

Article

Analysis of investment policies in primary health care:
historical neoinstitutionalism applied to the Brazilian
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The investment policies for Primary Health Care (PHC) are fundamental to the health system organization. In the Brazilian Unified Health System (Sistema Único de Saúde - SUS), this aspect is even more relevant due to its structural role in the system. Despite their importance, studies on investment policies in PHC tend to be more descriptive, contributing little to the understanding of the historical and political process. This paper aims to fill this gap by analyzing the investment policies for PHC in SUS based on the historical neoinstitutionalism perspective. The primary and secondary data were collected through bibliographic review, document collection, and interviews with key actors. The data were analyzed using an inductive approach to associate characteristics of the health system and the Brazilian PHC model with the trajectory of federal funding policies aimed at investments in infrastructure, equipment, and technology in PHC. The results i) identify the strengths and weaknesses in PHC investment policies with a contextual and historical perspective of the contributing factors in this process, and ii) recommend actions, decision-making, and policies divided into the 3 categories – PHC investment history, need to finance PHC, and financing impact of the PHC results. Therefore, this study contributes to PHC and historical neoinstitutionalism studies and points out practical aspects to decision-makers to strengthen the investment policies for PHC in SUS.

Keywords: historical neoinstitutionalism; health policy; primary health care; health investment; health financing.

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Análise de políticas de investimento na Atenção Primária à Saúde: neoinstitucionalismo histórico aplicado ao sistema de saúde brasileiro

As políticas de investimento na Atenção Primária à Saúde (APS) possuem um papel fundamental na organização dos sistemas de saúde. No Sistema Único de Saúde (SUS), esse aspecto torna-se ainda mais relevante por ser o ente estruturante do sistema. Apesar de sua importância, os estudos das políticas de investimento na APS possuem um caráter mais descritivo que pouco colabora com o entendimento do processo histórico e político. Para suprir essa lacuna, este artigo tem como objetivo analisar as políticas de investimento para a APS no SUS, com base na perspectiva do neoinstitucionalismo histórico. Os dados primários e secundários foram coletados por meio de revisão bibliográfica, levantamento documental e entrevistas com atores-chave. Para a análise desses dados, buscou-se, de forma indutiva, associar características do sistema de saúde e do modelo de APS brasileiro à trajetória das políticas de financiamento federal destinadas a investimentos em infraestrutura, equipamentos e tecnologia na APS. Os resultados apresentados: i) identificam fortalezas e fragilidades nas políticas de investimento na APS, com uma lógica contextual e histórica dos fatores que contribuíram para esse processo e ii) recomendam ações, tomadas de decisão e políticas divididas em três categorias: histórico do investimento na APS, necessidades de financiamento na APS e impacto do financiamento nos resultados da APS. Portanto, este trabalho contribui com os estudos sobre a APS e o neoinstitucionalismo histórico e aponta aspectos práticos para os tomadores de decisão, com o objetivo de fortalecer as políticas de investimento na APS do SUS.

Palavras-chave: neoinstitucionalismo histórico; política de saúde; atenção primária à saúde; investimento em saúde; financiamento em saúde.

Análisis de las políticas de inversión en atención primaria de salud: neoinstitucionalismo histórico aplicado al sistema de salud brasileño

Las políticas de inversión en atención primaria de salud (APS) desempeñan un papel fundamental en la organización de los sistemas de salud. En el Sistema Único de Salud brasileño (SUS) ese aspecto se torna aún más relevante, por ser la entidad estructurante del sistema. A pesar de su importancia, los estudios sobre las políticas de inversión en la APS tienen un carácter más descriptivo que contribuye poco a la comprensión del proceso histórico y político. Para llenar esa laguna, este artículo tiene como objetivo analizar las políticas de inversión para la APS en el SUS desde la perspectiva del neoinstitucionalismo histórico. Los datos primarios y secundarios se recolectaron a través de revisión bibliográfica, relevamiento documental y entrevistas a actores clave. Para el análisis de estos datos, se buscó de forma inductiva asociar características del sistema de salud y del modelo de APS brasileño con la trayectoria de las políticas de financiación federal destinadas a inversiones en infraestructura, equipos y tecnología en la APS. Los resultados presentados i) identifican fortalezas y debilidades en las políticas de inversión en APS con una lógica contextual e histórica de los factores que contribuyeron a este proceso y ii) recomiendan acciones, tomas de decisiones y políticas divididas en 3 categorías - historial de la inversión en APS, necesidades de financiamiento de la APS e impacto del financiamiento en los resultados de la APS. Por lo tanto, este trabajo contribuye a los estudios sobre APS y neoinstitucionalismo histórico y señala aspectos prácticos para los tomadores de decisión con el objetivo de fortalecer las políticas de inversión en APS del SUS.

Palabras clave: neoinstitucionalismo histórico; políticas de salud; atención primaria de salud; inversión en salud; financiación de la salud.

1. INTRODUCTION

The structuring of health systems based on Primary Health Care (PHC) is one of the main recommendations of the United Nations for achieving Universal Health Coverage, a key target of the Sustainable Development Goals (SDGs) by 2030 (United Nations [UN], 2019). In addition to improving health outcomes, the effective functioning of health systems also brings economic and social benefits to nations (World Health Organization [WHO], 2018). Recognising health systems' economic and social value is crucial for governments to enhance financing mechanisms for health systems, including PHC.

