

CONTRACTING FOR PRIMARY HEALTH CARE IN BRAZIL: THE CASES OF BAHIA AND RIO DE JANEIRO

DISCUSSION PAPER

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Edson Araujo
Luciana Cavalini
Sabado Girardi
Megan Ireland
Magnus Lindelow



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of Bahia and Rio de Janeiro**

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Health, Nutrition and Population (HNP) Discussion Paper

Contracting for Primary Health Care in Brazil: The Cases of Bahia and Rio de Janeiro

Edson Araujo,^a Luciana Cavalini^b Sabado Girardi^c Megan Ireland^d and Magnus Lindelow^e

^a Economist, Health, Nutrition and Population Global Practice, The World Bank Group, Washington, DC, USA

^b Adjunct Professor, Medical Sciences College, Rio de Janeiro State University, Rio de Janeiro, Brazil

^c Researcher Fellow, Medical School, Federal University of Minas Gerais, Minas Gerais, Brazil
Health, Nutrition and Population Global Practice, The World Bank Group, Washington, DC, USA

^d Consultant, Health, Nutrition and Population Global Practice, The World Bank Group, Washington, DC, USA

^e Practice Leader, Health, Nutrition and Population Global Practice, The World Bank Group, Brasilia, Brazil

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Abstract: This study presents two case studies, each on a current initiative of contracting for primary health services in Brazil, one for the state of Bahia, the other for the city of Rio de Janeiro. The two initiatives are not linked and their implementation has independently sprung from a search for more effective ways of delivering public primary health care. The two models differ considerably in context, needs, modalities, and outcomes.

This paper does not attempt to evaluate the initiatives, but to identify their strengths and weaknesses, initially by providing a background to universal primary health care in Brazil, paying particular attention to the Family Health Strategy, the driver of the basic health care model. It then outlines the history of contracting for health care within Brazil, before analyzing the two studies.

The state of Bahia sought to expand coverage of the Family Health Strategy and increase the quality of services, but had difficulty in attracting and retaining qualified health professionals. Rigidities in the process of public hiring led to a number of isolated contracting initiatives at the municipal level and diverse, often unstable employment contracts. The state and municipalities decided to centralize the hiring of health professionals in order to offer stable positions with career plans and mobility within the state, and chose to create a State Foundation, acting under private law to manage and oversee this process. Results have been mixed as lower than expected municipal involvement resulted in relatively high administrative costs and consequent default on municipal financial contributions. The State Foundation is undergoing a governance reform and has now diversified beyond hiring for primary care.

The municipality of Rio de Janeiro, which until recently relied on an expansive hospital network for health care delivery, sought in particular to expand primary health services. The public health networks suffered from inefficiency and poor quality, and it was therefore decided to contract privately owned and managed, not-for-profit, Social Organizations to provide primary care services. The move has succeeded in attracting considerable increases in funding for primary health and coverage has increased significantly. Performance initiatives, however, still need fine-tuning and reliable information systems must be implanted in order to evaluate the system.

Keywords: Primary Care, Contracting, Health System, Brazil

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Correspondence Details: Magnus Lindelow, World Bank (mlindelow@worldbank.org).

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PREFACE

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study and share rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself.

This led to the formation of a joint Japan–World Bank research team under the Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the support of the government of Japan.

This Country Report on Brazil is one of the 11 country studies on UHC that was commissioned under the Program. The other participating countries are Bangladesh, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication “Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies,” available at:

<http://www.worldbank.org/en/topic/health/brief/uhc-japan>

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

INTRODUCTION

Brazil formally embarked on its path to universal health care some 25 years ago with the creation of the Unified Health System or SUS (*Sistema Único de Saúde*). Health care as the right of the individual and duty of the state was written into the 1988 constitution and was the culmination of a broad-based reform process throughout the 1980s that sought democratization and improved social rights. In particular, the “Sanitary Reform Movement” (*Movimento da Reforma Sanitária*)¹ strove for a fundamental break from the prevailing “curative privatizing model” that promoted expanded social security coverage and prioritized curative personal medical care in favor of a “collective public health model” built on the premise of universal access, equity, integrality (comprehensiveness), decentralization, and social participation.

Prior to the SUS, the Ministry of Health (MOH) focused on public health and disease-specific programs, while the social security institutions provided medical coverage. Initially, coverage was only provided to formal sector workers, and was then expanded to any self-employed workers who made social security contributions, while states and philanthropic organizations provided services for the rest of the population, but coverage remained limited (Gragnotati, Lindelow, and Couttolenc 2013). Primary care was delivered through Basic Care Units, but the coverage was inadequate, poorly distributed geographically, and suffered from a lack of trained providers.

In a political decision to reorient and reorganize health care delivery away from a facility-centered, passive, curative care approach toward a more comprehensive primary health care approach, the Family Health Strategy (FHS) was created at national level in 1994.² The FHS was designed to expand coverage of primary care with an emphasis on whole-person care and the social context, and to provide a first point of contact with the broader health system.

Since its launch, coverage of the FHS has expanded rapidly across the country. There are currently over 35,000 Family Health Teams, present in 96 percent of municipalities, and with estimated population coverage of 57 percent accordingly with Department for Basic Care (Diretoria para Atenção Básica - DAB) database).^{3,4} The expansion was accompanied by decentralization, with the growth in outpatient facilities occurring almost entirely at municipal level. Priority expansion of services into more rural, poorer municipalities, and to poorer communities within them, has enhanced equity of access. Utilization rates have risen across all states and particularly in those with lower levels of income. The FHS has also affected the way Brazilians use public services, reducing the role of hospitals as the “usual source of care” (from 35 percent in 1998 to 21 percent in 2008) and increasing reliance on primary care facilities (from 42 percent to 57 percent of the population) (Macinko 2011). Several studies have also demonstrated that the FHS has had a significant impact on outcomes, including infant mortality (Gragnotati, Lindelow, and Couttolenc 2013).

¹ An informal coalition of health professionals, academics, and others who demanded both a public health system responsive to and controlled by the public and health as a fundamental human right to be guaranteed by the constitution.

² The FHS was initially known as the Family Health Program. From early on, however, it became clear that the actions and principles of the Family Health Program were more far reaching than a program per se and it was renamed the FHS. For simplicity, this report refers to FHS throughout.

³ Coverage is determined by a person’s residence within the defined catchment area of a Family Health Team.

⁴ Data from Jan 2014, available at: http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php

The rapid expansion of primary care over the last two decades is an impressive accomplishment, due in large part to a massive increase in federal spending on primary care since 1995. Primary health care now accounts for 20 percent of federal spending on health, of which 65 percent goes to the FHS. At the same time, states and municipalities have also expended investment and recurrent spending in primary care.

After a rapid expansion over the first 10 years of implementation, coverage started to stagnate around 2006. In particular, expansion in larger municipalities and metropolitan areas has lagged. In addition, there has been a growing concern with the quality of care, ranging from quantity and quality of human resources to a concern with the effectiveness of care provided at primary level.

The constraints to expanding coverage and improving quality are in large part related to human resources. Rigidities within the public system over employment and services, in particular the requirement to contract health professionals as civil servants on long-term contracts with limited remuneration flexibility has led to significant problems in the hiring and retention of professionals. Many municipalities have therefore resorted to diverse and often unstable and short-term forms of hiring, but these have been increasingly criticized and challenged on legal grounds, thus undermining the long-term effectiveness and sustainability of the FHS.

Given these challenges, many states and municipalities started searching for ways to circumvent public sector rigidities that hampered expansion of primary care coverage. Contracting out the provision of health services has emerged as one option, and initiatives have been adopted throughout the country. This paper looks at two particularly noteworthy experiences: that of contracting a State Foundation (*Fundação Estatal*) in the state of Bahia, and contracting with Social Organizations (*Organizações Sociais* or OSs) in the city of Rio de Janeiro. Both specifically contract for the provision of primary health services, and both have contracted with not-for-profit entities operating under private law.

PART 1: BACKGROUND

1.1 THE FHS AND PUBLIC SECTOR RIGIDITIES

The FHS is based on Family Health Teams composed of a doctor, nurse, nurse assistant, and four to six community health workers, organized by geographic regions, with each team providing primary care to around 1,000 families (about 3,500 people). The teams are either based in the Basic Care Units or operate from purpose-built Family Health Clinics that host numerous Family Health Teams. The Family Health Teams are expected to provide comprehensive and integrated primary care to the target population, through services provided in the facility and through outreach activities. In 2004, oral health teams were added to the program, consisting of a dentist and either an oral health technician or an assistant.

