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ESSAY

Institutionalizing the evaluation and monitoring of Primary Health Care in the SUS: contributions to a strategic research agenda

Institucionalização da avaliação e monitoramento da Atenção Primária à Saúde no SUS: contribuições para uma agenda estratégica de pesquisa

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(Em nome da Rede de Pesquisa em Atenção Primária à Saúde – Rede APS da Associação Brasileira de Saúde Coletiva – Abrasco)

DOI: 10.1590/2358-28982024E29249I

ABSTRACT Primary Health Care (PHC) is the base of the Unified Health System (SUS). Strengthening it requires constant evaluation of its processes and outcomes. The PHC Research Network (Rede APS) is promoting an intense debate on strengthening the PHC model, which is territorialized, community-based, and organizes the Health Care Network in the SUS. This essay aims to present a history of initiatives to monitor and evaluate Brazilian PHC and to propose a research agenda involved in consolidating the SUS and strengthening the Family Health Strategy (ESF). It is the result of a critical reflection on the production of knowledge on PHC in Brazil, the fruit of a debate on the political and strategic agenda of the PHC Network with the participation of sectoral actors. The agenda is structured around eight central axes, considering the PHC model to be integrated into care networks, management and financing, work management, digital health, infrastructure, comprehensive health care, and monitoring and evaluation. The PHC Research Network advocates universal coverage by a qualified ESF and the construction of a National Monitoring and Evaluation Policy to guide PHC management and care in the SUS.

KEYWORDS Primary Health Care. Research. Unified Health System. Brazil.

RESUMO *A Atenção Primária à Saúde (APS) é a base do Sistema Único de Saúde (SUS). Fortalecê-la exige permanente avaliação de seus processos e resultados. A Rede de Pesquisa em APS (Rede APS) promove intenso debate sobre o fortalecimento do modelo de APS de base territorial, comunitária e ordenadora da Rede de Atenção à Saúde no SUS. Este ensaio tem o objetivo de apresentar um histórico das iniciativas de monitoramento e avaliação da APS brasileira e a proposição de uma agenda de pesquisa implicada com a consolidação do SUS e o fortalecimento da Estratégia Saúde da Família (ESF). É resultante da reflexão crítica acerca da produção de conhecimento sobre APS no Brasil, fruto do debate em torno da agenda política e estratégica da Rede APS com participação de atores setoriais. A agenda está estruturada em oito eixos centrais, considerando o modelo de APS a ser integrado às redes de atenção, gestão e financiamento, gestão do trabalho, saúde digital, infraestrutura, atenção integral à saúde, e monitoramento e avaliação. A Rede APS defende a universalização da cobertura por uma ESF qualificada e a construção de uma Política Nacional de Monitoramento e Avaliação para orientar a gestão e o cuidado da APS no SUS.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Pesquisa. Sistema Único de Saúde. Brasil.*

Introduction

The universality of the right to comprehensive and longitudinal health care requires the creation of national health systems, structured by means of Health Care Networks (RAS) and organized by Primary Health Care (PHC), which should guide the patient's path through the system[1]. Since its creation, the Unified Health System (SUS) has made remarkable progress in PHC coverage, quality, and results, as well as in RAS organization[1,2]. Nevertheless, important bottlenecks remain. They are related to SUS underfunding, to the scarce public supply of services in regional RAS, and to the insufficiency of professionals trained and appraised to PHC community-oriented work that joins the clinical quality of individual care to a collective approach.

PHC work requires a multiprofessional team of generalist practice that performs individual and collective actions with citizens and service users residing in a given territory geographically defined upon sociocultural criteria, such as historical aspects of neighborhood characteristics, existence of community, sports, political or recreational associations, and use of those and other equipment and services by the population.

PHC in Brazil has the Family Health Strategy (ESF) as a priority care model, and is widespread throughout the country. The ESF, although unable to fully coordinate care and offer comprehensive coverage, is moving towards a model of vigilant care for the health of the person and the community[3].

Providing SUS'PHC improvement of access and quality requires the organizational permanence of a national evaluation and monitoring policy. Throughout the twentieth century, health evaluation developed significantly, providing essential concepts and tools to assist in the process of planning and implementing health programs and services, analyzing their results as for effectiveness, efficiency, and equity. Despite relevant problems persist against the permanence of those SUS processes, it is unthinkable to build a SUS of quality for the population without strong investments in evaluation that provide managers, professionals and social control of adequate information so to guide the course of health policies[4,5].

In this context, the recording, transmission and use of health information are of fundamental importance for the coordination of care, local planning and network planning, in addition to allowing the monitoring of indicators and easing the processes of health monitoring and evaluation.

ESF benefited from the use of health information since the implementation of the Primary Care Information System (SIAB) in 1998 until the implementation of the Program for the Improvement of Access and Quality of Primary Care (PMAQ-AB)[6]. Despite that, a series of difficulties appeared in recent years concerning its monitoring and evaluation, such as financial discouragement, the end of PMAQ-AB and, more recently, the centralization of information around the seven indicators of Previne Brasil[7].

Overcoming inequalities in universal access and provision of a problem-solving and quality PHC also depends on the creation of monitoring processes and evaluation surveys. It is also necessary to evaluate PHC actions as to identify care gaps, to know the population groups facing access difficulties, to 'hidden' or 'neglected' populations, and to understand the reasons for those shortages and their relation with other levels of care.

The current challenge, therefore, is not only to monitor and evaluate health policies, but also, above all, to legitimate evaluation and make it a permanent process, aligned with SUS constitutional principles of universality, integrality and social participation, along with sufficient funding to adequately meet the population needs. This requires cultural, social and political response as to critically address various perspectives and existences in a country of continental dimension and profoundly unequal such as Brazil.

In addition, PHC evaluation studies can be important inducers of improvements in care quality, as shown in studies resulting from the three cycles of PMAQ-AB[2,4].

Thus, the objective of this article is, based on a brief history of PHC evaluation and monitoring initiatives under SUS, to introduce a Strategic Agenda for PHC Research prepared by the PHC Research Network (PHC Network) of the Brazilian Association of Collective Health (ABRASCO), so to inform the debate on the legitimacy of a national policy for PHC assessment and monitoring and PHC research funding.