Health systems consist of organisations, people, and actions that aim to promote, restore, or maintain health (WHO, 2000). To achieve these goals, health systems need to perform several basic functions, such as providing individual and collective services; developing health professionals;

ensuring access to essential medical products, vaccines, and quality technologies; maintaining health information systems; mobilising and allocating financial resources; and ensuring leadership and governance of the health system (WHO, 2007).

PHC is widely recognised as the most appropriate way to provide access to the health system and is directly associated with a more equitable distribution of health among populations (Fernandez et al., 2024; Starfield et al., 2005). Responsible for providing essential health services – including the management of non-communicable diseases and public health actions – adequate PHC funding is crucial for ensuring the good performance of health systems (Hanson et al., 2022).

The analysis of health system financing is key to understanding the interactions between healthcare providers and the population, including who pays for care, when payment is made, how much is paid, to whom, and what types of services are obtained (Papanicolas et al., 2022). Investments, in turn, constitute a strategic part of health system financing (Jamison et al., 2013). Investments refer to the expenditure on goods and services that will be used in the production of other goods and services.

One of the most important functions of government is to determine how to invest and distribute its resources (Atun & Moore, 2021). These decisions influence the design and performance of the health system. In this regard, the analysis of financing requires viewing health systems as complex organisations. Their performance is influenced by contextual factors and structural components, which establish dynamic and interactive relationships.

In Brazil, the implementation of the Unified Health System (SUS) has led to improvements in access to health services and health outcomes across the country (Castro et al., 2019). Despite being chronically underfunded, federal financial incentives in the SUS have driven the expansion of healthcare provision. The creation of the Basic Care Floor (PAB) was a successful example, which enabled the expansion of PHC (Massuda, 2022). However, this expansion has not been homogeneous in terms of infrastructure, workforce, supplies, and technology, leading to variations in care quality.

In recent years, several descriptive and quantitative studies have been developed to better understand the evolution of PHC investment policies. However, these studies have done little to deepen the historical, political, and organisational understanding of this evolution. To address this academic and practical gap, this study aims to analyse PHC investment policies within the SUS, guided by the perspective of historical neoinstitutionalism.

For this analysis, a combination of documentary analysis, interviews with key stakeholders, and a review of the specialised literature was employed. The study model sought to associate the characteristics of the health system and the Brazilian PHC model with the historical institutional trajectory of federal funding policies directed at investments in infrastructure, equipment, and technology for PHC. Based on the identification of strengths and weaknesses in PHC investment policies, recommendations are provided for the SUS. Thus, this study contributes i) to academic debates in the fields of public administration, political science, and public health by advancing discussions on PHC investment policies through historical neoinstitutionalism, and ii) to practice by offering recommendations to decision-makers at municipal, state, national, and international levels on PHC investment policies within the SUS.

2. HISTORICAL NEOINSTITUTIONALISM AND HEALTH POLICIES

In recent years, neoinstitutionalist theories have been used as a theoretical framework to analyse the evolution, behaviour, and relationships of various phenomena, including public policies. This theoretical approach seeks to understand how institutions – the central focus of analysis – interact with society, influence societal behaviours, and are influenced by them, thus shaping individual and collective behaviours (Vielba, 2005).

Within the realm of public policy, the development of neoinstitutionalism has led to the conception of four distinct branches to help comprehend aspects of redistribution, regulation, modernisation, and liberalisation, namely: historical, neo-economic, normative, and billiard ball models (Reich, 2000). Hall and Taylor (2003) align with Reich's (2000) thinking but synthesise these into three branches: historical, rational choice, and sociological.

While i) rational choice neoinstitutionalism focuses on the rational interests of actors and how they maximise outcomes based on normative contexts, and ii) sociological neoinstitutionalism emphasises that institutions arise from and are shaped by the cultural and social contexts in which they operate, iii) historical neoinstitutionalism centres on the temporal evolution of political institutions and how they do or do not shape actors' behaviours (Hall & Taylor, 2003). Therefore, to fulfil the objective of this study, which is to analyse PHC investment policies in the SUS, historical neoinstitutionalism is the most appropriate theoretical foundation.

Although historical neoinstitutionalism focuses primarily on formal political institutions, this approach does not exclude the analysis of other factors that explain collective or individual behaviours (Immergut, 1998; Radaelli et al., 2012). From this perspective, when historical neoinstitutionalism is used to analyse public policy, emphasis is placed on the historical sequence of events, the patterns of dependence and the relationship between them, and the critical junctures that influence institutional change or continuity (Graf, 2023).

There are historical moments that characterise political and institutional transformations, whether formal or informal, which can often lead to changes in the adopted public policies (Barzelay & Galego, 2006). Recently, the COVID-19 pandemic was one such historical moment that brought about institutional and policy changes within public administration, leading to the implementation of new public policies to mitigate its effects (Ongaro & Longo, 2021).

Previous studies have shown the use of historical neoinstitutionalism to examine health policies in the context of national health systems, such as the SUS. Powell (2016) discusses the importance of historical moments for institutions to enable the transformation and improvement of health policies, and consequently, health systems, as seen in the British National Health Service (NHS). In the Brazilian context, Cavalcanti et al. (2022) demonstrated how the political-institutional and historical context of cooperation between government and academia was crucial for the development of a specific public health policy – the National Programme for Improving Access and Quality in Primary Care (PMAQ-AB).