Key to the rapid expansion of the FHS was the creation of the Basic Health Transfer (*Piso da Atenção Básica*), which made available significant amounts of federal funding for primary care in the form of block grants from the federal government to the state and municipal level. The Basic Health Transfer has two components: a fixed amount transferred directly to the municipalities on a per capita basis; and a variable amount for the implementation of strategic priorities such as the FHS based on the number of Family Health Teams registered. The creation of this funding source was fundamental to expanding the FHS, both because it entailed a shift from funding based on volume or procedures toward one based on population, and because the funding was related to the number of Family Health Teams, creating an incentive for expanding primary care.

As part of the decentralization of the SUS, municipalities have responsibility for management and delivery of the FHS, and are required to adhere to constitutional norms and public law on employment (recruitment, contracting, and payment of professionals) and services. Direct employment options are limited to three types contract (as defined by the constitution and administrative law):

- **Public civil servant contracts** are permanent positions that must be contracted through public competitions (merit-based). These positions, which require municipal legislation, are characterized by a statutory regime that defines rights, social protection, and permanent (open-ended) contracts, and are hence considered “protected employment”.
- **Temporary contracts** are allowed under circumstances of “exceptional public interest”. These positions also require the adoption of specific legislation at municipal level.⁵
- **Commissioned positions** are reserved for directorial or high-level managerial functions.

In all cases, levels of remuneration are defined by the municipality. However, salaries are harmonized within municipalities, and there is limited scope for variation across specialization, geographic location, or performance. Municipalities may, however, opt not to manage the health services directly, but instead to contract all or parts of their services to external bodies such as State Foundations, OSs, cooperatives, or other private sector entities, but must adopt legal frameworks to do so.

In addition to the direct constraints on public hiring, other federal laws, such as the law of fiscal responsibility (*Lei de Responsabilidade Fiscal*) that limits municipal spending on personnel to a maximum of 60 percent of the municipal budget, also indirectly present barriers to expanding

⁵ Since the constitutional provision for temporary employment was regulated in 1993, there have been extensive debates and rulings concerning what constitutes “exceptional public interest” and what categories of staff can be contracted through this modality.

social services. There is also shortage of medical doctors with an interest and appropriate qualifications for working in primary care, particularly in underserved parts of the country.⁶

1.2 NEW CONTRACTING MODALITIES IN THE HEALTH SECTOR

Taken together, the above constraints severely limit the ability of many municipalities to expand the number of Family Health Teams and create the stability and accountability for performance required for these teams to operate effectively. The rigidities of public sector employment extend beyond primary health care and the health sector, and both federal ministries and local government entities have long tried to find ways to circumvent them. Initially, at national level, federal ministries, including the MOH, established contracts with universities or public foundations that could provide services such as research or technical cooperation under simpler mechanisms. Later, the MOH established technical cooperation agreements with international organizations, in particular United Nations (UN) agencies. By the end of the 1990s, the majority of health professionals working for the MOH were hired indirectly through foundations or international organizations. However, over time, federal auditors imposed restrictions on these practices, and although indirect contracting remains important, it has declined over the last decade.⁷

Recognizing the need to increase flexibility in public contracting and service provision, the *Programa Nacional de Publicização* was approved as part of the State Reform process in 1998. The law authorized the transfer of responsibility for running public services and management of public goods and personnel to a specific set of qualified entities, including OSs, civil society organizations (*Organização da Sociedade Civil de Interesse Público - OSCIP*), nongovernmental organizations, philanthropic organizations, cooperatives, and private companies. The objective of the reform was to create an instrument that allowed the transfer of certain activities carried out by the state that would be better served by the private sector, without needing state permission or concessions. It would be a new form of partnership that called upon the “third sector” (i.e. neither public nor private) to provide services of social interest and public use, but that do not necessarily need to be undertaken by public bodies.

One form of contracting that has emerged as particularly important for the health sector is that of OSs. As part of the State Reform process⁸ of the 1990s, the *Programa Nacional de Publicização* paved the way for the production of goods and services in the nonexclusive government domain, including health, education, culture, scientific research, and the environment, by not-for-profit entities. It was a new model of public administration based on setting up strategic alliances between state and society that sought to mitigate operational dysfunctions of public administration, while maximizing results of social action—in other words, providing an institutional framework for the transfer of state activities to the third sector and thereby helping improve state and non-state governance (Ministério da Administração Federal e Reforma do Estado 1998).

Formally, OSs are legal entities under private law, operate on a not-for-profit basis, carry out activities of social value and operate in partnership with the state. They are primarily financed by public funds and must adopt governance arrangements that allow for state representation. They are subject to public audit (by the *Tribunal de Contas*) and ministerial supervision. Given that OSs operate outside the scope of public administration and have greater flexibility in the areas of human resource management and procurement, they are expected to generate significant quality and efficiency gains (Conselho Nacional de Secretários de Saúde 2012).

⁶ See also Girardi and Carvalho (2007) for reasons behind municipalities' irregular hiring of health professionals.

⁷ The scale of these types of contracts was so significant that audit authorities could not simply ban them. Instead, Adjustment of Conduct Terms (*Termo de Ajuste de Conduta*) were introduced that required the substitution of these professionals with public officials, and the contracts with the international organizations were not renewed.

⁸ Guided by the Plan for the Reform of the State Apparatus (*Plano Diretor da Reforma do Aparelho de Estado—PDRAE*).

The first experiences with contracting of OSs was in science and technology, with some laboratory services contracted out immediately after the new legislation in 1998. The state of São Paulo was also an early adopter of the OS model as a more flexible alternative for hiring professionals while incorporating private sector management practices, initially focusing on the health sector. The state contracted the management of some hospital services in 1998, and today OSs are involved in most aspects of health service delivery, including hospital management, ambulatory clinics, urgent and emergency care, specialist services, care for the aged, laboratory and imaging services, logistics, and referrals. Inspired by the São Paulo experience, other local governments have adopted the OS model in health, including the state of Para for some hospital services, a number of states for urgent and emergency care facilities, and the municipality of Rio de Janeiro for primary health care.

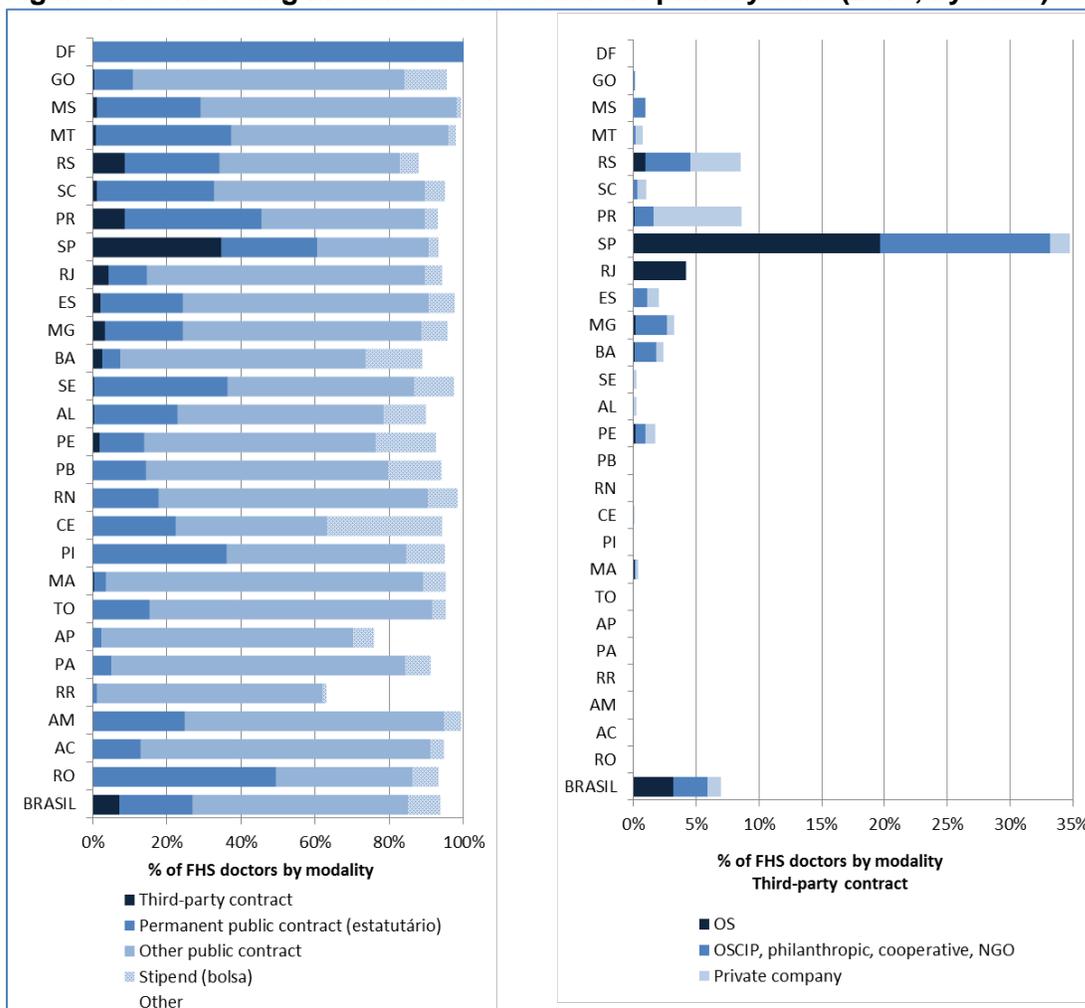
Over the last decade, some states in Brazil have also pursued other options for improving the delivery of health services. Specifically, the possibility of using State Foundations started in 2005, when the federal government, through the Ministry of Planning, Budget and Management and the MOH, and aided by the National School of Public Health and a group of lawyers, began studying broader legal and institutional options for overcoming the rigidities in the health system (Fundação Estatal Saúde da Família 2009). State Foundations are decentralized administrative institutions that carry out public activities and provide social services.⁹ Hence, although the State Foundations are public sector entities, they can contract and manage staff under private sector law.