The proposed research agenda was outlined upon PHC main challenges, showing the capability of the research role in the production of knowledge to subsidize decision-making for care with equity improvement. It was created by means of a recurrent process based on critical analyses of the national PHC policy and debates among PHC groups of researchers and entities representing professionals who make up the management committee of PHC Network. They include the Brazilian Association of Family and Community Nursing (ABEFACO), Brazilian Nursing Association (ABEn), Brazilian Society of Family and Community Medicine (SBMFC), Brazilian Association of Medical Schools (ABEM), Brazilian Association of Dental Education (ABENO), Brazilian Association of Collective Oral Health (ABRASBUCO), National Confederation of Community Health Agents and Endemic Diseases Control Agents (CONACS), and the National Health Council (CNS) representatives.

Background

SUS is the largest universal health system in the world; so, to talk about PHC in Brazil is to talk about 5,570 municipalities responsible for granting access to PHC services and for integrating themselves into regional RAS to ensure timely access, each municipality holding its own internal inequalities while remaining within its state and macro-region. Macinko et al.[8] draw attention to the sociodemographic conditions and the evolution of investments in health since the 1988 Constitution, when the right to health was defined for the implementation of the public, free and universal SUS, being its fiscal financing and co-participation a responsibility originated in the three levels of government. That design provided the system with a decentralized dimension and great responsibility at the local level to install and maintain primary comprehensive care services articulated with a care network. The authors underline the accelerated pace at which the process occurred and the priority given to ESF by means of a multiprofessional composition of teams and community approach.

Brazilian PHC is internationally recognized for its broadening and qualification since its origin, even if chronic underfunding be recognized, and aggravated by neoliberal-inspired governments. Throughout family health history, many experience reports and studies focused on the most varied local issues and more methodologically refined analyses have addressed to the contribution of family health in improving access, to reducing hospitalizations for Primary Care Responsive Conditions[8], to reducing health ethnic-racial and social inequities[9], to increasing elderly survival[10], among others[11]. Concomitantly, nationwide policies sought not only to evaluate but also to induce improvement in PHC quality standards[2,4].

PHC evaluation in Brazil follows the path of the very SUS creation and has gradually reached greater complexity and national and international prominence, both in academic publications and in its influence on health policies. Even facing setbacks, such as the dismantling of evaluation experiences caused by the Bolsonaro government, which abandoned the PMAQ-AB and created the Previne Brasil, there is a growing appraisal body producing a rich reflection on PHC national experience. In addition, the monitoring of FHS indicators

is remarkable, at least since 1998, by means of SIAB creation, which allowed some level of information monitoring generated by Family Health teams (eSF) in their daily work[6]. SIAB was improved in 1999 and 2002 and followed by other experiences, such as the one related to the Pact for Health and, currently, by the Health Information System for Primary Care (SISAB) and by SUS electronic medical record (e-SUS)[12].

In 2011, the National Policy of Primary Care (PNAB) defined PHC as

> [...] responsible for the coordination of care by means of the elaboration, monitoring and management of unique therapeutic projects and the monitoring and organization of the user flows between points of attention[13].

That makes PHC one of the most complex SUS health policies, also in terms of the structure of services and work processes as in relation to the challenges for the management regarding its financing and articulation in the care networks. A policy of this nature has gone through numerous assessing processes, ranging from modest normative initiatives to evaluate the structure and process of a local nature to evaluation research aimed at analyzing PHC impact on the health of the Brazilian population[6], placing Brazil among the countries that provide the highest qualified PHC scientific production throughout the world[14].

Federal initiatives for global evaluation and improvement of the Brazilian PHC quality to be noted: the Baseline Studies of the Family Health Broadening and Consolidation Project (ELB/PROESF) started in 2005; the ESF Quality Improvement Assessment (AMQ) started in 2005; and the PMAQ-AB, carried out in three cycles between 2011 and 2018. In a clear estrangement from PMAQ-AB and its cycles, the recent political conjuncture of a far–right government (2019-22) created the Previne Brasil Program in 2019, limiting the evaluation to a set of seven indicators never fully implemented. Thus, the process of legitimating complex SUS'PHC assessment is broken.

Recently, the introduction of the Primary Care Assessment Tool (PCATool) on a national basis in the design of the 2019 National Health Survey to approach access to services based on the perception of users[6] is also noteworthy.

The history of those evaluation experiments is not a straight line to progress. There are learnings, conflicts, achievements and setbacks still lacking a systematic accountability. In summary, some issues driven by the implementation of those policies can be glimpsed.

PROESF addressed municipalities of more than 100 thousand inhabitants, intensifying the implementation of normative evaluation on a national scale. Normative evaluations, although restricted in their explanatory potential, allow the actors involved to identify relevant advances and gaps in the structure and processes to be accounted for by management. That way of evaluating ESF, to some extent, is found in AMQ and PMAQ-AB experiences, whose evaluation instruments also bring some degree of explicitness about what PHC is doing locally.

Those processes proposed methodologies for discussing the evaluation requirements necessary to analyze the actions of professionals and managers, working as a modality of permanent education, and enabling immediate changes in the short and medium terms that would impact on the improvement of care offered to the population. Concomitantly, that process of continuing education provided by AMQ and PMAQ-AB, connected to cyclical evaluation strategies by entities outside the municipality, would have the potential to generate a permanent and legitimated movement toward quality improvement. The municipality's adherence to PMAQ-AB was voluntary as was the choice of the number and selection of teams that would participate in the external evaluation research carried out by universities. If convenience sampling generated fair criticism, it seems to have contributed to the collaboration of the respondents, and the

criticism was dissipated due to the growing adherence of municipalities and teams, in addition to the consistency of the results among the studies throughout the cycles of the Program[2,4].

PMAQ-AB aggregated fund-to-fund transfers grounded on performance metrics of municipalities, services and health teams. Municipalities applied those resources heterogeneously. However, the modality of intergovernmental financial transfers inspired by performance-based payment models, added an element to PHC evaluation policy not applied in previous experiences.

A relevant aspect regarding PMAQ-AB legitimating design was the involvement of universities in the external evaluation process, contributing to the creation of a broad group of actors debating and participating in PHC evaluation. Thus, the results of the external evaluation could be widely analyzed by multiple approaches, providing consistent information to guide national policies.

