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CHALLENGES IN THE MANAGEMENT OF HEALTH POLICIES AT THE PRIMARY AND TERTIARY CARE LEVELS OF THE SINGLE HEALTH SYSTEM

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Abstract: The present study aimed to assess the challenges in the management of health policies at the primary and tertiary care levels in Brazil. Health care in the Unified Health System was addressed at different levels of complexity (primary and tertiary care) and the challenges faced in the management of health policies with a focus on the National Policy on Primary Care and the National Policy on Hospital Care. As for the approach, the research is classified as a narrative literature review. To carry out the same, articles indexed in databases, LILACS, MEDLINE, SciELO, in the years 2000 to 2021, were selected by searching the descriptors: health management, health policies and the unified health system. The main results show that even with the transfer of resources, funding is among the challenges that generate the greatest impact on the management of health policies in the scope of primary and tertiary care, the inadequate structure for functioning compromises the supply and quality of health services, as well as showing how the demand for health exceeds the capacity offered in the establishments. It is concluded that all policies present challenges and need to undergo revisions that make them more appropriate to the reality of the country, and it is essential that governments, managers and the population fulfill their role, as there is still much to do for SUS.

Keywords: Health Management, Health Policy, Health Unic System.

INTRODUCTION

The creation of the Unified Health System (SUS) was gradual and evidenced by successive reorganizations in care models and democratic health transition (SOUTO; OLIVEIRA, 2016). In this historical process, before the establishment of this System, the right to health was exclusive and only benefited social security contributors. It is noteworthy, in 1930, the Retirement and

Pension Institutes, in which the benefits were by professional categories, were soon unified in 1965, creating the National Institute of Social Security (REIS et al., 2010).

In the meantime, in 1977, the National System of Assistance and Social Security was created, and the National Institute of Medical Assistance of Social Security, which were established with the purpose of providing medical assistance financed by the acquisition of hospital services from the private health field (REIS et al. al., 2010).

Furthermore, the evolution of Brazilian Constitutions, including the 1967 Constitution (CRFB/67) that preceded the 1988 Constitution of the Federative Republic of Brazil, caused apprehension in the various social strata, due to authoritarianism and health still remained restricted, in which it was like the Constitution of the Civil-Military Dictatorship. Thus, the right and universal access to health was ensured after its incorporation into the Federal Constitution by the Health Reform, which consists of a primordial right of public relevance, represented by SUS (LARA; SILVA, 2015; DUARTE, 2015).

The SUS was created in the National Constituent Assembly of 1987-1988 and institutionalized from the promulgation of the Constitution of the Federative Republic of Brazil of 1988 (CRFB/88), and its structuring was legalized by Laws Nº 8.080/90 and Nº 8.142/90, as well as As guaranteed, in art. 196 of CRFB/88, which states that:

> "Health is a right of all and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other diseases and at universal and equal access to actions and services for their promotion, protection and recovery" (BRAZIL, 1988).

In this context, the SUS has contributed to improving the quality of life of Brazilians, mainly through the democratization of care. Therefore, Primary Health Care (PHC) is understood as structuring the health system and works as a gateway for the user to the service, through the provision of health promotion and disease prevention actions (SILVA et al., 2016).

Great progress towards strengthening PHC took place with the creation of the Family Health Strategy (ESF) in 1994, which is a model of care with an emphasis on promoting the health of families and the community, which operates through ordinances of the Ministry of Health (AGUIAR et al., 2015; GOMES et al., 2020).

In this scenario, the Federal Government published the National Policy for Primary Care (PNAB) in 2006, which culminated in the organization of the system through structured, organized care networks with guiding actions for health services (GOMES et al., 2020).

Meanwhile, Tertiary Care was in need of reorganization in health services. This level of care encompasses a set of hospital actions and services, with the aim of providing health care (BRASIL, 2001). According to this conception, the Brazilian Hospital Care Reform Plan was launched, in which they were decisive for the National Hospital Care Policy (PNHOSP), whose main purpose is to restructure and enable hospital care (SANTOS et al., 2018).

On the other hand, problems are still found in the management of these health policies inherent to funding, service structures and continuity of care, at different levels of complexity. It is worth mentioning that to solve these problems, it requires the competence of managers for better quality in the health service (MARKLER et al., 2015).