A number of states and municipalities have established State Foundations in recent years, including Sergipe, Rio de Janeiro, Parana, and Curitiba. Most State Foundations focus on contracting staff for the hospital system, and on providing continuing education and other support services to staff and the health secretariats. However, the State Foundation in Bahia was established as a partnership with municipalities with the explicit goal of supporting the expansion and strengthening of primary care in the state.

Third-party contracting of medical doctors in primary care is still limited, accounting for just under 7 percent of all contracts, with OSs the most important modality (Figure 1). Permanent public civil servant contracts or other form of public contract (temporary or commissioned positions) are the predominant form of contracting of medical doctors in primary care (nearly 80 percent of all doctors), but irregular forms of contracting through stipends and other means are also rather important in many states.

⁹ A key difference between a State Foundation and an OS is that a State Foundation is a public (state-owned) institution, albeit operating under private law, whereas an OS is a privately owned institution.

Figure 1: Contracting modalities for doctors in primary care (2013, by state)



Source: Data from Cadastro Nacional de Estabelecimentos de Saúde; compiled by the authors.

1.3 TWO CASE STUDIES

Although third-party contracting of staff in primary care remains low nationally, it is an important modality in some states, and given continued rigidities of public sector contracting, it is likely to grow as states and municipalities seek not only to expand primary care but also improve performance.

This paper looks at two cases of contracting in Brazil. The first is that of contracting a State Foundation in the state of Bahia, and the second is the contracting of OSs in the city of Rio de Janeiro (see Table 1 for a comparison of the two models). In both cases, the aim was to expand primary care in underserved areas and improve performance through enhanced accountability and more flexible management. However, the means for achieving these goals were very different in the two locations, as were the results.

Table 1: Comparison of contracting models

	Bahia	Rio de Janeiro
When started	2009	2009
Contracting entity	Participating municipalities and the state government of Bahia	Municipality of Rio de Janeiro
Contracted entity/entities	State Foundation	Social Organizations
Stated aims	To formalize and expand employment in primary care and improve quality	Provide primary health services
Main responsibilities of contracted entity	Hiring and training of professional and management support to primary care	Hiring and managing complete Family Health Teams and the services they provide in facilities provided by the municipality
Full-service management	No	Yes
Legal regime	Private law	Private law
Employment regime	Consolidation of Labor Laws (CLT) ¹	CLT
Ownership	Public	Private
Supervision	Office of the Comptroller General ²	Office of the Comptroller General
Funding	Public	Public

SOURCE: Compiled by the authors.

1. CLT is the main piece of legislation relating to Brazilian labor law and procedural labor law. It was created by in 1943, unifying all the existing labor legislation in Brazil. Its main aim is the regulation of individual and collective labor relations. Other labor laws, such as for those working as legal entities (*Pessoa Jurídica*), independent/freelance contract workers, or public civil servants, are covered under a federal statutory legal regime.

2. CGU (Controladoria-Geral da União) or “Comptroller General” is the federal agency responsible for technical supervision, internal control, and public audit.

PART 2: BAHIA CASE STUDY: THE STATE FOUNDATION EXPERIENCE

2.1 BACKGROUND

With 14 million inhabitants, Bahia is the fourth most populous state and the sixth largest economy in Brazil, in a territory slightly larger than France. Bahia has 417 municipalities, and 72 percent of the population lives in urban areas. The largest city by far is Salvador with 2.9 million inhabitants, but there are a further five cities with over 200,000. Bahia, like other states in the Northeast—the poorest region in Brazil—lags behind the rest of Brazil in socioeconomic development. Although the state has seen a dramatic fall in poverty in recent years, 14 percent of the population is still living in extreme poverty (Brazilian Institute of Geography and Statistics and Institute of Applied Economics).¹⁰

Over the last decade, the state has increased spending on primary health care, reaching 14 percent of the total budget in 2010, but progress on key health indicators has been slow. Even when compared with other states in the Northeast, Bahia has the highest rate of maternal mortality, the highest proportion of children with low birth weight, and the highest incidence of tuberculosis (Fundação Estatal Saúde da Família 2009). In 2009, 31 percent of women's deaths were associated with pregnancy and delivery, and the maternal mortality ratio is 73 per 100,000 live births, one of the highest in Brazil and almost double the Millennium Development Goal target.

Implementation of the FHS in Bahia started in 1997 and since then has been the principal strategy for strengthening primary care in the state. Since its introduction, FHS coverage has increased continuously, and in 2007, after a decade of implementation, coverage had reached nearly 50 percent. By 2011, FHS implementation had reached all the municipalities, with 2,748 Family Health Teams in place, covering close to 60 percent of the population. Similar to other parts of Brazil, expansion of coverage has been slower in larger municipalities, with coverage of less than 40 percent in large municipalities (over 80,000 inhabitants), against over 80 percent in small municipalities (under 20,000 inhabitants) (Diretoria de Atenção Básica 2013).

Although many municipalities in Bahia have managed to expand FHS coverage, they have also faced multiple implementation challenges, including, as elsewhere in Brazil, attracting and retaining health professionals, in particular doctors. This has led to a high reliance on temporary or irregular work contracts (e.g. contracting through private companies, cooperatives, or nongovernmental organizations), relatively high salaries, concern about fiscal and contractual irregularities, high turnover and instability of teams, and excessive competition between municipalities for scarce health professionals. Moreover, as a result of contractual arrangements, accountability for performance (e.g. complying with the 40 hours a week requirement for doctors) has often been weak, and there has been little systematic effort to ensure continuing education for health professionals in primary care facilities (Fundação Estatal Saúde da Família 2009).

¹⁰ The extreme poverty line is defined as the cost of the basic food basket that supply the minimum individual calorie intake. This varies between regions, states, and urban, rural, and metropolitan areas.

2.2. THE STATE FOUNDATION FOR FAMILY HEALTH CARE IN BAHIA

The human resource challenges of the health sector in Bahia were far from unique, tackled by a unique approach developed by the state. In 2005 Bahia, along with a few other states (Rio Grande do Sul, Rio de Janeiro, and Sergipe), started a process of defining options for overcoming the rigidities of human resource management and other operational functions in the health system. The objective was to create an institution within the public domain that was subject to government oversight but that had the administrative agility of the private sector.

In Bahia, the primary focus was on primary care, the responsibility of municipalities rather than state-run hospital services.¹¹ The model would hence need to permit governance arrangements involving both the states and municipalities. The OS model was considered but rejected on the grounds that the state wanted a solution within the public domain. There was also a feeling that an OS would not allow for the long-term approach to career management of health professionals that the state wanted. Another option considered was a state consortium of municipalities, but it was also rejected based on the legislative requirements associated with the model.¹²

In January 2007, after seminars, debates, and meetings with stakeholders from the executive, judiciary, as well as civil society, the Bahia State Health Secretariat (*Secretaria de Estado da Saúde da Bahia*—SESAB) proposed the State Foundation as the most appropriate solution. A State Foundation is a state-owned, not-for-profit institution that integrates indirect public administration, but operates within private law and with private sector governance mechanisms, such as employment contracts.¹³ It was expected that this solution would offer budgetary and operational agility, and create conditions for offering inter-municipal career paths for health professionals. A Complementary Law that laid the foundation for the State Foundation for Family Health Care in Bahia (*Fundação Estatal Saúde da Família da Bahia* or FESF) was passed by the State Legislative Assembly in December 2007.¹⁴

The FESF was designed as a strategy for municipalities with the greatest problems in attracting and retaining health professionals and in improving the quality of primary care in a coordinated manner.¹⁵ It entailed a tripartite contract between the participating municipalities, the state, and the foundation, and would allow both municipalities and health professionals to plan for the medium to long term based on formal contracts, clear career paths, and professional development. At the same time, the population in the municipalities would benefit from greater stability and quality of services provided, which was expected to encourage mayors to participate.