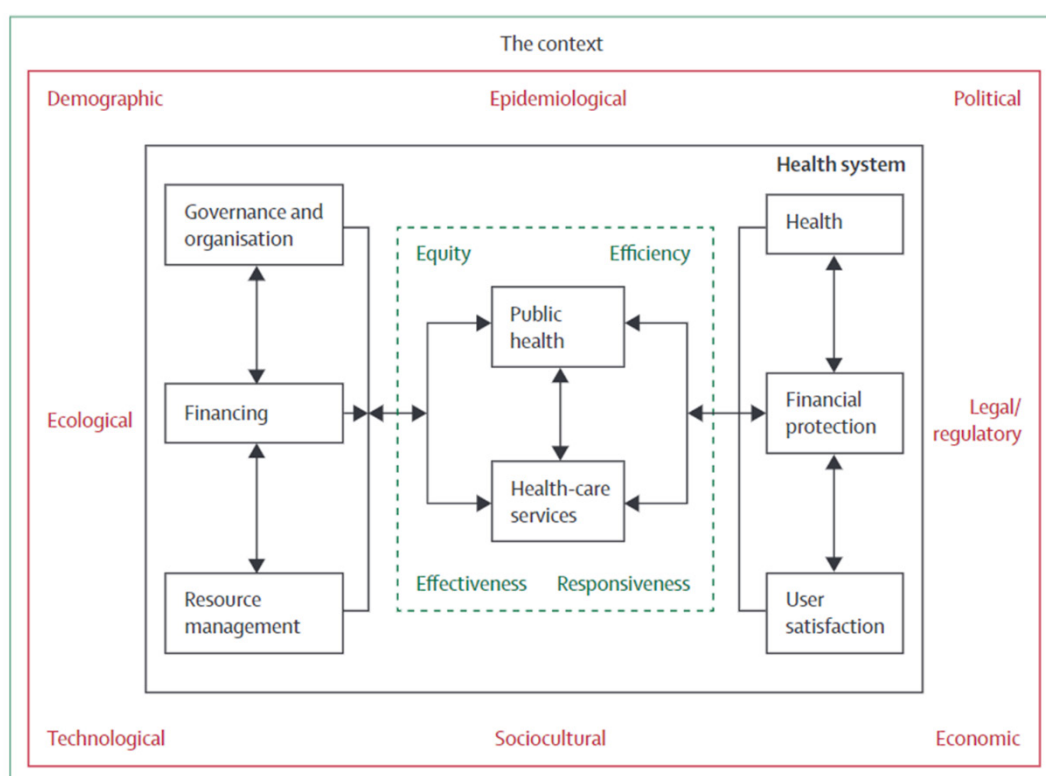
3. METHODOLOGY

3.1. Research design

This is an exploratory study aimed at diagnosing PHC investment policies within the SUS, describing and analysing the strengths and weaknesses of these policies in light of their historical trajectories. The study presents an articulated analysis of the characteristics of the health system and the PHC model in Brazil, focusing on investment policies that have allocated resources to infrastructure, equipment, and technology for PHC. Therefore, the study is based on a qualitative analysis grounded in historical neoinstitutionalism, where institutional changes, shaped by historical context and the passage of time, are essential for understanding policy processes (Hall & Taylor, 2003).

To characterise the SUS, the theoretical-methodological framework proposed by Atun and Moore (2021) for health system analysis was employed. According to the authors, such analysis requires viewing health systems as complex organisations whose performance is influenced by contextual factors (epidemiological, demographic, technological, economic, political, regulatory, cultural, and environmental) and by structural components that establish dynamic and interactive relationships, as illustrated in Figure 1.

FIGURE 1 HEALTH SYSTEMS ANALYSIS MODEL



Source: Atun and Moore (2021).

3.2. Data collection

This study adopted an exploratory, qualitative, and historical-institutional approach, utilising both primary and secondary data sources. Secondary data were obtained through documentary research, followed by the analysis of documents that describe the health system and investment policies. The main technical documents included in the study's documentary research are as follows:

- The Brazilian Public Health System. International Seminar on Health System Trends and Challenges in the America (Ministério da Saúde, 2002);
- Guiding Document for Investments in the Care Network (Ministério da Saúde, 2022);
- Primary Health Care Secretariat Portal (SAPS) (Ministério da Saúde, 2023a);
- New PAC: Health will receive R\$ 31 billion in investments over the coming years (Ministério da Saúde, 2023b).

Primary data were collected through semi-structured interviews with key stakeholders involved in the execution and/or formulation of PHC and health investment policies at the Ministry of Health (MS), state or municipal health departments, as well as members of the national councils of state health secretaries (CONASS) and municipal health secretariats (CONASEMS), as shown in Box 1. A total of seven semi-structured interviews were conducted, resulting in approximately 250 minutes of recorded material.

BOX 1 CHARACTERISATION OF KEY STAKEHOLDERS INTERVIEWED

Government Sphere	Government Structure	Number
Federal	Ministry of Health	3
State	National Council of State Health Secretaries (Conass)	1
	State Health Secretary	1
Municipal	National Council of Municipal Health Secretaries (Conasems)	1
	Municipal Health Secretary	1

Source: Elaborated by the authors.

3.3. Data analysis

The evaluation of documentary research data and interviews was conducted based on the SUS analysis model and its governance system. Following an inductive approach, an analytical matrix was created using the insights gathered from the interviewees (Box 2).