The management of health policies faces several challenges from their implementation, coverage to their maintenance. It is observed that these challenges play a fundamental role

in the operationalization of policies and their effectiveness. Thus, there is a need to describe these problems and generate solutions compatible with reality. The identification of problems in the management of health policies is essential to achieve satisfactory results in their implementation and adequate coverage.

Primary Health Care is the user's gateway to the Unified Health System and the management of problems at this level of complexity makes it possible for most health conditions to be resolved without the need for referral to other levels of complexity. Thus, it can be seen that the management of Tertiary Health Care problems will also provide adequate treatment for conditions that can be resolved at this level of complexity, taking into account the doctrinal principles of the SUS.

Thus, it is extremely important to identify and solve the problems and challenges encountered in the management of PNAB and PNHOSP. In view of the considerations that express the importance of the challenges imposed on the management of public health policies at the different levels of complexity of the SUS, the present work has the following research problem (problem-question): What are the challenges of management for the implementation of policies public health services within the scope of Primary Health Care and Tertiary Health Care?

In the search to answer the guiding question outlined for the present study, the general objective was defined to evaluate the challenges in the management of health policies at the primary and tertiary care levels in Brazil. To achieve the general objective, the following specific objectives were defined: (1) Present the structure of the levels of health care in the SUS; (2) Present the objectives, assumptions and principles that guide the actions of PNAB and PNHOSP; and (3) Identify the challenges faced in the management of health policies at the primary and tertiary care levels.

METHODOLOGICAL PROCEDURES

This research is classified as a narrative literature review. According to Marconi & Lakatos, 2017, "the narrative literature review adopted is capable of promoting the proper discussion regarding the object of study defined in the present research work, seeking an innovative conclusion and the development of new studies".

As a data collection instrument, data was collected from articles, which address the assessment of challenges in the management of health policies at the primary and tertiary care levels in Brazil. The objective of this survey was to synthesize the articles that address the aforementioned themes.

For data collection, articles indexed in databases such as Latin American and Caribbean Literature on Health Sciences (LILACS) and Medical Literature Analysis and Retrieval System Online (MEDLINE), Scientific Electronic Library Online (SciELO), in the years 2000 to 2021 and through research on the Descriptors in Health Sciences (DeCS): "Health Management", "Health Policy" and "Unified Health System". All publications that did not meet the aforementioned criteria were excluded. Then, the articles were read to assist in the analysis of the research objectives and results.

HEALTH CARE LEVELS OF THE SINGLE HEALTH SYSTEM

PRIMARY HEALTH CARE

The organization of the health system in Brazil is based on levels of complexity, primary or basic care is the first level, secondary or medium complexity care is the second level and tertiary or high complexity care is the third level. Based on this premise, the flow of care in the system follows a hierarchy between levels

where communication is extremely important, governed by reference and counter-reference. For the development of this work, a greater focus was given to primary and tertiary care (RAMOS, 2018).

Primary Health Care (APS) is the first level of access to the health system, characterized as the gateway through the Primary Health Care Units (UAPS), and had its guidelines revised by Ordinance No. September 2017, where it was defined in its art. 2 that:

> "Primary Care is the set of individual, family and collective health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance, developed through integrated care practices and qualified management, carried out with a multidisciplinary team and aimed at the population in a defined territory, for which the teams assume health responsibility" (BRASIL, 2017).

The PHC health services are consolidated in the Primary Health Care Units, which can be of two models. In the traditional model, there is no linked Family Health Strategy team, and the type of care is provided by spontaneous demand, that is, when the user seeks an emergency or outpatient service. The other model is the UAPS with ESF, in which the Family Health Strategy (ESF) teams are inserted, which are responsible for the integrality of care, and order the flow of assistance to the other levels of care. They act as multiprofessional teams focused on disease prevention, health promotion and recovery, offering outpatient care with low technological density, responsible for greater coverage and resolution of demands for health services (CONASS, 2015; HYPPOLITO, 2021).

The ESF is the primary care model in force throughout the country, with multi-professional teams working in pre-defined territories, where community health agents work, who carry out home visits in order to accompany families and refer them when necessary. to medical and dental care for chronic and acute conditions in Basic Health Units. (GIOVANELA et al., 2021)

The FHS teams are composed of the following professionals: community health agent, nurse, specialist in Family Health or general practitioner, nursing assistant or technician, and these teams can also count on the performance of a dental surgeon and assistant or technician in oral health. Professionals are responsible for monitoring the registered population and maintaining the bond (CONASS, 2015).