The most important function of the FESF is to contract health professionals, in particular doctors, nurses, and dentists, for primary care on behalf of participating municipalities. All recruitment by the FESF is governed by the Plan for Employment, Careers and Salaries (*Plano de Empregos, Carreiras e Salários* or PECS), which is based on public competitive processes and formal labor

¹¹ In other states, such as Sergipe, State Foundations have been created to administer the hospital network and perform other functions.

¹² The legislation for consortiums imposes defined governance arrangements involving an assembly of its mayors. In Bahia, with 417 municipalities, this would have meant drafting complex legislation that could only be amended with authorization by every municipality. It was hence felt that this option would likely be cumbersome and slow.

¹³ Its legal basis is similar to a state-owned company, except that it functions in the social rather than economic domain and hence it may not commercialize its services on the market (*Fundação Estatal Saúde da Família* 2009).

¹⁴ Consultation and approval involved the State Health Council (*Conselho Estadual de Saúde*) and a specially created Joint Commission (*Comissão Paritária*) that included users, professionals, and management.

¹⁵ The key strategic objectives of the FESF defined in the founding documents were to formalize the employment contracts of health professionals in Family Health Teams; expand the coverage of the FHS; and improve the quality of the actions, services, and management involved in primary health care.

contracts that allow for mobility across health teams, for career advancement by merit, for continuing education, and for employment stability. This is a pioneering feature of the FESF that was explicitly designed to address the challenges faced by many municipalities in attracting staff by offering both financial and career incentives for professionals to accept positions in underserved areas. By centralizing the hiring of professionals for primary health across the state, the FESF would create economies of scale and help reduce competition between municipalities and the high rotation of professionals.

The FESF was also expected to provide support to participating municipalities for the management and organization of Family Health Teams and the development of primary health care, including training, limited supervision, and the introduction of management practices supporting quality improvement in primary care.

2.3. ACHIEVEMENTS AND IMPLEMENTATION ISSUES

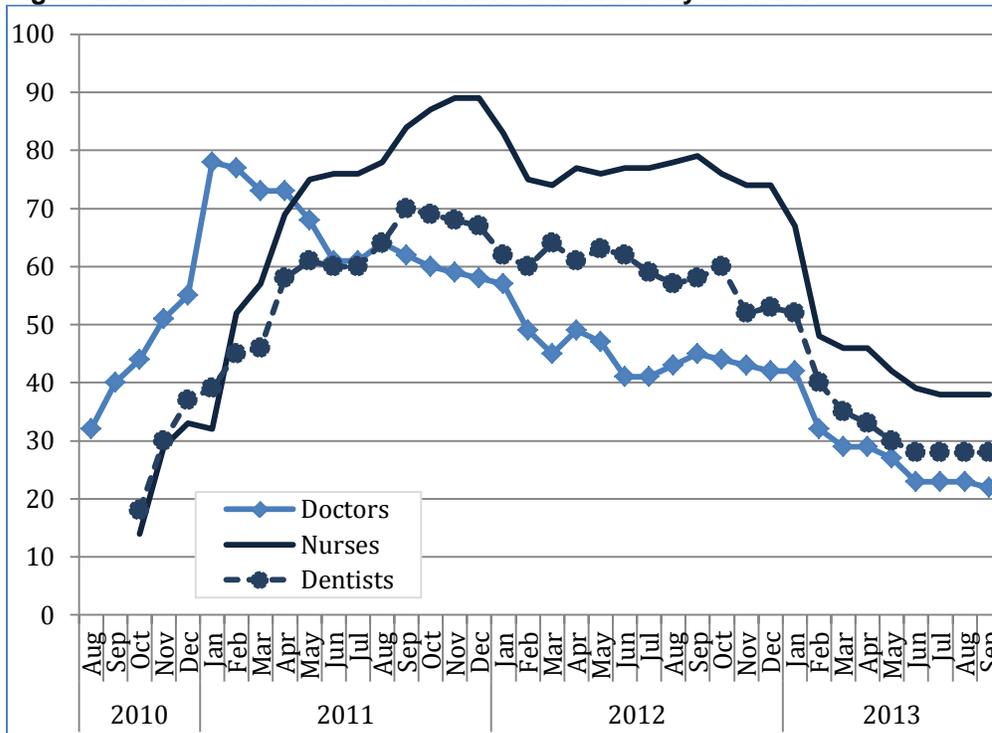
After approval of the law that laid the foundations for the FESF by the State Legislative Assembly in December 2007, mayors, municipal secretaries of health, municipal councils, professional bodies, and other stakeholders continued deliberations throughout 2008. By the second half of that year, municipalities started approving authorizing laws for participation in the FESF. In March 2009, the commission for the creation of the FESF¹⁶ approved the statute of the State Foundation, elected the Inter-Federative Council, and conducted the election for the Board of Trustees (*Conselho Curado*), and in July 2009 the FESF was finally registered as a legal entity (Fundação Estatal Saúde da Família 2009).

In total, 256 mayors signed terms of Commitment and Adherence to the FESF and 110 proceeded to pass authorizing laws. However, when the contracting process began in September 2009, which entailed signing technical cooperation agreements and management contracts between the municipalities and FESF, only 40 municipalities actually contracted the FESF to hire health professionals.

Reflecting municipalities' low participation, the FESF contracted only around 180 Family Health Teams, well below the earlier expected roughly 1,000. Two open public competitions have been carried out. In early 2010, 500 positions opened for doctors, 298 for dentists, and 326 for nurses. This competition experienced delays due to legal issues and the successful candidates were only invited to take up their positions in early 2011. The second competition was held in 2012 and opened 137 positions for doctors. In addition to the competitions, 12 temporary professionals were hired through a simplified selection in 2012 and another 20 in 2013. The number of staff contracted by the FESF peaked in late 2011 and started declining in mid- to late 2012 (Figure 2).

¹⁶ Composed of the state governor, the state minister of health, and Council of Municipal Health Secretaries.

Figure 2: Number of health care workers contracted by the FESF



Source: Girardi 2014.

With few municipalities participating, the FESF also accounted for a low share of total health professionals in the state: at the peak in 2011 this was just under 8 percent of primary care units, but less than 2.5 percent in 2013 (Table 2).

Table 2: Evolution of primary health facilities

	2010	2011	2012	2013 ^a
Primary health facilities	4,100	4,103	4,165	4,294
Primary health facilities with FESF ^b	163	316	307	104
% primary health facilities with FESF	3.98	7.70	7.37	2.42

Source: Girardi 2014

a. Data until September 2013.

b. Facilities with at least one FESF-contracted health professional (doctor, nurse, or dentist).

There are a number of reasons for the lower than expected participation by municipalities in the FESF. One concerned costs. The fact that FESF offered stable contracts with social security benefits and competitive salaries meant that the cost of hiring professionals through the FESF was comparatively expensive. Nor did the expected economies of scale materialize. As a result, administrative costs for participating municipalities were high, and the FESF was not able to achieve significant bargaining power in the state labor market. Some municipalities were also reluctant to surrender their autonomy to hire and manage their publicly employed health professionals.

Of the 40 municipalities contracted in 2009, only 12 still had a contract in 2014. One of the main reasons for the decline has been the high proportion of municipality–FESF contract defaults.

Many municipalities were not transferring funds to the FESF, partly because of a perception that the costs were too high, and yet retained the staff until their contracts were terminated. In late 2012 the default rate on management contracts with municipalities reached 80 percent of revenues. In addition, municipal elections were held at the end of 2012 that changed management in some municipalities, to the detriment of FESF.

Other factors against the FESF also came into play, such as the simultaneous implementation of other national programs aimed at supplying medical staff to underserved areas, in particular the Program for the Enhancement of Professionals in Primary Care (*Programa de Valorização dos Profissionais na Atenção Básica—PROVAB*)¹⁷ and, more recently, the “More Doctors” program (*Mais Médicos*).¹⁸ Some municipalities dismissed FESF-hired professionals in preference for professionals hired under these programs at lower cost.

