context marked by the contraction of health financing (30).

Even though under the PNAB 2017, eABs should be governed by the same principles and guidelines as family health teams and should be temporary, one criticism has been that they are not required to include ACS. This criticism is

TABLE 2. Comparison between PNAB 2011 and PNAB 2017 by topic, Brazil, 2018[a]

Topic	PNAB 2011	PNAB 2017
Financing of primary care organizational models	Only family health teams were financed with federal resources.	- Maintains financing of the family health teams as a priority and finances eAB in lesser amounts.
ACS/ACE	- Family health teams must have ACS (1 for every 750 people; maximum of 12 per team). - Definition of eight functions for ACS. - ACS work coordinated only by the nurse. - ACE not included in the family health/eAB team.	- Family health teams must have ACS in numbers that depend on the local need and epidemiological profile. In vulnerable areas, one ACS for a maximum of 750 people, covering 100% of the population, without a limit per team; optional in eAB. - Includes the functions of the ACE and adds 11 common functions for ACS and ACE; - Upgrades and increases the functions of ACS to 12; - Coordination of ACS work becomes the responsibility of the entire team (senior level).
Integration between primary care and health surveillance	Not mentioned.	Introduced in health service management and organization as a responsibility of the entities and all professionals.
Expanded Family Health and Primary Care Hubs	Called Family Health Support Hubs (NASF) and can act in conjunction with family health teams, including those of riverside, river, and Street Medical Clinics.	- Name changed to Expanded Family Health and Primary Care Hubs (NASF-AB), now supporting eAB as well as the family health teams.
Primary care manager	Not mentioned.	- Recognizes the position of UBS managers, recommending their inclusion as a new member of the team, with federal financial support. - Manager should be more senior staff, preferably from the area of health.
Composition of the teams	- Family health team: physician, nurse, nurse technician/assistant, and ACS. - As a complement, oral health team and NASF. - No definitions for eAB.	- ACE can be part of the family health team. - eAB should retain the parameters of the family health team and are authorized to be part of the ACS and ACE.
Supply of essential and expanded national eAB services and actions	None.	- Included in the effort to guarantee essential services in PHC for the entire population and more effective PHC.
Territorialization/linkage	Users could be linked to only one UBS.	- Managers are empowered to link users to more than one UBS.
Patient safety	Not mentioned.	- Included as the responsibility of all team members.
Regulation	Superficially and vaguely addressed.	- Professionals are expected to contribute to the regulation of access through PHC; - Brazil's Telehealth Networks and protocols are established as tools to support regulation.
Support points	Not mentioned.	- Recognized as a PHC structure for the delivery of care to scattered populations, adhering to general health safety standards.
Weekly team work load (hours)	- Family health teams = 40h. - Five types of family health team with different numbers of hours worked.	- Family health teams: 40h for all team members. - eAB: 40h per professional category (maximum of three professionals and minimum of 10h per category).
Population coverage per team	- 3,000-4,000 people per team.	- 2,000-3,500 people, with parameters based on territorial risks and vulnerabilities.
Continuing health education and training	- Found throughout the text but did not address health education and the physical structure for this activity.	- Included in the teams' work process, with an adequate physical structure and setting for it. - Includes health education, highlighting the role of PHC as a locus of training, research, and outreach.
Deadline for implementation	Not mentioned.	By decree, it establishes 4 months for the establishment of certified teams.

[a] AB = Primary care; ACE = agent to combat endemic diseases; ACS = community health agent; eAB = primary care team; NASF = Family Health Support Centers; NASF–AB = Expanded Family Health and Primary Care Hub; PNAB = National Primary Health Care Policy; UBS = Primary Care Unit.

compelling, given the key role of ACS in community mobilization and orientation, as well as in understanding and territorial outreach (31).

Still, the new PNAB expands the functions of the ACS under Law 13 595/2018, the amended version of law 11 350/2006 regulating the work of these agents. This innovation, however, has been called into question by public health organizations and considered to undermine the role of ACS by prioritizing activities of a clinical nature (30). Although is a valid point, it is important to consider that the expansion of ACS functions is the agenda of the category itself and was debated in the National Congress (see bill 6 437/2016). Thus, any analysis of the agenda requires a more in-depth study and recognition of the members and agents who promoted it.

The PNAB 2017 also recognizes the role of managers in primary care, recommending that they be part of the team, depending on local needs, and even be financed with federal funding. Various studies (32, 33) have noted the importance of including managers in primary care teams. Official data from the Ministry of Health show that hundreds of managers are working in different locations throughout the country.

Concerning the national supply of essential and expanded primary care services and activities, recognized during the PNAB review process as the "service portfolio," it should be noted that the adoption of the agenda was based on information obtained in the two first cycles of the PMAQ-AB, which showed that a high proportion of health teams did not offer services considered essential and typical of primary care.

Notwithstanding the fact that countless municipalities have already implemented their service portfolio and that some studies (34, 35) confirm that the definition of these portfolios helps to reduce inequities in the supply of primary care activities and services, other studies (29, 30) criticize the innovation, considering it a betrayal of the principle of comprehensiveness that will lead to arrangements focused on minimal care and revive the concept of selective PHC.

FINAL CONSIDERATIONS

The launch of the PNAB 2017 review was participatory in nature, reconciling the demands of tripartite management with the manifest need of the social control entities. Because the process was stepped up at an unstable political moment, technical support for the discussions substantially undermined, despite low-profile but significant victories in the disputes between technical experts and political-corporate interests.