SECONDARY HEALTH CARE

Secondary care is characterized by services of intermediate technological density, where specialized outpatient care is carried out in reference units to support PHC-sensitive conditions. This way, the user is referred to specialized care (GUEDES, 2019). Also, according to Gonçalves (2014), the actions carried out by the medium complexity go beyond the actions of primary care, but are not yet characterized as high complexity.

These services, also called specialized outpatient care, aim to meet the demands for procedures in which a professional or specialized equipment is needed. They usually take place in a structure outside the Primary Health Care Units, with a multiprofessional team (cardiology, gynecology, ophthalmology, dentistry, among others), seeking comprehensive care for the user, elaboration of a care plan and follow-up according to the condition presented, and communication with PHC also happens through reference and counter-reference (GUEDES, 2019). Examples of secondary care services are medical specialty centers, dental specialty centers, diagnostic and therapeutic support services, Emergency Care Units (UPA) (GONÇALVES, 2014).

TERTIARY HEALTH CARE

Tertiary care, known as hospital care, was established by Ministerial Ordinance No. 3,390, of December 30, 2013, and defines the National Policy on Hospital Care. This type of care is characterized by high complexity care, high technological density, high cost, with a multiprofessional and interdisciplinary team, and meets the referenced and spontaneous demand of conditions that require hospitalization due to the risk of complications (BRASIL, 2013).

Hospital care works through Hospitals, which can be public or private, meet the reference demands and previously scheduled by the PHC regulation service or by secondary care when the user needs to perform high-cost exams, hospitalization for elective surgeries or high-complexity care characterized as outpatient, but requiring high-technology service, such as dialysis and chemotherapy. Acute conditions are received through urgency and emergency, where the type of care is spontaneous demand, in which the user seeks this level of care without prior referral and in cases of more serious situations such as accidents, it is necessary to carry out of risk classification to assess the severity and resolution time of the condition (GONÇALVES, 2014; BRASIL, 2013).

PNAB ASSISTANCE MODEL

The Family Health Program was implemented in 1994 and has undergone consequent changes to the present day. It operated through ordinances of the Ministry of Health, until in 2006 the federal government published the PNAB through ordinance No. 648, of March 28, and later through Ministerial Ordinance No. reviewed. Through this ordinance, new modalities of teams were included to adequately meet the realities of the country, the Street Clinics to serve the homeless population, increase of the teams of the Family Health Support Center (NASF) that provide support to the teams of ESF, and creation of Basic River Health Units and ESF for Riverside Populations (CONASS, 2015).

According to the last update of the PNAB in 2017 through Ordinance No. 2436, it operates in accordance with the principles of the SUS, namely universality, equity and integrality. Furthermore, this ordinance assumes that, in order to compose the set of actions developed, the guidelines are operationalized in Primary Care: regionalization and hierarchization, territorialization and ascription, assigned population (person-centered care and resolution), longitudinality of care, coordinating care, ordering the networks and community participation (BRASIL, 2017).

It was through the PNAB that the system was organized through structured and organized care networks with guiding actions for health services (GOMES et al., 2020). The Health Care Networks (RAS) were implemented in the SUS by Ordinance No. 4,279/2010, which seek the continuity of care in an integral way and are conducted by the APS (BRASIL, 2010). According to Mendes (2010, p. 2300), the RAS "are polyarchic organizations of sets of health services", constituted by the following elements: the population, the operational structure and the health care model. The RAS came to support PHC in order to improve access and quality of health services at different levels of care, in order to integrate them and provide continued care.

Networking has been shown to be fragmented due to failures in the continuity of care, where there is an increased focus on acute conditions. To characterize this fragmentation, we can mention the search for care at levels of care that are not compatible with the type of user demand, compromising factors ranging from funding to the time it

takes to resolve the complaint (MENDES, 2010).

Currently, Brazil has a Primary Health Care model that is essential to promote disease prevention, health promotion and education, the Family Health Strategy. This is the user's gateway to the health system, where the care model has the capacity to solve acute and chronic health conditions, carry out follow-up and monitoring of the population, following the principles of Universality, Equity and Integrality. The PHC service portfolio is an organizing aspect of health actions aimed at fully serving users and presenting the services offered in the municipalities (CUNHA et al., 2020).