Beyond trying to centralize and coordinate the contracting of health professionals for Family Health Teams, the FESF intended to increase the quality of services through various strategies. First, the professionals hired by FESF were expected to be better qualified for their positions as a result of a more rigorous hiring process. Moreover, the conditions offered by the FESF (stability, social security, career development, etc.) were also expected to help attract qualified professionals.

Second, professionals hired by the FESF undergo six months of compulsory (and remunerated) training (*Formação Inicial do Trabalhador*), during which they assess population health and propose action plans under the supervision of FESF tutors. All FESF professionals are offered continuing education for specialization or masters programs.¹⁹

Third, health professionals contracted by the FESF are also offered performance incentives (*Gratificação por Produção e Qualidade*). This is a bonus of 25–50 percent of base salary, paid monthly, dependent on meeting the goals set by the FESF. These goals are monitored quantitatively and qualitatively through a dedicated Primary Care Monitoring System (*Sistema de Monitoramento de Atenção Primária*), with payment based on the number of days worked and results.

Fourth, all contracts between municipalities and/or the state with the FESF include targets and goals, to which a 10 percent variable portion of payments from municipalities to the FESF is linked. The evaluation of the targets and goals is based on trimestral reports drafted and sent by the FESF to the Monitoring and Evaluation Commission (*Comissão de Acompanhamento e Avaliação do Contrato*).²⁰ Decisions are reached by consensus and the variable funds are only paid once the trimestral report is approved. To achieve these targets and goals, the FESF provides support to contracting municipalities and Family Health Teams.

It is very difficult to assess whether the FESF has helped improve the quality of primary health care in the contracting municipalities, because implementation is recent and because contracting with the FESF was voluntary and the participating municipalities cannot be compared in a straightforward manner with other municipalities. However, the recent performance evaluation of primary care under the National Program for the Improvement in Access and Quality of Primary

¹⁷ PROVAB is a federal program that encourages education of Brazilian doctors by offering a one-year, mainly practical, postgraduate course in family health, in which they are placed within primary health facilities in underserved locations, under institutional supervision. The program intends to benefit around 1,500 municipalities.

¹⁸ *Mais Médicos* is a federal program that aims to attract Brazilian and foreign doctors to expand the number of family doctors in underserved areas. The program also invests in primary health infrastructure and foresees, from 2015, medical students spending two years in medical residency in primary care facilities, as a precondition of graduation.

¹⁹ By distance from the University of Rio Grande do Sul or the University of Feira de Santana.

²⁰ The Monitoring and Evaluation Commission is made up of the FESF (Director General, Director of Service Management, Director of Internal Management and Procurement) and SESAB (Directors who have services contracted with the FESF and the Legal Counsel's office).

Health Care (*PMAQ*), provides some points of comparison. The survey evaluated Family Health Teams based on five criteria: municipal management; structure and operating conditions of the units; access and quality of care and organization of the work processes of teams; employee enhancement; and access, utilization, participation, and user satisfaction.

Table 3 shows the score per criterion for the PMAQ evaluation of doctors, nurses, and dentists, according to membership in FESF teams. Any team with at least one professional hired by the FESF active in 2013 is considered an FESF team. Where teams do not have an FESF professional one year, it was recorded if they had an FESF professional active the previous year/s (2010 to 2012) or had never had an FESF team member. The data show that those teams with current FESF staff have consistently better ratings, while teams with FESF staff in the past are very similar to those that never had FESF contracted staff. The differences cannot be attributed to the FESF of course, but warrant further investigation.

Table 3: Average score of Family Health Teams in PMAQ evaluation (FESF vs. non-FESF)

Dimension	Teams with FESF member in 2013	Teams with FESF member in the past	Teams never having had FESF member	Total
General evaluation	1.71	2.09	2.07	2.05
I Municipal management and development of primary care	2.05	2.39	2.20	2.21
II Structure and operation of primary care units	2.11	2.45	2.46	2.43
III Recognition and support of staff	1.47	1.95	2.28	2.19
IV Access, quality, and organization of work processes	2.08	2.38	2.34	2.33
V Utilization, participation, and client satisfaction	2.13	2.37	2.50	2.46

Source: Girardi, 2014.

Note: For each criterion, the teams were scored on a scale 1–3 (1 = very good, 2 = good or above average, 3 = regular or average or below average).

2.4. THE FUTURE OF THE FESF

The FESF model depended on a significant share of municipalities in the state contracting out human resource management in primary care to the foundation, but for a range of reasons this did not happen, and over time the number of municipalities doing so declined even further. The leadership of the FESF undertook an administrative and governance reform to reduce administrative costs, seeking to strengthen the focus on quality, productivity, and efficiency by finding a balance between administrative costs for the number of employees and ensuring an appropriate administrative structure for strategic planning and management for results.

In practice, the FESF was obliged to diversify its activities from contracting the workforce to include contract with SESAB to hire professionals to develop its home care services linked to the state hospital network, regulatory activities, institutional support to PMAQ, and other services. Hence, although the FESF continues to engage on primary health and work with municipalities, the share of revenues from SESAB has increased steadily. In 2013 the “humanization program”

accounted for 62 percent of FESF employees, home care 14 percent, and the FHS only 6 percent. The FESF is therefore now 75 percent financed from SESAB and 25 percent from the municipalities.

While the implementation of the FESF did not work out as planned, SESAB management remains favorable to the State Foundation as a management model for public health, and the state is looking into expanding the scope of foundation activities further to also include the development of pharmaceutical technology and health education. There is an understanding among municipal and state policy makers as well as the wider health sector actors in the state, that in the future State Foundations must receive tripartite funding, from the federal, state, and municipal levels, to offer formal, fully protected employment contracts.

PART 3: RIO DE JANEIRO CASE STUDY: THE OS EXPERIENCE

3.1. BACKGROUND

After the federal capital was moved to Brasília in the 1960s, Rio de Janeiro suffered a long economic decline and only started picking up in 2005. Now with around 6 million inhabitants, Rio de Janeiro is the second largest city in Brazil. The city is marked by social and economic inequality. The poor make up about 10 percent of the population and income inequality, measured by the Gini index, is greater than for the country as a whole. About a third of the poor live in *favelas*, where the poverty rate is 15 percent. Life expectancy at birth of men living in the wealthiest parts of the city was 12.8 years longer than that of men living in deprived areas, which in part is explained by extremely high homicide rates in the *favelas* (Szwarcwald et al. 2011).

With the creation of the SUS and a focus on decentralization and primary care, a network of Basic Health Units was implanted in areas of the city underserved by the hospital network, but the two systems ran in parallel. When the FHS was created its implementation was slow off the mark and despite the good results of the piloting phase it did not take off, and in fact there existed some antagonism between the traditional Basic Health Units and the newer Family Health Clinics.

Traditionally, Rio de Janeiro has had an extensive hospital network, including facilities under federal, state, and municipal management, but very limited primary health care provision. For many years, the hospital network ensured access to basic care through outpatient departments and emergency rooms, as well as critical inpatient services and specialist care. However, access to the poorer segments of the population has long been problematic, and has become increasingly so as the population, and health care needs, have grown. Moreover, the hospital network does not provide preventive services or health promotion, and integration and coordination of care has been weak.

In 2001, a new management team at the Municipal Secretariat of Health of Rio de Janeiro drew up details for a project creating 600 Family Health Teams, including the conversion of some Basic Health Units. But this new impetus also met some resistance from District Health Councils, which feared a loss of control of existing facilities, as well as from professionals and the population, which did not fully understand the proposed changes. By the end of 2001, only 23 Family Health Teams had been set up, and by 2005 the FHS was still practically nonexistent with only 57 Family Health Teams covering just 3.3 percent of the population.

When the FHS was initiated and the federal government increased its investment in primary care, many of the smaller municipalities were quick to make the most of the funding available to boost service provision. However, in the large municipalities such as Rio de Janeiro with extensive hospital and ambulatory services, the response was slower. In 2005, the MOH therefore decided to provide financial inducements to encourage expansion of the FHS in cities with over 100,000 inhabitants.²¹

With the launch of the *Saúde Presente* program in 2009, a newly elected government in the municipality of Rio de Janeiro started an effort to expand FHS coverage. But in light of the challenges faced in earlier efforts to expand coverage, linked to cumbersome recruitment and procurement processes and limits on municipal spending on personnel imposed by the Fiscal Responsibility Law, the municipal government decided to break with direct management and instead contract with OSs for delivering primary health care services.²² In this way, the

²¹ This was done through the Project for Expansion and Consolidation of Family Health (*Projeto de Expansão e Consolidação da Saúde da Família—PROESF*), which provided federal support for equipment, training, and other costs associated with the expansion of the FESF, as well as the support to recurrent costs that all municipalities were entitled to.