PHC Network was created upon those evaluation processes that included other national researches. In addition, it brought together research groups, gradually associating to its management committee entities representing PHC professionals. It also fostered the participation of research groups from public universities in the external evaluation processes, adding legitimacy to the processes, as advocate the use of AMQ instruments as a stage of PMAQ-AB self-evaluation. Besides, it provided the analysis and dissemination of results by arranging special supplements of journals and biweekly bulletins.

Previne Brasil, on the other hand, focused on a normative evaluation of seven health indicators related to the team work process, linking that evaluation to a payment for performance, which was not fully implemented. In addition, Previne Brasil proposed to following up the resident population by means of 'active record' in the last two years, which violates the universality principle due to centralizing intergovernmental financial transfers on the number of recorded users to finance the system without ensuring universal coverage[6].

What for and why to evaluate PHC?

In the case of public policies, evaluation is an action of citizenship and social control over the fulfillment of the State's obligations. It provides information on the scope, strengths and weaknesses of decisions made and actions undertaken. Thus, the monitoring of indicators and PHC evaluation studies in SUS should emphasize compliance with SUS principles and guidelines, in addition to PHC principles and attributes. Thus, the action of evaluating cannot be restricted to measures; it must induce changes, generating "institutional and professional improvement"[5(554)].

PHC Network, formally constituted in 2009, has since its inception boosted the production of knowledge in health evaluation, especially as for PHC, by means of the deepening of theoretical, methodological and technical elements linked to political analyses associated to contextual, political, socioeconomic, cultural and ideological factors. Regarding health practices, additional effort aimed at explaining the technical procedures for collecting, processing, analyzing and interpreting data derived from research and evaluation experiences of policies, programs, services and technologies developed by teaching and research institutions linked to PHC Network; has allowed for critical review and articulation between theoretical and empirical dimensions in the research carried out. Such initiatives seek to unveil the various characteristics of the same intervention and its results, in various places and territories, and to technically suggest fair and reasonable distribution of resources following the population health needs[15,16].

The thinking raised therein broadened inter-institutional relations and contributed to the improvement and consolidation of

some themes, including PHC monitoring and evaluation policy, as the technical quality of the patient health care, seeking to optimize comprehensive health care practices. PMAQ-AB itself enjoyed PHC Network support in the theoretical and technical formulation, favoring the nearness of universities, management and service, which allows for the creation of a replicable model for monitoring and evaluating actions[2,4]. Thus, for example, information was transmitted as to the impact of the policy and performance of the health system; and as to monitoring and evaluation of personnel training actions within PHC scope, mainly the Mais Médicos Program.

The evaluation process of ministerial initiatives has impacted a dynamic of relations among researchers and a growing trend of interest of research groups following lines of research related to health evaluation, importantly unfolding the development of consultancies and the process of valuing, investing in and advancing research funded by development agencies.

PHC Network, in collaboration and partnerships, strengthened the monitoring and dissemination of research results, contributing to the understanding of the various scenarios of PHC policies, making visible the need of developing broader and more relevant projects for the monitoring of priority interventions and programs with repercussions at different levels – national, state and municipal – in facing difficulties for the policy development throughout the national territory and for the identification of the PHC model potentiality and improvement.

In terms of conjunctural changes, several scientific or technical publications, by means of the formulation of critical positions, PHC strategic political agendas within SUS, periodic newsletters and quarterly editions of 'PHC in Review', organized in a continuous and systematic way, appraised the political debate on the design of intervention proposals. The initiatives contributed from the conceptual and practical point of view, and, at that time of public health policies reconstruction in Brazil, health awareness of the subjects and thinking can subsidize evaluation actions that raise necessary propositions by means of operational support from universities or research centers, given the need to resume public notices to develop research.

The urgency of constructive health awareness is reinforced for the guidance of evaluation practices and ways of rethinking health evaluation in the country due to the engagement of researchers, users, health professionals and managers from all regions of Brazil and various different segments of SUS. So, it is important to consider not only the theoretical rationality exposed in texts on the subject but also the capacity of PHC Network as a collective subject, aiming at the redefinition of parameters and the construction of new proposals for policy evaluation in the rebuilding of health practices with the participation of the various actors and the joint with SUS management bodies – and, primarily, to strengthen a comprehensive, strong and problem-solving PHC.

PHC strategic research agenda: what is the role of research in the process of rebuilding Primary Health Care in Brazil?

Over the last three years, PHC Network has provided an intense debate on the strengthening of a PHC model of territorial and community–based ground, and RAS guidance. The debate was systematized in documents available on PHC Network website:

- Grounds for comprehensive, problem–solving, territorial, and community-based Primary Health Care under SUS: critical

aspects and propositions[15], 2022;

• 14 technical notes dealing with PHC various aspects, resulting in studies and recommendations, 2021/2022;

• Manifesto of PHC Network at the Free, Democratic and Popular Conference[16], 2022; and

• An alternative for overcoming Previne Brasil Program: Proposals for the allocation of federal resources for PHC, a document prepared by the Brazilian Association of Health Economics[17] involving PHC Network researches and other health entities, 2023.

That fundament of PHC policy analysis guided the proposition of a compromised research agenda, supported by the ethical–political commitment as to the consolidation of SUS, and ESF strengthening of a PHC structuring model. It is of central importance for improving the population health and reducing unjust social inequalities, deepened by the advances of neoliberal policies in the last six years of far–right governments in Brazil.

The agenda was organized into eight axes, each composed of a set of priority research themes. The axes were organized as per the crucial aspects of a comprehensive, problem-solving, territorial-based and community-oriented PHC implementation integrated to RAS, identified from the critical impact on studies carried out in the country, allowing for the identification of current challenges and knowledge gaps that comprised research objectives.

In a way to contextualize the axes of the agenda and the research proposals, some of the main PHC challenges will be briefly introduced, reinforcing the role of research in the production of knowledge capable of subsidizing the decision-making of managers, professionals, users and community organizations in the implementation of policies for PHC reconstruction and strengthening in Brazil. For each axis, the respective research proposals are organized in tables.

Axis I: Population, territory, social participation and equity

The population is the center of RAS. Thus, as for PHC, it is essential to think about the population in its territorial dimension and as a subject of the health-disease and care processes. Three major challenges of this axis are: universalization of FHS coverage; strengthening of PHC community and territorial dimension; and guarantee of subjects' social participation and emancipation.