BOX 2 ANALYTICAL MATRIX FOR PHC INVESTMENT

Categories	Subcategories
Historical Investment in PHC	Infrastructure
	Equipment
	Territorial Diagnosis
	Resources Allocation
Needs for PHC Financing	Legal Framework
	Stakeholder Participation
	Regionalisation
	Technological Update
Impact of Financing on PHC Outcomes	Access
	Comprehensiveness
	Resolution Capacity

Source: Elaborated by the authors.

4. RESULTS AND DISCUSSIONS

4.1. Characterisation of the Brazilian health system

4.1.1. Organisation and governance

The SUS was established based on principles defined by the 1988 Federal Constitution – health as a universal right and a responsibility of the State – and was subsequently regulated by federal laws, decrees, and ministerial orders. Decentralised to the municipal level, governmental responsibility is shared between the three levels of government – federal, state, and municipal – which have political, financial, and administrative autonomy. The SUS includes mechanisms for social participation at all levels of government. Additionally, the health system is open to private sector participation.

The Ministry of Health (MS) is responsible for formulating national health policy, financing, and providing technical cooperation to subnational levels, including the national coordination of health surveillance, information, control, auditing, and health system evaluation (Marques et al., 2016). Municipalities are mainly responsible for providing health services, especially PHC. States are tasked with organising regional networks, providing technical and financial cooperation to municipalities, and offering medium and high-complexity services.

Inter-federative commissions, integrated planning processes, and financing agreements have been essential in establishing shared responsibilities and promoting collaboration among the different levels of government. The Tripartite Intermanagerial Commission (CIT), comprising representatives from the MS, the National Council of Health Secretaries (CONASS), and the National Council of Municipal Health Secretariats (CONASEMS), is responsible for discussing and approving national

health policies. Similarly, at state and regional levels, Bipartite Intermanagerial Commissions (CIB) and Regional Intermanagerial Commissions (CIR) negotiate the implementation of national policies and the definition of state policies.

Health planning is mandatory at all levels of government, following a bottom-up approach from the municipal to the federal level. This process aims to harmonise health needs, considering epidemiological, demographic, and socioeconomic factors with available resources and health policy goals. However, despite legal provisions for an integrated planning cycle across federal spheres, challenges such as weaknesses in the organisation of the regional health system, inequalities in the allocation of financial resources, and manager turnover limit the effectiveness of the bottom-up planning process (Massuda et al., 2023).

4.1.2. Financing

The SUS is financed by general tax revenues from contributions and taxes involving all three levels of government. The percentages of financial investment by municipalities, states, and the federal level in the SUS are currently defined by Complementary Law No. 141/2012. In 2019, total health expenditure in the country was 9.6% of GDP, with 59.1% from private sources and 41.9% from public revenues (WHO, 2023). Since the 2000s, municipalities have experienced the highest percentage growth in SUS spending, compensating for the relative reduction in the federal government's share (Funcia, 2019).

Despite the reduction in federal participation, federal financial incentives continue to have substantial power in driving the implementation of national health policies at the local level. Additionally, the creation of a fund-to-fund resource transfer system has enabled a rapid flow of resources from the federal government to subnational spheres, facilitating financial transfers from the federal government to states and municipalities in response to the COVID-19 pandemic (Massuda et al., 2023).

The allocation of financial resources in the SUS is regulated by normative provisions that define the responsibilities of each level of government and the conditions necessary for states and municipalities to assume responsibility for managing the SUS. Although the Basic Operational Standard (NOB-96) established the calculation of federal resource transfers based on population, allocation remains largely linked to the logic of supply, existing installed capacity, and the revenue needs of healthcare providers, which are concentrated in more developed areas and in actions not always aligned with the population's needs. At the state level, the criteria used to distribute resources among municipalities were generally not explicit (Ministério da Saúde, 2002).

Resources from the Union's general budget for states and municipalities are also allocated through "Programme/Action" resources and "Parliamentary Amendments". Programme/Action resources are budgetary allocations where public and private entities submit project proposals based on pre-defined programmes by the granting public body. Parliamentary Amendment (EP) resources involve budgetary allocations where the Legislative Branch can influence the Union's General Budget to refine the proposals submitted by the Executive Branch (Conselho Nacional de Secretários Estaduais de Saúde [CONASS], 2003). The growing importance of EP resources in the SUS is noteworthy, given the significant increase in the volume of resources allocated through this channel (Vieira & Lima, 2022). In 2014 and 2015, EPs represented 3.2% and 1.7% of the Ministry of Health's budget, respectively, while in 2016, 2019, and 2022, these values rose to 7.1%, 10.1%, and 9.9%, respectively (Piola & Vieira, 2024).

4.1.3. Resources generation and management

Managing physical, technological, and workforce resources in a decentralised health system like the SUS, within a continental and highly unequal country such as Brazil, is a significant challenge. Regarding healthcare infrastructure, the SUS has promoted a substantial expansion of non-hospital establishments, particularly Basic Health Units (UBS) and Emergency Care Units (UPA), driven by federal policies and funding, and implemented by local governments. The same was not observed in the distribution of hospital beds, which remain concentrated in wealthier regions of the country and in the private sector, as became evident during the COVID-19 pandemic (Rache et al., 2020).