²² The administrative rigidities associated with human resource management have been referred to in earlier sections. On procurement, an oft-cited example is Federal Law 8.666/1993, which limits any public body

municipality would also signal an attempt to break with the perceived lack of coordination and efficiency of the existing health network managed by municipal, state, and federal governments.

3.2. THE OS MODEL FOR PRIMARY CARE IN RIO DE JANEIRO

The interest in the OS model in Rio de Janeiro was in large part inspired by São Paulo's experience with OSs in the hospital sector and increasingly in other areas of health care. Yet the proposal to contract with OSs to expand the FESF model met significant resistance, including from professional interest groups, although the proposal was eventually adopted with two conditions: first, that OSs could only be contracted for provision of primary care, namely the FHS; second, OSs could only provide care in new facilities (and could not take over management of existing facilities).

OSs are an institutional innovation, but do not constitute a new legal form as they have been included under the existing legal framework for civil not-for-profit associations (Ministério da Administração Federal e Reforma do Estado 1998). They are a model of partnership between the state and/or the municipality and society. The municipality continues to promote and exercise strategic control over the social actions through entering into a management contract with OSs that foresee that public policy objectives are met. The management contract is the instrument that governs the actions of the OS, with which performance targets are agreed to ensure the quality and effectiveness of services.

As noted, OSs operate outside public administration and within private law. This design was conceived to give these entities greater administrative autonomy than possible within the state apparatus. In return, their management must assume greater responsibility, with social participation, in managing the facilities and in improving efficiency and quality of services, with an emphasis on results (Ministério da Administração Federal e Reforma do Estado 1998).

Contract annexes detail the responsibilities and goals for the OS, as follows:

- **Basic Aspects of Organization:** Communicating with the target population, receiving and referring users to the appropriate services, and recording all medical procedures and other activities, including administrative data.
- **Best Clinical Practices:** Adoption of clinical protocols, in consensus with experts, on clinical workflows defined by the MOH and the Municipal Secretariat of Health of Rio de Janeiro.
- **Users Services:** Channels of information and communication individualized and personalized care, and evaluation of user satisfaction.
- **Referral with other levels of care:** Defining conditions sensitive to primary care (Gibbons et al, 2012), and adhering to the Regionalization Plan of the State Secretariat of Health of Rio de Janeiro.
- **Health Promotion and Disease Prevention:** Including these activities with health care in Family Health Clinics.
- **Health Information Systems:** maintain the official Health Information System as defined by the ministry of health and send regularly these data to the Municipal Secretariat of Health of Rio de Janeiro. These are the Sistema de Informações sobre Atenção Básica (SIAB) - or Primary Care Information System - and the Sistema de Informações Ambulatoriais do SUS (SIA-SUS) - or SUS Ambulatory Information System).

All contracts between OSs and the municipality of Rio de Janeiro are standardized. Their main objective is to provide primary health services within the new Family Health Clinics and Basic

from spending more than R\$ 8,000 (under US\$ 3,500) on any goods or services without issuing a public tender. The tendering process is usually slow and ineffective and does not necessarily guarantee the transparency it is intended to provide.

Health Units. The contracts contain a defined set of health services that are to be managed, maintained, and equipped with human resources by OSs. The only difference between the contracts is the geographic area. Contracts are signed for two years and are renewable if at least 80 percent of the objectives and goals are met.

As defined in the contracts, there are two methods of payment:

- **Fixed payments**, which are calculated per the number of Family Health Teams and Oral Health Teams and an estimate of resources required to cover the Portfolio of Basic Services (*Carteira Básica de Serviços de Atenção Básica*); and
- **Variable payments**, which relate to performance-based payment. Health units are required to produce trimestral reports relating to agreed-on indicators. The variable payments are made based on performance in three sets of indicators:
 1. **Variable part 1**—incentives paid to the OSs based on adoption of management practices. Specifically, they are based on the trimestral reports of productivity and quality of services offered, defined by a set of indicators (Annex 1). The maximum amount is 2% of the total contract value, and is associated with achieving 80–100% of the targets set and 1% for achieving 60–79% of targets. If less than 60%, the OSs will still receive this payment, but it must then be invested (infrastructure, equipment, training, etc.) in those units that are not achieving their targets.
 2. **Variable part 2**—incentives to health units based on a set of specific indicators as reported in trimestral reports (Annex 2). Targets are not defined in the contract but are agreed between the OS and the administrative area it covers. When goals are achieved, each health unit receives a trimestral direct transfer of R\$ 3,000 for each Family Health Team. If the goals are not achieved, the funds are then invested in the health unit, as above.
 3. **Variable part 3**—incentives for each Family Health Team or Oral Health Team based on a set of specific indicators (Annex 3). If the targets are achieved a performance incentive is paid to each team member, to a maximum of 10% of the monthly base salary. This performance incentive is measured by accounting units (*Unidades Contábeis*), and the target involves performing 300 accounting units. If less than 20% of the indicators (the equivalent of 60 accounting units) are achieved by a given team, the corresponding amount is invested as above.

The OSs are monitored by the Technical Evaluation Commission (*Comissão Técnica de Avaliação*—CTA).²³ The monitoring indicators linked to the three variable sources of funding define the scope of evaluation. The Commission is required to produce quarterly monitoring reports, assess the financing and economic indicators of the OSs, and report to the Municipal Health Secretariat and district council.

Since 2010, the OSs have opened several recruitment procedures in the form of public selection, as recommended by the municipality of Rio de Janeiro, in order to ensure transparency in the selection process. Employment contracts are established for an indefinite period, and the conditions for termination of contracts follow the CLT. All members of the Family Health Team undergo a compulsory introductory course, in which the basic principles of the FHS are presented as well as the Family Health Clinics' general workflow. In addition, all the OSs operating in Rio de Janeiro offer continuing medical education courses to their employees and to other health professionals.

²³ The CTA consists of representatives of the cabinet of the Municipal Secretary of Health, the Subsecretariat of Primary Health Care (SUBPAV), the Management Secretariat (SUBG), as well as representatives from the administrative regions where the OSs operate.

The health facilities managed by the OSs are responsible for providing their patients with the basic medication included in the Municipal Register of Medicinal Products. They have an interest in providing essential medicines to the most prevalent chronic diseases (diabetes, hypertension, asthma) and programmatic diseases (AIDS, tuberculosis, and Hansen's disease) as the supply of these drugs is evaluated as an indicator of the variable part of the financial transfers. The supply of drugs must, however, be balanced against efficiency indicators that seek to minimize medical consultation costs. In most cases, the municipality owns all primary health care facilities.

3.3. ACHIEVEMENTS AND IMPLEMENTATION ISSUES

In Rio de Janeiro, the contracting of OSs in primary health care was made possible by Law 5026 enacted in May 2009. The law defined the process that qualifies the OSs to manage the financial, physical, and human resources of the municipal treasury to maintain and structure the provision of primary health services in Family Health Clinics and Basic Health Units. To qualify, the OSs must be private not-for-profit entities acting in the health sector. As soon as Law 5026 was enacted a number of tenders were opened to select OSs to manage primary care with respect to the city's territorial divisions.

Since the municipality of Rio de Janeiro started contracting OSs to implement the FHS, the city's primary health facilities have been classified into three "types" depending on their participation with the FHS.

- **Type A:** *Entirely OS-managed Family Health Clinics*, with all of health professionals hired by OSs. These include new purpose-built Family Health Clinics since 2009, as well as previously existing Basic Health Units that were fully converted into Family Health Clinics. However, in the case of the later, the public officials already working there were assigned to the new Family Health Teams while their employment contracts remained with the municipality;
- **Type B:** *Partially OS-managed Basic Health Units*, in which Family Health Teams hired by OSs were incorporated into the existent health facilities;
- **Type C:** Basic Health Units that do not have any Family Health or OS participation.

Family Health Clinics are being implanted all over Rio de Janeiro, primarily by the construction of new clinics (85 new units since 2009), but also be converting Basic Health Units into Family Clinics (the 49 units that existed before 2009). The conversion of Type C units to Type B units will be completed by 2014 (Table 4).

Table 4: Evolution of Primary Health Care facilities by type A/B/C in Rio de Janeiro

Type of facility	Year established								Total
	Pre-2007	2007	2008	2009	2010	2011	2012	20131	
Type A	38	10	1	4	21	41	18	1	134
Type B	46	2	1	-	1	-	1	2	53
Type C	6	-	-	-	-	-	-	-	6
Total	90	12	2	4	22	41	19	3	193

Source: Anuário CEMAPS-RJ.