The first challenge refers to the universalization of PHC population coverage by means of ESF and overcoming inequities in the distribution of primary services in the national territory. In 2019, 70% of the population and above was covered by eSF throughout 85% of Brazilian municipalities, although large disparities still persist. High coverage, in general, was only achieved by smaller municipalities. Only 30% of the municipalities resided by 100 thousand to 500 thousand inhabitants and 10% of the municipalities populated by more than 500 thousand inhabitants reached such levels of FHS coverage[18]. In addition, it is essential to consider the parameters of population coverage and the territorial extension per team in the various territorial configurations, so to allow the fulfillment of PHC features.

In addition to the size of the municipalities, deep inequalities in the distribution of PHC services are still observed, especially in remote rural municipalities, where great dispersion and scarcity of households are present. They face persistent organizational and geographic accessibility barriers, such as long distances to the Basic Health Units (UBS), travel costs and precarious conditions of roads and land or river transportation, which restricts access for a large portion of the population[19]. Considering that Brazil provides about 50 thousand FHS teams in a 68% population coverage, it is estimated that at least 20 thousand more teams are

needed to universalize population coverage[11].

The second challenge is to strengthen ESF territorial and community approach, which requires eSF qualification for the use of tools regarding the recognition of the territories and the construction of links with the communities that live in the areas covered by the teams. These processes include the use by teams of digital technologies for the recognition of territories. A powerful tool for the connection among teams and communities is the popular education, a drive for the consolidation of health democratic processes, especially under the current conjuncture of growing neoliberal policies and denialist conceptions.

Dantas et al.[20] report that the neoliberal agenda obstructs the development of solidary popular education practices and experiences of knowledge among professionals and social movements. The growth of denialism and obscurantism has harmed the construction of dialogues and experiences of popular education that,

> [...] show the power of dialogue in questioning the world and also in the construction of other forms of sociability that involve relations of solidarity and empathy[21].

The third challenge is the broadening of social participation in PHC. The approach to health as a social construction is one of the guiding and structuring principles of PHC work, standing out the role of permanent dialogue with all sectors of society. The importance of spaces for social participation as an exercise of citizenship is noted, which articulate various dimensions of social rights so to reduce social inequalities[22]. A nationwide study applying data from PMAQ-AB cycle 2 revealed contradictions among the views of professionals and users over the existence of Local Health Councils (CLS) in the UBS. While 56% of teams reported the existence of CLS, 31.3% of users reported that "*there is no CLS*", and 48.7% was not aware[23]. The users lack of knowledge demonstrates the weakening of such social participation devices. Recognizing this situation, in 2023, CNS launched a campaign to create CLS in the UBS so to widen those spaces, ensure social participation, and radicalize democracy (CNS Resolution No. 714, of July 2, 2023)[24].

Proposals for the development of research that aim at the production of knowledge to support the decision-making process in facing the challenges of Axis 1 are listed in *table 1*.

Table 1. Priority Research Themes – Axis I: Population, territory, social participation and equity

Axis I: Population, territory, social participation and equity
Evaluate PHC population coverage as to ESF and other team modalities, sizing the enrolled population, as per the records of the entire resident population (homing or living on the street, whether or not UBS user);
Evaluate PHC equity as to geographic areas (urban peripheries; municipalities and remote rural areas) and social groups from the perspective of intersectionality (social class, race/color, gender, LGBTQIAPN+, age, disabled people);
Studies on PHC humanization practices as to the principles of transversality, dependence between care and management, and affirmation of protagonism and autonomy of subjects;
Studies on the use of instruments and tools for territorialization by PHC teams and managers as for planning, operationalization, and monitoring of health actions, as per health needs of the population;
Studies on popular education and its interfaces within PHC work as per the dimensions of care, social participation and health training, including systematization of experiences and initiatives for the empowerment of individuals, the community and popular social movements in the territories;

Table 1. Priority Research Themes – Axis I: Population, territory, social participation and equity

Axis I: Population, territory, social participation and equity
Studies on the UBS health educational practices, standing out methodologies and problematizing potentialities and challenges of groups, collectives and health educational processes and their unfolding in the territories;
Evaluate processes and mechanisms of social participation and community engagement as per planning, delivery of health services and strategic decision-making on health resources;
Studies with individuals, community/movements and social groups on the role of health councils as to the protagonism and empowerment of subjects in decision-making impacting health.

Source: Prepared by the authors.

Axis II: PHC model integrated into care network and intersectoral policies

The first major challenge of this area is to coordinate care within care networks[8]. Studies have revealed the still incipient role of PHC and the lack of RAS care coordination, which requires PHC strengthening and regulatory mechanisms, as well as the increase in access to specialized and hospital care[25]. Stands out the necessary incorporation of surveillance into eSF work process, integrating individual and collective practices of health provision, disease prevention and health care for the population. Such integration remains inconclusive, given the need to articulate knowledge and various models of action for the population health arising from socio-historical conditions of the health system's structure[26].

PHC health surveillance comprises the development of health provision actions and intersectoral actions, emphasizing the experiences of three important programs: the Health Academy and Health at School Programs, which are strategies favoring health provision actions within ESF scope and the strengthening of citizens' protagonism; and the Bolsa Família Program and its positive effects on the population health by means of synergistic mechanisms amidst poverty reduction – built on income transfer –, and the increase access to PHC services – subject to health conditions –, as evidenced from impact evaluations[11,27,28]. Along this axis, research proposals aim to evaluate PHC models as for their relation with health network and other social sectors, summarized in *table 2*.

Axis III: PHC management and financing model

The cornerstone of PHC reorganization is the management model. As Santos[29] emphasizes: PHC as a SUS strategic service has an essentially public vocation that is not used for privatization, concession or outsourcing processes. PHC strategic role of regulating access to SUS other levels of care is noteworthy and characterized by its essentially public nature. However, limits imposed on public spending on health, combined with managerialist ideas advocating the false idea of greater efficiency in private management, have favored the growth, since the 1990s, of new forms of PHC management, such as Social Organizations, State Foundations under Private Law and Civil Society Organizations[3] – a process that requires impartial evaluation.

Funding is intrinsically related to the management model. In 2019, Previne Brasil determined the end of the priority for ESF and the growth of primary care teams; supported the inequitable distribution of resources among municipalities, including the reduction of resources provided by federal co-financing for PHC. Additionally, it has provided a model

> [...] medical-centered, focused, of assistance character, distant from the bond with the territory and the community, without priority for multiprofessional care, guided by the production logic (production goals), to the detriment of the broadened scope of care, containing prevention and provision of health[30].