Regarding the workforce, one of the main advancements has been the expansion of multidisciplinary teams. However, significant inequality in the distribution of professionals persists, particularly doctors. The More Doctors Programme, implemented by the MS in 2013, innovated by providing doctors through the federal government to remote areas and regions lacking medical care. This resulted in reduced care gaps and contributed to improved healthcare coverage in smaller and economically disadvantaged municipalities (Özçelik et al., 2021).

In the area of medicines and technology, Brazil stands out for its network of public and private laboratories with the capacity to produce medicines and vaccines. However, Brazil's technological and productive dependency on external health products is increasing. Between 2002 and 2017, the list of essential medicines and medical products grew from 327 to 869 items. Despite the advances promoted by pharmaceutical assistance policies in the SUS, including the Popular Pharmacy programme, access to medicines remains highly unequal among population groups, and out-of-pocket spending on medicines remains high (Boing et al., 2022).

A similar challenge exists concerning information technologies. Despite the expansion of information systems and the advancement of initiatives such as telehealth, particularly in remote regions, which have contributed to the continuing education of the SUS workforce, challenges remain, including integration across levels of care and government spheres, and the promotion of decision-support tools (Pinto et al., 2022).

4.1.4. Service delivery

The Brazilian health system is composed of a public-private mix that ensures the provision of a wide range of health services. State and municipal governments primarily deliver collective health actions, such as vaccination, surveillance, and other public health activities. Healthcare services within the SUS are provided by public establishments, particularly in PHC and emergency care, while a large portion of hospital services, specialised outpatient care, and laboratory support are contracted from private providers (Viacava et al., 2018). Although subnational governments have autonomy in service delivery, they must follow national guidelines when receiving federal funding.

In addition to private service providers, philanthropic and for-profit entities, the private health system also operates through supplementary health insurance. This segment comprises private health insurance companies, which cover just over fifty million people, approximately 25% of the Brazilian population. However, even those who do not use public health services benefit from collective public health surveillance and actions provided by the SUS.

4.1.5. *PHC in the SUS*

PHC in the SUS is regulated by the National Primary Care Policy, first introduced in 2006 and revised in 2012 and 2017. The PNAB regulates the scope of actions to be provided by PHC, the types of services subsidised by the federal government, and the responsibilities of the federated entities for this level of care. PHC is responsible for primary health care for the Brazilian population through health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harm reduction, palliative care, and health surveillance within the SUS (Ministério da Saúde, 2023a). The Family Health Strategy is the priority strategy for the operationalisation of the PHC model in the SUS.

Federal PHC funding began in 1991 with the Community Health Agents Programme (PACS), followed in 1994 by the Family Health Programme (PSF), targeting the poorest areas of the country. Established in 1996 by NOB-96 and implemented in 1998, the Basic Care Floor (PAB) consisted of a fixed component, calculated per the number of inhabitants of a municipality, and a variable component linked to priority policy incentives. In this way, the PAB changed the payment logic based on the number of procedures performed and universalised PHC funding across the country. With resources transferred regularly and automatically by the National Health Fund to municipal health funds, it was possible to finance health services in poorer municipalities lacking basic infrastructure, promoting a gradual and continuous shift in the healthcare model (Massuda et al., 2022). After twenty years, in 2019, the federal government replaced the PAB with the rules established by the “Previne Brasil” programme, which now follows four criteria: weighted enrolment, performance-based payment, incentive for strategic actions, and financial incentive based on population criteria (Massuda, 2020).

4.2. Characterisation of investment policies in the SUS

Since its implementation, only three major federal programmes have been dedicated to investments in the infrastructure of the SUS: Reforsus, PAC-Saúde, and Requalifica UBS. Active between 1996 and 2000, Reforsus was the first programme to direct federal financial resources towards infrastructure and equipment investments. With approximately US\$ 750 million in loans from international organisations (World Bank and IBRD), the programme focused most of its resources on medium and high-complexity services, although PHC was one of its components. Weaknesses identified included excessive bureaucracy in the contracting and execution of projects, leading to low financial implementation, as noted in a performance audit by the Federal Audit Court (Tribunal de Contas da União [TCU], 1999).

Launched in 2007, the Growth Acceleration Programme (PAC) was a federal government initiative aimed at promoting the country’s economic and social development through investments in various sectors, particularly infrastructure. Although health was not initially prioritised, it gained prominence in the second phase of PAC, launched in 2010, which included investments in urban sanitation and the construction and renovation of health facilities, including Basic Health Units (UBS) and Emergency Care Units (UPA).

Implemented in 2011, Requalifica UBS focused exclusively on PHC. With over R\$ 5 billion allocated, the programme covered more than 25,000 UBSs, representing almost 50% of the total at the time. Requalifica UBS utilised federal government resources from PAC and introduced innovations, such as fund-to-fund transfers and a computerised system for programme accreditation and monitoring. However, limitations included the lack of internal controls for monitoring and evaluation and the need for criteria to address regional inequalities in resource distribution (Bicalho, 2012).

Relaunched in August 2023, the New PAC prioritised health as one of the federal government's main investment areas for the first time. The Ministry of Health plans to invest R\$ 31 billion in primary care, specialised care, telehealth, emergency preparedness, and the Health Economic-Industrial Complex (Ministério da Saúde, 2023b). These investments aim to support the construction of new basic units, polyclinics, and maternity hospitals, the purchase of ambulances, and the expansion of vaccines, blood products, and telehealth access. Box 3 presents the strengths and weaknesses of the two main programmes: Reforsus and Requalifica UBS.