1. Data from January to September 2013.

To date, six OSs (Table 5) have won tenders to manage Family Health Teams in 10 health areas (*Áreas de Planejamento*—APs). However, only five are still in operation as one of the contracts was cancelled due to not meeting minimum standards, and the contract for that territory was passed to another OS.

Table 5: OSs operating in primary care in Rio de Janeiro 2009-2013

OS	Year of first contract	# type A clinics	# type B clinics	Description of OS
Viva ¹	2009	22	41	Established in 2009 as a branch of the NGO Viva Rio to provide primary health to the favelas in Rio de Janeiro's Southern Zone.
Fiotec ²	2009	1	1	Fiotec was established in 1998 to manage the financial resources of Fiocruz research, development and innovation projects. In 2009 it initiated the management of Family Clinics in the Manguinhos neighborhood, where Fiocruz is located. It also contracts personnel for the four biggest general hospital emergency room in Rio de Janeiro.
SPDM ³	2009	21	26	Established in 1933 in São Paulo to hire health professions for the Escola Paulista de Medicina. It now operates in 6 states in Brazil contracting for all levels of health professionals. Its primary care health program was established in 2001 in São Paulo.
Fibra ⁴	2011	3	21	Established in 1998 and only operates in Rio de Janeiro, managing financial and human resources for primary, hospital and emergency care.
IABAS ⁵	2011	23	53	Established in 2008 to provide public healthcare management in three states (São Paulo, Rio de Janeiro, and Maranhão). In Rio de Janeiro it operates in primary care, geriatric care, ambulatory clinics and school health.

Source: Cavalini, 2014.

¹ Viva Comunidade.

² Fundação para o Desenvolvimento Científico e Tecnológico em Saúde (Fiotec).

³ Associação Paulista para o Desenvolvimento da Medicina (SPDM).

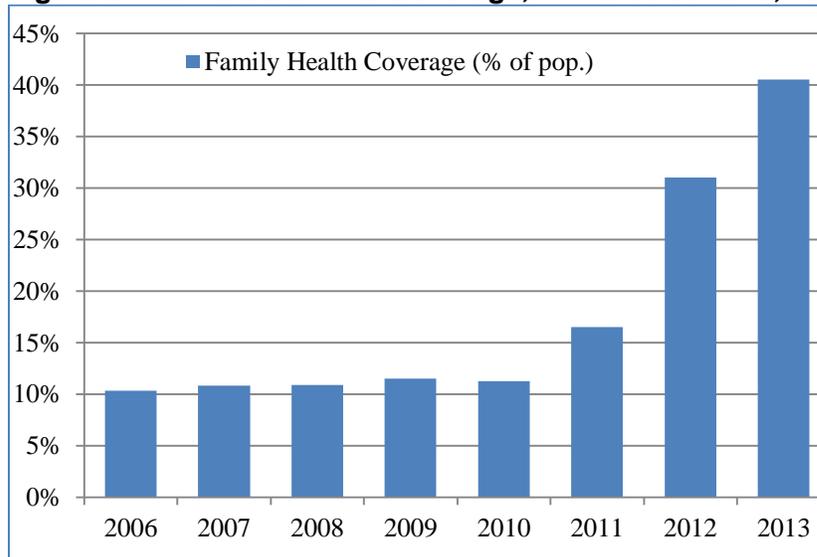
⁴ Fibra Instituto de Gestão e Saúde.

⁵ Instituto de Atenção Básica e Avançada à Saúde (IABAS).

The financial reports of the OSs are only available for the last two years (2012-2013). They show a concentration in the hiring of community health agents, doctors, nurses, nurse technicians and administrators. This is to be expected as the FHS assumes a large number of community health agents working over small territories in direct contact with the families within them. Equally, doctors, nurses and nurse technicians form the base of Family Health Teams, as are administrators that help manage them. The OSs have not encountered any problems in attracting professionals. In fact, a critical feature of the OS model is the simplified hiring and the flexibility to pay differentiated (and higher) salaries. Doctors, hired by OSs can earn over twice much as public officials, nurses can earn up to 36 percent more, dentists can earn up to 65 percent more, and yet nurse technicians are paid as much as 36 percent less. The higher salaries for the more qualified positions has facilitated hiring and hence created the conditions for the expansion that has been observed. While some have benefitted from higher salaries, the increased wage inequality may negatively impact the provision of care.

The new Family Health Clinics were successful in rapidly increasing coverage, in part due to the characteristics of Rio de Janeiro whereby large populations live in favelas (Figure 3). The clinics were implemented in underserved areas with high population density. They were often very large and in some cases managed to incorporate laboratories, medical imaging centers, social services and emergency services within the clinics.

Figure 3: Estimates of FHS Coverage, in Rio de Janeiro, 2006-2013

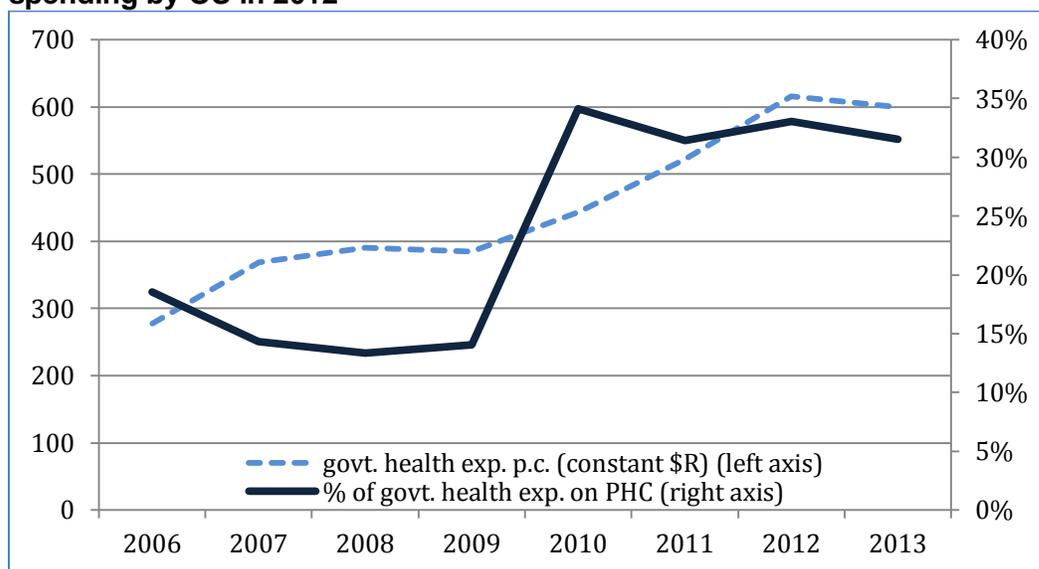


Source: Sistema de Informações sobre Atenção Básica—SIAB.

Note: This figure only shows coverage for the FHS, but the population continues to have access to primary health services at Basic Health Units. Due to different reporting systems however, coverage estimates are not available for the Basic Health Units.

Reflecting the rapid expansion of the FHS, the last half-decade has seen a significant increase in government health spending in Rio de Janeiro (Figure 4). From 2006 to 2012, total spending more than doubled in real terms. There has also been an important shift in spending toward primary care. Before 2010, spending on primary care in Rio de Janeiro was less than half the national average, but since 2010 spending on primary care has tripled and is now equivalent to a third of total health spending per capita.

Figure 4: Total and primary health spending in Rio de Janeiro, 2006-2012, and total spending by OS in 2012



Source: SIOPS.

The expansion of the FHS in RJ was expected to result in improved coverage of priority interventions (antenatal care, management of patients with chronic diseases, etc.) and, ultimately, improved outcomes. It is still early to assess the extent to which these goals have been achieved. Nonetheless, available data suggest that relative to 2007, the municipality has seen a near doubling of primary care consultations, a large increase in the number of chronic disease patients under active management, and a reduction in avoidable admission from diabetes and associated complications. However, there has only been a modest increase in the share of pregnant women with seven or more prenatal consultations (Table 6).

Table 6: Trends in Key Indicators in Rio de Janeiro Municipalities (2007-2013)

	2007	2013	% change
Population	6,178,762	6,429,923	4
Primary health care consultations	3,566,747	6,846,453	92
Pregnant women with 7 or more prenatal consultations	68.5%	70.8%	3
Number of diabetics under management	125,317	231,960	85
Number of hypertensive patients under management	544,414	791,951	45
Avoidable admission: diabetes and complications	3.6%	1.0%	-71

Source: Official administrative data provided by the Health Secretariat of Rio de Janeiro Municipality.