By collaborating with this vicious circle, parliamentary amendments became a budget parallel to SUS management priorities, placing at the center of this understanding the power relation between the Executive and the Parliament, as well as the role of inter-federative relations and SUS spaces of collegiate and tripartite management in the structuring of federal resources. In addition, the creation of the Agency for the Development of Primary Health Care (ADAPS), currently called the Brazilian Agency for Support to the Management of the Unified Health System (AgSUS), requires investigations into the impacts of this type of device on SUS resource management. The strong privatizing sense of these measures was noted by Morosini et al.[7] when analyzing Previne Brasil.

Thus, this axis contains research questions aiming to characterize the public-private relations within PHC management, and to investigate the efficiency and impacts of management and financing models on the equity of resource distribution, on PHC improvement and on the quality of PHC services (*table 2*).

Table 2. Priority Research Themes – Axis II: PHC model integrated in the care network and in intersectoral policies and Axis III: PHC management and financing model

Axis II: PHC model integrated in the care network and in intersectoral policies
Evaluate experiences and PHC coordinating strategies for the health care network, analyzing PHC participation in care regulation mechanisms that provide timely comprehensive care for users, based on SUS principles of universality, equity, and integrality;
Analyze experiences of regionalized management of health care network that strengthen PHC as care coordinator;
Evaluate the impacts of different PHC techno-assistance models (ESF; simplified PHC teams, others) on access to services, quality of care, and impacts on the population's health problems;
Analyze strategies and innovations for integrated surveillance and health care within PHC scope, strengthening the territorial-based community guidance and social participation;
Evaluate PHC organizational accessibility mechanisms (schedule, waiting time, reception);
Evaluate PHC linking with other social sectors as for the implementation of intersectoral policies to address the social determinants of health, including socioeconomic and environmental factors, and health behaviors as well.
Axis III: PHC management and financing model
Evaluate different modalities of health management and public-private relations and their impact on the organization and quality of PHC services;
Develop evaluation models with comparative indicators to evaluate the efficiency of PHC management models;
Analyze the modalities of resource allocation for PHC and their effects on equity as for the distribution of resources and improvement of the community and territorial care model regarding the Family Health Strategy;
Evaluate the impact of parliamentary amendments on the distribution of federal resources toward PHC;
Evaluate Adaps and its replacing agency impacts on the creation of actor and interest networks involving municipal managers, corporations and public-private relations.

Source: Prepared by the authors.

Axis IV: Work management and restructuring and refinement of PHC work processes

A central issue in the reconstruction and improvement of PHC quality is work management, whose main challenge is to make labor relations less precarious, currently defined by the multiplicity of contracting modalities and types, many of those without guarantee of labor rights and with harmful impacts on the safety and health of PHC workers. The work precariousness, characterized by health professionals working in part time basis, shorter workload, and multiple employment contracts, has contributed to reducing retention and increasing turnover of professionals, resulting in the fragmentation of work processes, which, in turn, determines the fragmentation of health care. The analysis comprising only two months of the year (June and October 2023) revealed a reduction in the number of eSF without physicians, possibly due to the resumption of Mais Médicos Program, and the carrying on or increase in the absence of remaining professionals, indicating the need to broaden the aim of providing policies to other PHC health workers[31].

Research proposals for this axis emphasize the workforce centrality for PHC quality, which requires debating models of PHC work management, especially public-private relations, standing out their impacts on the modalities of hiring and bonding, retention and turnover, and on the quality of life and health of health professionals, mainly mental health. Policies incepted in 2023 should also be evaluated for their possible impacts on management, mainly the resumption of SUS National Table of Permanent Negotiation; the National Program for Gender Equity, Race and Appreciation of Women Workers within SUS; the definition of Nursing Floor Salary; the Mais Médicos Program – National Strategy for the Training of Specialists in Health; the processes of continuing education of PHC professionals and managers, and on the performance and practices of multiprofessional teams (eMulti) regarding technical-pedagogical support, matrix support and individual and collective care in PHC territories (*table 3*).

Table 3. Priority Research Themes – Axis IV: Work management and restructuring and refinement of PHC work processes

Axis IV: Work management and restructuring and refinement of PHC work processes
Evaluate the work management models of PHC professionals taking into account the public-private relation and their impacts on the modalities of hiring and labor relations, definition and turnover cutback, quality of life, and health of PHC workers;
Analyze the characteristics of health work processes of health professionals as per the expanded concept of health, concerning multiprofessional performance, inter-professionality, the continuity and integrality of care and community orientation, bearing in mind health care models;
Analyze PHC workforce building noting the multiprofessional character of teams and their distribution in various local and regional contexts;
Analyze the impact of violence and acute and chronic stressors on work processes and mental health of PHC professionals;
Analyze the effectiveness of continuing education programs for professionals and managers as to care of individual and collective health needs and local planning of health actions;
Analyze the supply of physicians in remote and disadvantaged areas and its impacts on access and health condition;
Analyze the profile of professionals who work for Family Health teams (eSF/PHC) as to training and evolution in the number of specialists concerning Family and Community Medicine and Nursing;
Analyze the proportion of oral health teams (eSB) to the quantity of eSF and the effect on access to oral health;
Analyze the practices and forms of insertion of Community Health Agents (ACS) in teams and the training process development for those workers;

Table 3. Priority Research Themes – Axis IV: Work management and restructuring and refinement of PHC work processes

Axis IV: Work management and restructuring and refinement of PHC work processes
Evaluate the performance and practices of multiprofessional teams (eMulti) as for technical-pedagogical support, matrix support, individual, group and home care; collective activities, case discussions, shared care among professionals and teams, provision of health actions at distance, joint construction of therapeutic projects and interventions on the territory; and intersectoral practices;
Analyze the different forms of matrix support for PHC teams.

Source: Prepared by the authors.

Axis V: PHC digital health

The first challenge for the use of digital health in PHC as a strategy to broaden access is precisely the guarantee of internet access in health units and for the population. As to data from the National Record of Health Establishments, as of September 2023, published in the Support Panels of the National Council of Municipal Health Secretariats (CONASEMS), 30% of UBS in Brazil do not provide an internet connection, percentage that is higher in the North (45%) and Northeast (40%) regions[32].