At the conclusion of the process, a policy forged in the debate on interfederal management was published in which stakeholder interests prevailed, while some technically justifiable innovations were included only half-heartedly and superficially. This should result in greater attention to current proposals and be considered in future studies on the implementation of the current PNAB.

Added to this is the fact that Brazil's political and economic situation poses a real challenge to operationalization of the new policy. Implementing the guidelines in the text depends on a major infusion of federal funds; however, far from an expansion of public investment in health, it is actually being restricted (see constitutional amendment 95/2016, the new SUS funding proposal – unification of funding blocks – and the increase in primary care expenditures with the launch of the Program for the Automation of Primary Care Units and the Technical Training Program for Health Workers). However, these programs may not be urgent in the current phase of PHC in Brazil, and their design does not appear to be ideal. Furthermore, consideration should also be given to the imminent ratification of the constitutional amendment to raise the minimum wage of ACS and ACEs.

Finally, it should be emphasized that PNAB implementation will not depend exclusively on the text, but on the tangled corporate, political, and economic interests that heavily influenced the discussion and reformulation of the policy throughout the process. The expectation is that these interests may come together to create accessible and effective PHC, strengthening the SUS as a whole. Whether this expectation becomes a reality, however, will depend heavily on the participation and leadership of society in the fight for the right to health in Brazil.

Acknowledgements. The authors would like to thank the technical staff of the Department of Primary Health Care/ Ministry of Health who were involved in the review of the National Primary Health Care Policy.

Conflicts of interest. The authors declare the existence of a conflict of interest, since they are technical staff of the Department of Primary Health Care/ Ministry of Health, Brazil and participants in the review of the National Primary Health Care Policy.

Disclaimer. Authors hold sole responsibility for the views expressed in the manuscript, which may not necessarily reflect the opinion or policy of the RPSP/ PAJPH or the Pan American Health Organization.

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Manuscript received (original Portuguese version) on 14 January 2018. Revised version accepted for publication on 7 September 2018.

RESUMEN

Política Nacional de Atención Básica en Brasil: un análisis del proceso de revisión (2015-2017)

Objetivo. Presentar y discutir los acontecimientos relacionados con el proceso de revisión de la Política Nacional de Atención Básica (PNAB) en Brasil, de manera deobtener información que pueda contribuir a futuros análisis sobre la formulación, implementación y evaluación de esa política.
Métodos. Se evaluó el relato de la experiencia de los participantes del proceso de revisión de la PNAB a partir del análisis de contenido, complementado por un análisis documental.
Resultados. El proceso de revisión de la PNAB, que tuvo lugar entre 2015 y 2017, presentó marcadas disputas técnico-políticas entre el Ministerio de Salud y las instancias representativas de las secretarías municipales y estatales de salud. Los principales cambios introducidos por la nueva versión de la PNAB son la posibilidad de financiamiento de otros modelos de organización de la atención básica además de la Estrategia Salud de la Familia, la ampliación de las atribuciones de los agentes comunitarios de salud, la construcción de la oferta nacional de servicios y acciones esenciales y ampliadas de atención básica, y la inclusión del gerente de atención básica en los equipos.
Conclusiones. La implementación de la nueva PNAB, fruto de las disputas entabladas en el campo de la gestión interfederativa, dependerá de la confluencia de intereseshacia la efectivización de una atención primaria accesible y resolutiva, fortaleciendoel Sistema Único de Salud, lo que requiere la participación y el protagonismo de lasociedad en la lucha por el derecho a la salud en Brasil.

Palabras clave Política de salud; atención primaria de salud; Estrategia de Salud Familiar; evaluación en salud; Brasil.

RESUMO

Política Nacional de Atenção Básica no Brasil: uma análise do processo de revisão (2015-2017)

Objetivo. Apresentar e discutir acontecimentos relacionados ao processo de revisão da Política Nacional de Atenção Básica (PNAB) no Brasil, de modo a evidenciar narrativas que possam contribuir para análises futuras sobre a formulação, implementação e avaliação dessa Política.
Métodos. Trata-se de relato de experiência de participantes do processo de revisão da PNAB, a partir da análise de conteúdo complementada por análise documental.
Resultados. O processo de revisão da PNAB, ocorrido entre 2015 e 2017, foi fortemente marcado por disputas técnico-políticas entre o Ministério da Saúde e as instâncias representativas de secretarias municipais e estaduais de saúde. As principais mudanças introduzidas pela nova versão da PNAB são a possibilidade de financiamento de outros modelos de organização da atenção básica além da Estratégia Saúde da Família; a ampliação das atribuições dos agentes comunitários de saúde; a construção da oferta nacional de serviços e ações essenciais e ampliadas da atenção básica; e a inclusão do gerente de atenção básica nas equipes.
Conclusões. A implementação da nova PNAB, fruto de disputas travadas no campo da gestão interfederativa, dependerá da confluência de interesses no sentido da efetivação de uma atenção primária acessível e resolutiva, fortalecendo o Sistema Único de Saúde, o que requer substancialmente a participação e o protagonismo da sociedade na luta pelo direito à saúde no Brasil.

Palavras-chave Política de saúde; atenção primária à saúde; Estratégia Saúde da Família; avaliação em saúde; Brasil.