Primary health care: the health care system reform in Rio de Janeiro

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The democratisation process that led to the creation of the Sistema Nacional de Saúde Brasileiro (SUS; Brazilian National Health System) during the 1980s aimed essentially to reorientate the health care model in Brazil. The development of the ‘Family’s Health Strategy’ programme (the backbone of the National Health System), took place during a period of significant change in the country and its conception was heavily influenced by the WHO Alma Ata declaration principles of universality, inclusiveness and equity. The basic principles of the SUS are decentralisation and social participation.

The Atenção Primária à Saúde (APS; Primary Health Care) is understood as a strategy of reorientation of the model of health care and can be defined as:

1. A group of values: the right to the highest standard of health care, solidarity and equity;
2. A group of principles: governmental responsibility, sustainability and intersectoriality, meaning social participation; and
3. A group that is inseparable from structural elements of the health services structure: access to first contact, integration, longitudinality, coordination, family and community guidance and cultural competence.

According to the Pan-American Health Organisation (PAHO), Primary Health Care services should constitute the basis of any national health care system, as it is considered to be the best strategy for producing sustainable improvements and greater equity in a population's health. In order to respond to the demands of the changes in the population epidemiologic profile, which now includes a growing prevalence of chronic diseases, the national health care system in Rio de Janeiro has been focusing on better coordination between the different levels of attention and between various organisations. The consolidation of an integrated health care network is precisely the role that Primary Health Care services in Rio de Janeiro play.

This integrated health care network is characterised by a defined territory and population, with a wide range of health care institutions and services coordinated at the Primary Health Care level. The network is constituted by or coordinated with the use of electronic information systems, with a care model centred on the individual, the family and on the community/territory, under a single and adequately financed management system.

The Municipality of Rio de Janeiro is situated in the southeast of the country, and has a population of some 6,320,744 inhabitants. The reform of the city’s health care system commenced in 2009, and was coordinated and organised by APS.

In December 2008, family health care in the municipality reached just 3.5 per cent of the city’s population (targeted through 62 family health teams). This figure increased to 26.1 per cent in October 2011 (478 complete teams providing access to health care for 1,649,100 inhabitants).

Each family health care team comprises one general practitioner, one nurse, one nursing technician, six community health workers and one community health care invigilator, all of whom are responsible for approximately 3,450 people in the community. The team not only provides general health care for these individuals but also is responsible for maintaining the follow-up care of those patients who require access to other forms of health care, such as secondary care or hospital networks, on a long-term basis.
In order to respect the principle of equity, this expansion of outreach by the family health care teams happened in a heterogeneous way and did not occur simultaneously. The areas with the greatest gaps in health care services, located in the west, were attended to first. The outreach of APS in those areas reached levels above 90 per cent, even in those areas furthest away from the centre.

During this period, 43 new Primary Health Care units were built, increasing the total number of units in the city to 172. Important components were taken into consideration during the building of these units to foster both the motivation of the professional staff and to provide greater comfort for the service users. Some examples include better use of sunlight and air circulation within the units, energy-saving initiatives, and the use of rain water for gardens and toilets.

In order to standardise the Primary Health Care provision for the city, in August 2010 the portfolio of APS services was launched with a set of procedures that were to be utilised by all units according to their capabilities. The portfolio enabled APS not only to increase its services to the population but also the resolvability of each of the family health care teams, making APS more widely accessible and less focused on procedures exclusively related to prevention/promotion or, at the other extreme, to emergencies.

A further mechanism that improved the quality of service in the APS network was the computerisation of every work centre in the family health care units and the installation of electronic records. Since January 2011, this computerisation enabled the establishment of a payment system relating to the performance of each health care professional through two sets of variables: one for each health care unit and one for each family health care team, with quality indicators that look to improve the organisational system of the clinic. Part of the salary of the professionals (up to 10 per cent) can be made up of those two variables.

Preliminary results showed a greater satisfaction with the provided services amongst the population, as access to health services widened, as well as among health professionals, who were more motivated to use good clinical practices. Furthermore, it is already possible to observe a decrease in hospitalisation rates for conditions more commonly treated by Primary Health Care, such as non-contagious chronic diseases. Results also showed a reduction in child mortality and cardiovascular diseases, particularly in the areas with a greater expansion of Primary Health Care. A further result is the decrease in demand for emergency treatment in larger hospitals, which, in turn, have improved the services they provide for more serious emergencies. It is also evident that, in the community where the health care units are built, there have been improvements in the urbanisation of the neighbouring regions. These include better mobility for people and income generation for many inhabitants in the neighbourhood, who end up working in the family health care clinic. There are also indirect income-generating improvements such as the creation of local businesses, which, in turn, results in the increase of value of housing in those areas.
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