When remote and rural municipalities are concerned, challenges increase to ensure connectivity and stable energy supply at higher costs, being essential to establish partnerships with the federal government to connect PHC units in remote locations[33]. In addition, the country still faces major challenges regarding the equity of internet access by the population. According to TIC Household Survey[34], the rate of connected households in Brazil was 80% in 2022. Among people aged ten years old and over, 149 million enjoyed access, while 27 million had never used the internet. The adoption of digital technologies in health care and surveillance can strengthen PHC problem-solving capacity.

To this end, in addition to ensuring access to the Information and Communication Technology (TIC), ethical dilemmas in the use of these tools must also be regarded; the security of user data; and the necessary training in digital literacy for professionals and users. The adoption of TIC requires the implementation of public policies that regulate and provide necessary resources for equipment and connectivity throughout the national territory, including access to the internet by the population, providing the conditions for ethical, equitable, universal and comprehensive health care, guided by specific studies (*table 4*).

Axis VI: Infrastructure of PHC units

The covid-19 pandemic evinced the precariousness of most UBS physical structure in the country. For the process of PHC rebuilding, significant investments will be necessary to ensure the structural conditions that safeguard compliance with biosafety standards and accessibility to facilities, sufficiency of equipment, inputs, medicines and vaccines; and internet connectivity and health transport systems to connect patients to other levels of care. In 2024, federal resources of around R$ 7.4 billion are planned under the Growth Acceleration Program for UBS construction and renovation, and the awareness of these needs is recommended for better allocation of resources. Along this axis, proposals presented in *table 4* include studies that analyze the structural conditions of the basic health service network.

Table 4. Priority Research Themes – Axis V: PHC digital health and Axis VI: Infrastructure of PHC units

Axis V: PHC digital health
Analyze management processes and ensure their provision of equity in the distribution of resources and transparency in the processes of digital technology incorporation for the care of health needs;
Evaluate policies and strategies to broaden internet access to the population and health services, providing connectivity and adequacy of equipment (cell phones, computers and informational tools) within basic health units;
Evaluate the processes of continuing and popular education within PHC scope to provide digital literacy of health professionals and users in the use of PHC digital technologies;
Evaluate TIC use in health care processes within PHC scope to ensure electronic communications among health professionals and between health professionals and patients; seeing care equity and quality, and ethical issues;
Evaluate Telehealth strategies to ensure care and effective response to chronic and acute conditions in PHC services;
Analyze the use of digital technologies and equipment to improve PHC clinical problem-solving capacity, including remote access to specialized care and support for health professionals by means of a decisive second opinion of specialists;
Analyze the use of health information and interoperability of information systems and electronic medical records as to health care management;
Analyze experiences of using Artificial Intelligence in PHC.
Axis VI: Infrastructure of PHC units
Evaluate the structural conditions of basic health units regarding adequacy, biosafety and accessibility to facilities, equipment adequacy, inputs, medicines and vaccines; and internet connectivity and sanitary transport systems to connect patients to other levels of care;
Evaluate PHC organizational accessibility strategies (time, waiting time, reception);
Analyze the organization of PHC pharmaceutical services ensuring access to necessary medicines.

Source: Prepared by the authors.

Axis VII: Comprehensive and problem-solving quality care

This axis lists some health problems whose control depends on the organization of territorial-based PHC and community orientation, evidencing chronic conditions, mental health, and violence. The integration of PHC and surveillance practices, as included in the model of care axis, should be investigated in terms of its possible effects on the quality of life and health of the population – likewise, issues receiving little attention in the literature, such as the effectiveness of PHC actions toward palliative care and those addressed to indigenous health. Lessons learned during Covid-19 pandemic should guide PHC preparedness for future health emergencies, including the effects of the climate crisis. Investigation on PHC impact over the occurrence and distribution of those problems proposed along this axis are summarized in *table 5*.

Axis VIII: Monitoring and evaluation

Finally, PHC Monitoring and Evaluation (M&A) is itself an axis in the research agenda, being its components summarized in *table 5*. Among the bottlenecks are: the fragmentation and disarticulation of information systems; the updating of information and the possibility of tabulation in Tabnet/DataSUS; the availability, in permanent repositories, of databases for monitoring and analysis by means of external tools, such as statistical packages; continuing education for managers, health professionals and advisors; social communication of the evaluation processes and results. In addition, PHC'e-SUS difficulties favor the privatization of municipal information systems. Thus, it is

essential that data generated be of possession, domain, and public use, allowing access to databases for researchers, managers, and professionals (*table 5*).

Table 5. Priority Research Themes – Axis VII: Comprehensive and problem-solving quality care and Axis VIII: Monitoring and evaluation

Axis VII: Comprehensive and problem-solving quality care
Evaluate PHC impacts of access and quality on responses to the health needs of the population, emphasizing the following problems and illnesses: PHC-sensitive conditions; Chronic conditions; Mental Health and Violence;
Evaluate the impacts of PHC health provision development on the population health, especially the family and community orientation strategies;
Analyze care and training needs, implementation, effectiveness and efficiency of specific care strategies, such as palliative care, aging and frailty, multimorbidity and transition of care;
Analyze actions aimed at indigenous health developed in the Special Indigenous Health Districts (DSEI) within PHC scope;
Analyze strategies for preparing managers and health professionals to respond to health emergency.
Axis VIII: Monitoring and evaluation
Analyze policies and models of monitoring and evaluation to foster the improvement of PHC access and quality;
Develop models for evaluating PHC performance, employing the definition of quality indicators, by means of consensus techniques involving researchers, managers and health professionals; emphasizing proposals for assessing research and external assessment with the involvement of Higher Education and Research Institutions;
Develop models and matrix of indicators for monitoring and evaluating equity of access and quality of care as to socioeconomic conditions, race/color/ethnicity, gender, sexual orientation, age, disabled people;
Perform meta-analysis of assessing studies in primary health care

Source: Prepared by the authors.

Final remarks

Grounded on ESF and fostered by its principles and instruments, Brazil experienced a process of increasing institutional permanence of PHC evaluation, especially from 2003 to 2018, applying robust and comprehensive initiatives, such as PROESF, AMQ, and PMAQ-AB. That virtuous process is remarkable in at least three aspects: the collaboration between school, management, and services; its democratic nature, since the definition of indicators and instruments to the dissemination and analysis of data collected; and its acceptance and ability to influence political decision-making processes.