BOX 3 STRENGTHS AND WEAKNESSES OF THE REFORBUS (1996) AND REQUALIFICA UBS (2011) PROGRAMMES

ReforSUS	Strengths	• Federal government's effort to structure a programme for investing in infrastructure and innovation. • Pioneer federal investment programme. • Equity criterion in resource distribution (30%).
	Weaknesses	• International loan increased external debt. • Bureaucracy in contracting – delays and unmet deadlines. • Requirement for a counterpart from federal entities. • Low financial implementation. • 70% of total resources distributed on a per capita basis. • Concentration of resources in medium and high complexity services. • No resources for new construction.
Requalifica UBS	Strengths	• Fund-to-fund resource transfer mechanism. • Focus exclusively on PHC. • Resources for new UBS construction. • Over 25,000 approved UBS renovation, construction, and expansion proposals (nearly 50% of UBSs). • Expansion of PHC resources. • Digitalised programme system (SISMOB).
	Weaknesses	• Lack of internal control mechanisms. • No programme impact evaluation. • Deficiencies in Ministry of Health monitoring. • Potential for politically driven resource allocation. • Programme implementation deadlines unmet. • Programme discontinuity due to political changes. • Need for regional inequality-based resource allocation criteria.

Fonte: Elaborated by the authors.

4.3. Analysis of investment policies for PHC in the SUS

Based on the analysis of the interview data collected in this study, there was broad consensus on the need to establish a sustainable investment policy for the SUS. The following sections highlight points raised in the interviews and the literature that could inform the development of permanent and sustainable investment policies for the SUS, particularly for PHC.

4.3.1. Historical investment in PHC

4.3.1.1. Infrastructure and equipment

Investment in PHC has been highlighted in the literature as a key issue for strengthening health systems. In 2022, the Lancet Global Health Commission on PHC financing emphasised that all countries must invest more and better in PHC (Hanson et al., 2022). The Commission's main recommendation is that countries increase public resource allocation to PHC and modify their health financing mechanisms to prioritise people and address inequalities first.

There is substantial evidence that the financing model has enabled the expansion of PHC in Brazil, bringing numerous benefits to the country's health profile (Massuda et al., 2022). However, the expansion of coverage and access to services was not accompanied by consistent investment in PHC infrastructure and equipment. Currently, most PHC resources are allocated to operational expenses, primarily workforce costs (Vieira et al., 2022). Historically, there has been a discrepancy between the resources allocated to medium and high-complexity services and PHC. According to Soares (2007), the concentration of investments in medium and high-complexity services stems from the view that PHC is a municipal responsibility and requires relatively fewer resources.

On the other hand, Soares (2007) notes that between 1995 and 2001, R\$ 53 billion was invested in health infrastructure, which led to increased productive capacity in the network. This increase created a demand for more operational resources to maintain the expanded production. This statement highlights the lack of economic and financial predictability in planning, revealing a disconnect between investments and ensuring resources to sustain ongoing services.

From this, a key recommendation arises: **PHC infrastructure and equipment investment projects must estimate and align with the operational resources needed to ensure sustainability.**

4.3.2. Need for PHC financing

4.3.2.1. Territorial diagnosis as a basis for PHC Investment

The most recent census assessing PHC infrastructure in Brazil was conducted in 2012 during the first cycle of the Quality Improvement Programme (PMAQ). Based on PMAQ data, various studies concluded that over 75% of UBS had deficiencies (Bousquat et al., 2017); there was a reduction in UBS classified as restrictive or inadequate, reflecting greater availability of equipment and health teams (Kashiwakura & Gonçalves, 2019); and only 48% of UBS met the basic reference standard, with infrastructure being rated lowest (Facchini et al., 2018). Despite the advances in UBS infrastructure, structural problems persist in service provision.

It is time for another needs assessment. The last census was in 2011, and now it is time to develop a new programme. It is essential to conduct a large-scale survey, either online or through sampling, in the first half of next year (2023) (E1).

Interviewees emphasised the need for new investment policies to be based on information regarding the current status of Basic Health Units' infrastructure. The needs assessment should follow a regular, bottom-up approach, with territorial planning conducted by municipalities, supported by states and coordinated by the federal government. **Conducting a regular PHC investment needs assessment every five years is recommended.**

4.3.2.2. Resource allocation for PHC Investment

The situation regarding resource allocation for PHC has deteriorated over the past decade, given the reduction of federal investments in health. Nobre and Faria (2023) illustrate that, between 2013 and 2023, the percentage of resources allocated to health decreased by 6 percentage points. In absolute terms, the current allocation of R\$ 6 billion represents a 64.2% reduction compared to the R\$ 16.8 billion allocated in the previous decade. Moreover, there has been a notable increase in the influence of parliamentary amendments on resource distribution. Resource allocation through these amendments is not the best way to ensure sustainable investment policies in health, as the irregular release of funds hampers long-term, equitable, and efficient investments.

Given this scenario, it is recommended to **significantly increase the federal financial resources allocated to PHC investments, especially in construction, equipment, and workforce training.**

4.3.2.3. Legal framework to promote PHC investment

Managers report that expanding investments in PHC requires greater legal certainty. Both public and private sectors depend on this support to foster innovations and allocate resources. Moreover, they emphasise that it is the federal government's responsibility to develop well-structured and sustainable health investment policies anchored in legal frameworks, resilient enough to withstand political transitions.