The financing of this program is currently made through Previne Brasil, which extinguished the old financing model, the Fixed Basic Care Floor, which provided for payment calculated based on the number of people registered. (GIOVANELLA et al., 2020). With the change, according to Morosini et al. (2020), new criteria were implemented to guide new financing, weighted capitation, pay-for-performance, and incentives for strategic actions.

This care model requires managers' skills and competences to implement policies, monitor, manage and support family health teams in the development of health actions in the territories. Managers influence the quality of services provided and several problems are found in health management, among them the lack of planning, teamwork involving different professionals, the search for quality of care, universality, financing of public services, equity, excessive bureaucracy, decentralization and lack of popular participation (MARTINS; WACLAWOVSY, 2015).

THE MANAGEMENT OF PNHOSP

The historic landmark of Brazilian hospital care was evidenced from 2003 onwards, which followed the need for government efforts to reorganize the RAS, from a hospital perspective. This process triggered the Brazilian Hospital Care Reform Plan, followed by the National Humanization Policy, in which they were decisive for PNHOSP (SANTOS et al., 2018).

Ministerial Ordinance No. 3,390, of December 30, 2013, establishes the PNHOSP and designates the guidelines for hospital organization of the RAS, corresponding to the implementation of all hospitals, which promote health care, in order to restructure and enable hospital care. In article 6, its guidelines and principles encompass and comply with the principles of the SUS are these: Universality, equity, integrality, social control, regionalization of care and continuity of care, humanization, quality of care, management, tripartite funding and effectiveness in application of resources (BRASIL, 2013).

In view of this, the structuring axes comprise hospital care and management, workforce management, financing, contractualization and responsibilities of the Management spheres. Among them, the responsibilities of the spheres of management, relevant competences and attributions are segmented in a tripartite manner in each sphere of government. The PNHOSP grants the Ministry its definition, implementation, evaluation, monitoring and tripartite funding, having in common some aspects related to states and municipalities, such as funding (CARDOSO et al., 2020).

Also, according to Ministerial Ordinance No. 3,390, of December 30, 2013, pertinent to article 17, the management of hospital care will be based on: "In guaranteeing access and quality of care, in the fulfillment of goals agreed in the contract with the manager, efficiency and transparency in the application of resources and in participatory and

democratic planning, in line with the design of the RAS" (BRASIL, 2013).

It must be noted that tripartite financing and contractualization modalities regulate the link between the manager and the hospitals, considering regional and budget parameters, care improvement, responsibilities of each sphere and among others. Regarding the modality of contracting, it occurs through the agreement of health services between the local manager and hospitals, with a view to the allocation, transfer of financial resources, use of care protocols and prioritization criteria such public, private hospitals, as long as that meet the criteria, which can be for-profit or non-profit, the latter providing assistance between 60% and 100% to SUS services (SANTOS; PINTO, 2017; BRASIL, 2013).

Therefore, managers are responsible for regulating tertiary care, equivalent to high hospital complexity, which is still considered one of the problems inherent to hospital management, such as coverage and financing, in which the consecutive reduction of hospital beds, equipment and, inputs and the unequal flow due to the difference in supply between regions (NEGRI FILHO, 2016).

Furthermore, it was observed in the study by Aguilera et al. (2013), that managers pointed out problems related to service contracts with a private hospital in a municipality bordering Campo Largo, reporting the lack of accessibility through the Leitos Center of Curitiba and hospitals with low complexity, low resolution and the absence of regionalization of medium and high complexity services, due to economic, social and cultural differences in geographic space.

PNAB AND PNHOSP MANAGEMENT CHALLENGES

The challenges faced in management by both the PNAB and the PNHOSP are undeniable, at the primary and tertiary care levels. Regarding the management of the PNAB, challenges in financing were identified, which, even with the maintenance of the responsibilities of the three federative entities, found the low perspective of expanding financial resources, which induced the disregard of positions in decision-making and lack of autonomy managers (MELO et al, 2018).