We need to resume those efforts, to build a National Policy for PHC Monitoring and Evaluation that generates updated and detailed knowledge to guide the management and care of different population groups within SUS'PHC with equity. Such policy should be guided by a broad and purposeful perspective of health, by the understanding of the social determination of the health-disease-care processes, and by the care structuring in a vigilant model of health following the principles of SUS and PHC.

Thus, it urges to radicalize the process of PHC reconstruction and PHC monitoring and evaluation in Brazil, aiming at the coverage universalization by means of FHS, employing

qualified teams pleased with their work and performing their activities in UBS under an adequate environment. The provision of assessing research following the axes and components here discussed and the resumption of PHC assessment stability are capital to inform the necessary policies to face the challenges discussed.

In addition to working with users, it is necessary to improve our tools so to find people who are still excluded from PHC. The notion of 'territory' and 'community' is essential: we all live in some 'place' and we all have a history, more or less recent, with that 'place'. The 'local' is PHC field of work; so, the stability of a National Policy for PHC Monitoring and Evaluation that take into account the elements here discussed should be a vigorous instrument for providing equity in health and social rights for the Brazilian population in all territories.

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References

1. Fausto MCR, Almeida PF, Bousquat A. Organização da atenção primária à saúde no Brasil e os desafios para a integração em redes de atenção. In: Mendonça MHM, Matta GC, Gondim R, et al., editores. Atenção Primária à Saúde no Brasil: conceitos, práticas e pesquisa. Rio de Janeiro: Editora Fiocruz; 2018. p. 51-72.

2. Facchini LA, Tomasi E, Thumé E. Acesso e qualidade na atenção básica brasileira: análise comparativa dos três ciclos da avaliação externa do PMAQ-AB, 2012-2018. São Leopoldo: Oikos; 2021. p. 224.

3. Teixeira M, Matta GC, Silva Junior AG. Modelos de gestão na Atenção Primária à Saúde: uma análise crítica sobre gestão do trabalho e produção de saúde. In: Mendonça MHM, Matta GC, Gondim R, et al., editores. Atenção Primária à Saúde no Brasil: conceitos, práticas e pesquisa. Rio de Janeiro: Editora Fiocruz; 2018. p. 117-41.

4. Giovanella L, Mendonça MHM, Medina, et al. Contribuições dos estudos PMAQ-AB para a avaliação da APS no Brasil. In: Mendonça MHM, Matta GC, Gondim R, editores. Atenção Primária à Saúde no Brasil: conceitos, práticas e pesquisa. Rio de Janeiro: Editora Fiocruz; 2018. p. 569-610.

5. Felisberto E. Da teoria à formulação de uma Política Nacional de Avaliação em Saúde: reabrindo o debate. Ciênc saúde coletiva. 2006;11(3):553-63. DOI: https://doi.org/10.1590/S1413-81232006000300002

6. Tomasi E, Nedel FB, Barbosa ACQ. Avaliação, monitoramento e melhoria da qualidade na APS. APS. 2021;3(2):131-43. DOI: https://doi.org/10.14295/aps.v3i2.208

7. Morosini MVGC, Fonseca AF, Baptista TWF. Previne Brasil, Agência de Desenvolvimento da Atenção

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Primária e Carteira de Serviços: radicalização da política de privatização da atenção básica? Cad Saúde Pública. 2020;36(8):e00040220. DOI: https://doi.org/10.1590/0102-311X00040220

8. Macinko J, Harris M. Brazil's Family Health Strategy — Delivering Community-Based Primary Care in a Universal Health System. N Engl J Med. 2015;372(23):2177-81. DOI: https://doi.org/10.1056/nejmp1501140

9. Hone T, Rasella D, Barreto ML, et al. Association between expansion of primary healthcare and racial inequalities in mortality amenable to primary care in Brazil: a national longitudinal analysis. PLoS Med. 2017;14(5):e1002306. DOI: https://doi.org/10.1371/JOURNAL.PMED.1002306

10. Kessler M, Thumé E, Marmot M, et al. Family Health Strategy, Primary Health Care, and social inequalities in mortality among older adults in Bagé, Southern Brazil. Am J Public Health. 2021;111(5):927-36. DOI: https://doi.org/10.2105/AJPH.2020.306146

11. Guanais FC. The combined effects of the expansion of primary health care and conditional cash transfers on infant mortality in Brazil, 1998-2010. Am J Public Health. 2015;105(11):S585-99. DOI: https://doi.org/10.2105/ajph.2013.301452

12. Moreno AB. Muito além do básico: As bases de dados em saúde e a atenção básica à saúde no brasil. In: Mendonça MHM, Matta GC, Gondim R, et al., editores. Atenção Primária à Saúde no Brasil: conceitos, práticas e pesquisa. Rio de Janeiro: Editora Fiocruz; 2018. p. 265-89.

13. Ministério da Saúde (BR). Portaria nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS) [Internet]. Diário Oficial da União, Brasília, DF. 2011 out 24 [acesso em 2024 set 24]; Edição 203; Seção I:48. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html

14. Medina MG, Aquino R, Vilasbôas ALQ, et al. A pesquisa em atenção primária à saúde no Brasil. In: Mendonça MHM, Matta GC, Gondim R, et al., editores. Atenção Primária à Saúde no Brasil: conceitos, práticas e pesquisa. Rio de Janeiro: Editora Fiocruz; 2018. p. 569-610.

15. Rede de Pesquisa em Atenção Primária à Saúde, Associação Brasileira de Saúde Coletiva. Bases para uma atenção primária à saúde integral, resolutiva, territorial e comunitária no SUS: aspectos críticos e proposições. Rio de Janeiro: ABRASCO; 2022.