If a more robust bill is developed, it will create a normative model that provides more credibility, technical, and legal security not only for public partners but also for private ones (E4).

Thus, **the creation of a legal framework that supports and promotes PHC investment initiatives at state and municipal levels** emerges as a recommendation. This legal framework would provide the necessary foundation to implement and sustain significant improvements in health infrastructure and services, ensuring that efforts continue regardless of political changes.

4.3.2.4. Co-financing and state support for PHC investment

State health secretaries should play a vital role in financing and supporting PHC investments. Co-financing at both the state and federal levels would allow for pooling resources to maximise the impact of investments.

I believe state health departments have a role both in providing complementary financing to federal resources and in gathering information and directing resources. States could also participate in the design phase of the programme, for example, with the Ministry of Health covering 80% or 70% of construction costs and municipalities and state departments providing the remaining percentage. Alternatively, states could participate in the execution phase, supplying inputs (E1).

Thus, it is recommended that **state governments contribute to policy definition, resource allocation, and technical support to municipalities, aligned with federal initiatives.**

4.3.2.5. Health regions as units for scaling PHC investments

The regionalisation of the SUS, currently dividing the country into 450 health regions, can provide a new framework for federal and state governments to plan PHC investments across municipalities. A regional PHC investment plan allows for economies of scale and more targeted interventions, considering local realities.

“I believe that investment should consider health regions, with a focus on financing equity among them. Given that we have around 450 regions, it does not make sense for a group of municipalities—let’s say 30 within a region—to have part of their Basic Health Units highly qualified in terms of structures, equipment, and internet, while the rest of the region remains underdeveloped. Infrastructure should evolve in tandem with the region’s development” (E1).

It is therefore recommended to **plan national PHC infrastructure and equipment investments by health regions, prioritising those with significant gaps and aiming to achieve economies of scale.**

4.3.2.6. Technological update and digital transformation of PHC

In addition to modernising infrastructure and technology, accelerating the digital transformation of PHC within the SUS requires strategic investments. Resources should be directed towards implementing digital technologies such as electronic health records, scheduling systems, and regulation platforms, making access to services more agile for users. These tools are essential for integrating and coordinating care across different levels, improving communication between health professionals, and ensuring continuity of care.

A focus on technological upgrades and digitalisation will enhance efficiency and accessibility, especially through telehealth services and remote monitoring for patients with chronic conditions. These innovations would bring the health system in line with modern practices and create a more sustainable approach to service delivery.

The first thing we need is to start investing in digital technology for primary care, especially in service organisation. It is absurd that, given the available technology, patients are unable to book appointments online or perform a series of other tasks (E4).

It is thus recommended to **prioritise investments in technological modernisation, aiming to integrate and improve communication between the various actors involved in the health system.**

4.3.3. Impact of financing on PHC outcomes

4.3.3.1. Expanding access and resizing family health teams

The Family Health Strategy (FHS) still does not offer universal coverage as agreed in international agreements and pacts supported by Brazil. Investment in expanding Family Health Teams and infrastructure is essential for achieving this goal. Additionally, the relationship between team size and the population served must be re-evaluated. Teams should be resized to provide more comprehensive care, not only for managing chronic conditions but also for addressing acute and urgent needs, ensuring broader access for the population.

A recent study estimated that 25,600 new teams would be needed at an annual cost of R\$ 17.1 billion to achieve full coverage through the Family Health Strategy (Faria et al., 2022). Furthermore, an additional 16,000 health units would be required, necessitating R\$ 11.2 billion in investments. Beyond the creation of new teams and health units, attention must also be given to the 40,000 existing UBSs and the 48,000 teams already in operation. The depreciation of resources and the need for technological upgrades highlight the importance of continuous and sustainable investments.

It is essential to resize the population per team, allowing for more competencies in terms of meeting care demands and ensuring access to acute care. This also optimises infrastructures to provide 24-hour services, including weekends (E2).

Therefore, it is recommended to consider expanding the number of Family Health Teams and resizing team sizes to better meet the needs of the population in PHC investment policies.

4.3.3.2. Providing infrastructure to achieve universality and comprehensiveness in PHC

Investments in equipment and technology aim to create an environment that offers quality care and ensures patient safety. This includes adhering to basic sanitary standards such as proper facility dimensions, patient flow, waiting rooms, administrative areas, accessibility, appropriate designs for healthcare facilities, and the use of specific materials for medical structures. The design of PHC facilities is particularly important as these units are multifunctional, hosting outpatient treatments, diagnostics, community actions, and even integrative medicine.

In order to achieve universality and comprehensiveness, it is crucial to define the healthcare model to be implemented and direct investments toward providing the necessary infrastructure and equipment to support this model. Advances in technology and modern construction techniques are facilitating projects to renovate, expand, or construct new UBSs while addressing sustainability concerns and creating environments that are welcoming for patients and conducive to productive work for professionals.

It is crucial to clearly define the care model and ensure comprehensiveness. Funding should support sustainable and standardised units, with clear criteria to guarantee the universality and comprehensiveness of care (E2).

It is therefore recommended to align investments in infrastructure and technology with the defined care model to achieve universality and comprehensiveness in PHC.