According to Savassi (2012), he considers some aspects that must be a priority in the responsibilities of managers in view of the progress of the PNAB, such as: improving the physical structure of health units; the use and availability of technologies suitable for the work environment; demonstrate competence and knowledge in the area of expertise to the team's professionals; define the specific functions of sectors and employees; and ensure user satisfaction.

Other studies have shown that there are several problems inherent to the System, being the financing, structure and management within the scope of the SUS, which imply in the face of the diversities of more than 5,500 Brazilian municipalities, resulting in the stagnation of the expansion of coverage and the number of teams in the country in recent years, since there was no adherence to the PNAB by most municipal health managers (SANTOS, 2018).

While, Morosini et al. (2020), pointed out challenges through the arguments presented by managers in order to justify the new financing policy: expanding the autonomy of municipal managers in the use of federal resources; granting favors to the most vulnerable groups; provide cost-effectiveness in health policies, including the new PNAB, corresponding to Previne Brasil.

Regarding the challenges of PNHOSP management, they were peculiarly verified in

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indirect management, especially the model of Social Organizations, which spread due to resource limitations in the 1990s, and which still faces problems in the lack of coverage of tertiary care, overload of care and limitation of regional reference (TIBERIO; SOUZA, 2010).

The importance of the public manager in terms of controlling funding, coverage, ensuring access to contracted services, establishing monitoring, evaluation, association of costs according to sociodemographic needs, equity and regulation is highlighted (CARNEIRO JUNIOR; ELIAS, 2006). Also, according to Lorenzetti et al. (2014), the manager must have must develop methods that promote the efficiency of health services, health planning, health policies for the maintenance of health actions and services.

In this context, managers have support to conduct the health policies of the National Council of Health Secretary, in which it is a body represented by the State and Federal District, with the aim of covering and solving issues related to health and health policies, as well as the National Council of Municipal Health Departments, in which it is conceptualized as a body represented by municipal managers, with the purpose of addressing health-related issues (ROCHA et al, 2014).

The authors analyzed the financing of the PNHOSP, pointing out the implementation of cost analysis methodologies in order to improve transparency and effectiveness in the management of applied resources. In addition, they highlighted the main challenges related to the possibility of increasing resources for the feasibility of executing management contracts by Social Organizations that include procedures in the selection process and contracts, the forms of remuneration, as well as the reduction of federal budgetary participation to the investments with specialized and hospital care (BARBOSA, 2010; MACHADO et al., 2014).

The management of the highly complex components of health services must be carried out in an articulated way in a network and in line with the coordination of care as an essential presupposition for the effectiveness of health services for the population. However, it is necessary for the polyarchic network model to overcome the hospital-centered model (UZUELLI, 2019).

FINAL CONSIDERATIONS

Considering that the objectives (general and specific) were achieved, the present work presented a discussion of the challenges of managing public health policies in Brazil, within the scope of primary and tertiary care. Thus, we sought to discuss aspects related to the PNAB and the PNHOSP.

Since the creation of the SUS, Brazil has been able to offer health care in a dignified way to the entire population, but this system had to undergo several changes until it reached the current model through Ministerial Ordinances that regulated and revised health policies to meet to the country's reality. The SUS has been facing challenges since its creation, as well as the health policies incorporated into it.

The PNAB and PNHOSP, which are the main health policies in Brazil, have undergone updates since their implementation, and it is still clear that there are bottlenecks in which the challenges reported by managers are found. Several difficulties were identified, among them the main one, financing.

It was observed that the financing factor is crucial for the implementation of policies and development of health actions. Even with the transfer of resources, services are suffering from a lack of adequate structure for

operation, insufficient coverage in relation to the high flow of demand, overload of services and professionals.

Incorporated into the funding, there is a fragmentation of services evidenced by Mendes (2010), where there is a discontinuity of care associated with the absence of resolution. The lack of planning on the part of managers compromises the quality of the services offered, so it is reflected that the problems encountered are not limited to the financial resource factor.

Thus, there is still much to do for the SUS and to seek to improve the problems faced at the primary and tertiary care levels. With the resolution of these challenges, will new ones arise? Note that some challenges are inherent to the system, but which are not? How can managers, governors and the population be held accountable for fulfilling their role?

As long as there is a public health system with such a dimension of the SUS and which the majority of the population depends exclusively on, it is believed that there will always be something to review, monitor, develop and implement.

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