16. Rede de Pesquisa em Atenção Primária à Saúde [Internet]. Brasília, DF: ABRASCO; [sem data]. Atenção Primária à Saúde integral, resolutiva, territorial, comunitária e integrada à rede do SUS: Proposições da Rede de Pesquisa em APS da ABRASCO; 2022 ago 4 [acesso em 2024 jan 1]. p. 4. Disponível em: https://redeaps.org.br/wp-content/uploads/2022/08/APS-integral-resolutiva-territorial-comunitaria-e-integrada-a-rede-do-SUS-4-agosto-Conferencia-livre-e-popular-Proposicoes-da-Rede-de-Pesquisa-em-APS-da-ABRASCO.pdf

17. Pimenta A, Mendes Á, Lages C, et al. Uma alternativa para superação do Programa Previne Brasil: propostas para alocação de recursos federais para APS [Internet]. 2023 jun 30 [acesso em 2024 jan 1]. Disponível em: https://redeaps.org.br/wp-content/uploads/2023/07/Proposta-Modelo-Aloc-AB-em-2023_Versao-09-2023-30-06-2023-VF.pdf

18. Aquino R, Medina MG, Vilasboas ALQ, et al. Estratégia saúde da família: Evolução do modelo de organização da atenção primária à saúde no Brasil. In: Paim JS, Almeida Filho N, editores. Saúde coletiva: teoria e prática. 2. ed. Rio de Janeiro: Medbook; 2023. p. 317-40.

19. Fausto MCR, Almeida PF, Bousquat A, et al. Atenção Primária à Saúde em municípios rurais remotos brasileiros: contexto, organização e acesso à atenção integral no Sistema Único de Saúde. Saúde e Soc. 2023;32(1):e220382pt. DOI: https://doi.org/10.1590/S0104-12902023220382pt

20. Dantas DSG, Silva MRF, Torres RAM, et al. A Formação dos agentes comunitários de saúde em educação popular: implicação na produção do cuidado na Estratégia Saúde da Família. Motricidade [Internet]. 2018 [acesso em 2024 jan 1];14(1):157-63. Disponível em: https://scielo.pt/pdf/mot/v14n1/v14n1a21.pdf

21. Nespoli G. A educação popular é importante porque reconhece as condições de vida, atua a partir da realidade, promove e organiza redes de apoio social que, neste momento, são fundamentais [Internet]. [Entrevista concedida a Julia Neves]. EPSJV/Fiocruz. 2020 jun 1 [acesso em 2024 jan 25]. Disponível em: https://www.epsjv.fiocruz.br/noticias/entrevista/a-educacao-popular-e-importante-porque-reconhece-condicoes-de-vida-atua-a-partir

22. Mendonça MHM, Alves MGM, Spadacio C. Determinação social da saúde e participação social na aps. APS. 2022;4(1):54-60. DOI: https://doi.org/10.14295/aps.v4i1.227

23. Silveira Pinto R. Ensaios sobre assistência farmacêutica e participação da comunidade na saúde na atenção básica [tese na Internet]. Porto Alegre: Universidade Federal do Rio Grande do Sul, Faculdade de Farmácia; 2021 [acesso em 2024 jan 1]. p. 290. Disponível em: http://hdl.handle.net/10183/248826

24. Conselho Nacional de Saúde (BR). Resolução CNS nº 714, de 2 de julho de 2023. Dispõe sobre Campanha pela Criação de Conselhos Locais de Saúde nas Unidades Básicas de Saúde do SUS [Internet]. Diário Oficial da União, Brasília, DF. 2023 ago 23 [acesso em 30 jun 2024]; Edição 161; Seção 1:78. Disponível em: https://conselho.saude.gov.br/resolucoes-cns/resolucoes-2023/3089-resolucao-n-714-de-02-de-julho-de-2024

25. Almeida PF, Medina MG, Fausto MCR, et al. Coordenação do cuidado e Atenção Primária à Saúde no Sistema Único de Saúde. Saúde debate. 2018;42(esp1):244-60. DOI: https://doi.org/10.1590/0103-11042018S116

26. Prado NMBL, Aquino R, Vilasbôas ALQ. Atenção primária à saúde e o modelo da vigilância à saúde [Internet]. Salvador: Rede APS; 2021 [acesso em 30 jun 2024]. Disponível em: https://redeaps.org.br/wp-content/uploads/2022/01/NT_Vigilancia.pdf

27. Rasella D, Aquino R, Santos CAT, et al. Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities. Lancet. 2013;382(9886):57-64. DOI: https://doi.org/10.1016/s0140-6736(13)60715-1

28. Nery JS, Rodrigues LC, Rasella D, et al. Effect of Brazil's conditional cash transfer programme on tuberculosis incidence. Int J Tuberc Lung Dis. 2017;21(7):790-6. DOI: https://doi.org/10.5588/ijtld.16.0599

29. Santos L. Atenção primária e a privatização dos serviços de saúde. Rev direito sanit. 2022;22(2):e0014. DOI: https://doi.org/10.11606/issn.2316-9044.rdisan.2022.181323

30. Funcia FR, Moretti B, Ocké-Reis CO, et al. Nova política de financiamento do SUS [Internet]. Salvador: ABrES; 2022 [acesso em 2023 jun 30]. Disponível em: https://www.isc.ufba.br/wp-content/uploads/2022/07/Proposta-Nova-Politica-de-Financiamento-SUS-Abres.pdf

31. Conselho Nacional de Secretarias municipais de Saúde (BR). Brasília, DF: Conasems; [sem data]. Painel de equipes na Atenção Básica [Internet]. 2024 jan 17 [acesso em 2024 jan 25; atualizado em 2024 jun 17]. Disponível em: https://portal.conasems.org.br/paineis-de-apoio/paineis/19_equipes-na-atencao-basica

32. Conselho Nacional de Secretarias municipais de Saúde (BR). Brasília, DF: Conasems; [sem data]. Conectividade Unidades de Saúde [Internet]. 2024 jan 17 [acesso em 2024 jan 25; atualizado em 2024 jun 17]. Disponível em: https://portal.conasems.org.br/paineis-de-apoio/paineis/27_conectividade-unidades-de-saude

33. Organisation for Economic Cooperation and Development. Estudo da OCDE da Atenção Primária à Saúde no Brasil. Paris: OECD; 2021. DOI: https://doi.org/10.1787/9bf007f4-pt

34. Núcleo de Informação e Coordenação do Ponto BR, Centro Regional de Estudos para o Desenvolvimento da Sociedade da Informação-Cetic.br [Internet]. São Paulo: NIC.br; 2005. Pesquisa TIC Domicílios. 2022 jul [acesso em 2024 jan 17]. Disponível em: https://www.nic.br/media/docs/publicacoes/2/20230825143348/resumo_executivo_tic_domicilios_2022.pdf

Received on 01/22/2024
Approved on 04/15/2024
Conflict of interests: non-existent
Financial support: non-existent

Editor in charge: Magda Duarte dos Anjos Scherer