4.3.3.3. Enhancing PHC's capacity to resolve health issues

PHC within the SUS must be equipped with the necessary tools and technologies to expand diagnosis and treatment capabilities, thereby reducing unnecessary referrals to higher levels of care. Without appropriate resources, patients referred to more specialised services may not return to PHC, particularly when it is easier to obtain exams and procedures in one location. This disrupts the continuity of care in PHC and undermines the development of patient-provider relationships within Family Health Teams.

It is essential to link investments in PHC with professional training, enabling teams to carry out diagnoses and treatments directly at the point of care. Such an approach prevents care fragmentation and strengthens the bond between patients and healthcare providers. With the right technology, PHC professionals can play a pivotal role in prevention, early diagnosis, and treatment, contributing to a more integrated and patient-centred healthcare system.

All the information pertains to the basic diagnostics that can be provided during direct patient contact. By adding value through digital tools, we can offer much more resolution to the patient and enhance medical decision-making in situ (E4).

Thus, it is recommended to **link investments in equipment and technology with continuous professional training, enhancing PHC's capacity to resolve health issues.**

4.4. Recommendations for PHC investment policies

Box 4 presents the synthesis of the SUS PHC investment policies recommendations.

BOX 4 RECOMMENDATIONS FOR PHC INVESTMENT POLICIES

Categories	Subcategories	Recommendations
Historical Investment in PHC	Infrastructure and Equipment	1. Estimate and align PHC infrastructure and equipment investment projects with operating resource needs.
Needs for PHC Financing	Territorial Diagnosis	2. Conduct a regular PHC investment needs assessment every five years.
	Resource Allocation	3. Significantly expand federal financial resources allocated to PHC investments in construction and equipment, combined with workforce training.
	Legal Framework	4. Create a legal framework that supports and promotes PHC investment initiatives at state and municipal levels with transparency and sustainability.
	Stakeholder Participation	5. State governments should contribute to policy definition, resource direction, and technical support to municipalities, aligned with federal initiatives.
	Regionalisation	6. Plan national PHC infrastructure and equipment investments by health regions, aiming for economies of scale and prioritising regions with healthcare gaps.
	Technological Update	7. Direct investments towards technological modernisation, promoting care integration and facilitating communication among the various actors involved.

(continue)

Categories	Subcategories	Recommendations
Impact of Financing on PHC outcomes	Access	8. Consider expanding the number of Family Health Teams in PHC investments and resizing team sizes to better meet population needs.
	Comprehensiveness	9. Align investments in infrastructure and technology with a clear definition of the care model, aiming to achieve universality and comprehensiveness in PHC.
	Resolution Capacity	10. Link investments in equipment and technology with continuous professional development, aiming to enhance the resolution capabilities of PHC teams.

Source: Elaborated by the authors.

In analysing the recommendations proposed above, the importance of the historical neoinstitutionalism debate for PHC investment policies in Brazil becomes evident. For the recommendations related to increased financing and investment (1, 3, 6, 9, and 10) to be realised, a significant alignment among political institutions in the health sector across the three levels of Brazilian government (Cavalcanti et al., 2022), and their respective councils (CONASS and CONASEMS), is required, as well as a favourable historical moment (Graf, 2023) within the socioeconomic context, such as the economic recovery following the COVID-19 pandemic (Ongaro & Longo, 2021) and the resolution of a political crisis experienced in the previous six years.

The remaining recommendations (2, 4, 5, 7, and 8) also require strategic alignment and a favourable historical context, similar to those mentioned earlier. However, as these recommendations are more focused on the management capacity of specific governmental entities, they concentrate on changing the collective or individual behaviours of society (Hall & Taylor, 2003), specifically in the implementation and execution of PHC investment policies.

5. CONCLUSIONS

Although there are few studies specifically focused on PHC investments, existing research highlights the economic, social, and health benefits of investing in PHC. In Brazil, investment policies have historically been episodic and vulnerable to shifts in political and economic contexts. A concerning trend is the increasing reliance on parliamentary amendments to allocate federal investment resources for PHC. This mode of resource allocation presents numerous issues, including unclear distribution criteria, fragmented allocation, and a lack of control and transparency in execution.

In light of this situation, this study emphasises the importance of establishing clear and sustainable investment policies for PHC within the SUS. It is essential to efficiently allocate resources to address regional inequalities and ensure that investments in infrastructure, equipment, and workforce are matched by corresponding operational resources. The launch of the new Growth Acceleration Programme (PAC) in August 2023 presents a potential opportunity to address these long-standing issues in health policy.

This study provides an analysis of PHC investment policies in Brazil through the lens of historical neoinstitutionalism. Understanding the historical and political dynamics that shape PHC investment

policies is essential for identifying appropriate paths forward for policymakers. Therefore, the results presented here contribute to both academic research and practical policy-making at national, state, and municipal levels.

The limitations of this study include: i) the number of interviews conducted, which were limited due to time and resource constraints; ii) the absence of quantitative data and methods to assess historical changes; and iii) the lack of a systematic review of the literature and documentary research.

Future research should focus on: i) applying different theoretical perspectives, such as sociological and rational choice neoinstitutionalism, to analyse PHC investment policies, including perspectives from local, regional, or state actors; ii) monitoring and evaluating new PHC investment policies in Brazil; iii) incorporating quantitative methods, such as factor analysis, to gain deeper insights into the historical evolution of PHC investments; and iv) using systematic or scoping reviews to develop replicable scientific perspectives on the topic.

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DATA AVAILABILITY

The dataset supporting the results of this study is not publicly available.

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