The contracting of OSs is intended to improve performance due to their increased management capacity and flexibility as well as the introduction of performance incentives for both professional and health facilities. To date, however, the performance incentive modality has not operated as

planned. For the time being the payment of the variable part of the funding appears disconnected to achieving the targets. The data available indicate that targets have not been met, while the variable funding has been paid. This is likely to do with problems of information collection rather than poor quality care, and increased reporting of targets in 2013 indicates that reporting is improving. In addition there also appear to be distortions with respect to the financing of incentives. Currently the municipality transfers the variable part of the funding to the OSs regardless of their performance. The OSs on the other hand, only transfer these funds to the Family Clinics if they attain their targets and goals, and retain them if they do not. While any retained incentive funds are foreseen to be invested in the health facilities most in need, the fact that the OSs stand to capitalize on the poor performance of the Family Clinics they run, can represent disincentives for performance and quality.

3.4. THE FUTURE OF OSs IN RIO DE JANEIRO

In light of the remarkable expansion of FHS coverage from 8 percent in 2008 to 41 percent in 2013, the contracting of OSs can be considered a great success, especially taking into account that many of the Family Health Clinics were constructed from scratch. It can also be said, that this reform in the provision of primary health care has succeeded in attracting significant amounts of government funding to the health sector and in particular a huge increase in primary health spending.

Contracting with OSs is an interesting model that is based on longer-term relationships between the organizations and the municipality. The model requires a high-level of cooperation given that they share responsibilities in primary care, with the municipality responsible for policy and providing the infrastructure, while the OSs manage the provision of care and supply of basic drugs and some equipment.

The close relationship has provided conditions for close monitoring and problem-solving, and may have contributed to improving performance in ways that are hard to measure. On the other hand, the harder forms of performance accountability envisaged in the contract, in particular performance-based variable payments, still need to be fine-tuned in order to establish a mechanism that delivers on its intended aims and is workable, without inadvertently giving rise to distortions of incentives.

The model has also introduced a potentially problematic dynamic between health workers with regards to compensation. Currently, despite the standardized contracts between the municipality and the OSs, there is no correlation between the resources received by OS per contract and the salaries they pay. In fact wage inequality exists across the whole primary health network in Rio de Janeiro. Salary disparities exist between public officials assigned to OSs and professionals directly hired by them, between professionals hired by different OSs but within the same professional category, as well as between professional working in different geographical locations. OSs covering more remote, and often poorer areas of the city tend to pay lower salaries. They are therefore more prone to hiring the less qualified, younger professionals for shorter periods of time. Thus, arguably the introduction of OS has increased the inequality with the primary health system from the traditional management model that had standardized levels of pay. Now the more central, wealthier areas of the city are better able to attract and retain more qualified professionals, due to the higher wages, and thus arguably the quantity and quality of services provided to the wealthier areas of the city is higher than those offered to the more disadvantaged areas. Financial data, however, has only been available since 2012 and therefore the effects of such wage differentials have yet to be determined.

Although it is probably safe to say that the municipality would not have been able to expand coverage to the extent it has based on the traditional model, some of the gains in terms of quality and effectiveness of primary care may have as much to do with the Family Clinic model (combining multiple teams in purpose-built facilities) as with the OS model. In other words, the

ability to hire and manage staff in a flexible way has been an important gain, but the extent to which contracting out of management of facilities as opposed to simply providing staff is an important aspect of the model is not clear.

There is also insufficient data on costs and efficiency to assess the merit of the OS model relative to alternatives. This is partly an issue of the costs of increased salaries but also administrative costs must also be taken into account, both within the OSs as well as within the municipality. Assessments of efficiency and performance however must take a comprehensive analysis of performance. For instance, higher salary and administrative costs may be justifiable if associated with increased productivity and quality of care.

In order to carry out rigorous assessments, however, there is a need for implementation of reliable and accurate information systems, that as of yet, are not in place. Medium-term indicators are necessary for the measurement of the effectiveness of the system while long-term indicators are needed for the assessment of the impact on the morbidity and mortality of the population covered.

PART 4: DISCUSSION

Over the last couple of decades, international experience with contracting in the health sector has been growing. Although there are significant differences in context and processes behind these experiences, they have often been motivated by a desire to improve quality and efficiency of service delivery. The "traditional" model of service delivery through public sector providers, with salaried staff on long-term contracts has been seen as insufficiently responsive or dynamic due to problems of low-powered incentives, lack of management flexibility and a bureaucratic institutional culture. In contrast, private sector entities are often smaller and unconstrained by the myriad of administrative rules and constraints of the public sector. Hence, at least in principle, contracting can help improve both quality and efficiency by combining management flexibility with more high-powered incentives. Today, both for-profit and nonprofit providers play an important role in many health systems, in part because of the historic roots of these systems, but also as a result of policy decisions to "autonomize" providers or contract with the private sector as a means to improve the performance of service delivery.

As the experience with contracting has grown, so has the associated literature. Part of this literature is concerned with the conditions under which contracting the delivery of public services is likely to be effective, given the uncertainty and information asymmetry that is pervasive in the health sector (Bennett and Mills, 1998; Besley and Ghatak, 2003; Eggleston and Zeckhauser, 2002; Mills, 1998). There is also a growing body of evidence on specific experiences, including efforts to evaluate to what extent the performance of contracted service providers is superior to other models for delivering services (see, e.g. Liu et al., 2007; 2008; Loevinsohn and Harding, 2005; Perrot, 2006; Schlesinger and Grey, 2006).

Private sector provision of health services has long played an important role in the public health system in Brazil. When the SUS was established in the late 1980s, a significant share of health services, in particular in the hospital sector, was in private hands, including both philanthropic and for-profit institutions. States and municipalities have established volume-based contracting arrangements with these institutions to provide services for the SUS, and although the share of services provided by the private sector has declined, it remains significant.

However, this paper has focused on more recent experiences with contracting in primary health care in Brazil as a means to address rigidities and fiscal constraints in the public sector. One of these approaches is the reliance on nonprofit OSs in Rio de Janeiro. This approach dates back to the late 1990s and was first introduced in the health sector in São Paulo in 1998. Although the focus was initially on the hospital sector, the model has since expanded into other areas of health care, including primary care, and the municipality of Rio de Janeiro adopted the approach in 2009 as part of its effort to rapidly expand coverage of the FHS and improve the quality of services.

The second case focused on the experience of the State of Bahia with the foundation model. Unlike OSs, which are private entities, state foundations are autonomous entities within the public sector. Over the last few years, foundations have been established in numerous states and municipalities in Brazil. What is unique about the Bahia experience, however, is the foundation's focus on primary care, which means that it needs to involve not only state-level agencies, but also municipalities. The Bahia state foundation was established with the goal of providing a more coordinated and organized form of contracting doctors, nurses and dentists for family health teams in the state's municipalities, and in this way support the expansion of FHS coverage and also improve the performance. Hence, in the case of Bahia, the municipalities contracted with the foundation, which in turn contracted health professionals and performed some limited management functions.

The two cases that are the focus of this paper are both relatively recent. Nonetheless, given the interest in these contracting experiences both in Brazil and internationally, it is worth asking how they have fared. In terms of achieving the goals of expanding coverage and improving the quality

of primary care services, the picture emerging from the two cases is mixed. The municipality of Rio de Janeiro successfully managed to expand the coverage of primary health care through the FHS. This expansion, in turn, has been associated with a large increase in utilization of primary care services, which is expected to contribute to improved outcomes over the longer term. Inevitably, a number of implementation issues remain, in particular concerning the collection and compilation of data costs and performance, which is a critical element of the system of performance-related financial incentives that form part of the contract between the municipality and the OSs. At this point, there is hence limited basis on which to assess the quality of OS performance, and to compare services provided by OSs with those delivered based on alternative models.

In the case of Bahia, the FESF managed to contract a number of health professionals for participating municipalities, contributing to an expansion of coverage in these locations. However, despite a high level of initial support, the number of municipalities that actually established a contract with the FESF when it was established was very low, and has fallen further since. By the end of 2013, only 12 municipalities retained contracts with the FESF, accounting for 22 doctors, 38 nurses and 28 dentists. As a result, the intended economies of scale were not achieved, undermining the appeal of the model for municipalities. There are some indications that the FESF has contributed to improved performance where it is operating, but data are limited and by no means conclusive.

In assessing contracting experiences and comparing them against other approaches, performance in terms of coverage and quality is important, but the cost implications of the approach also need to be considered. It is often claimed that contracting will improve the technical efficiency of service delivery, although such gains may be partially offset by increases in administrative and transaction costs. However, evidence on these dimensions of contracting experiences is often scant, as is also the case for the two Brazilian cases. There is some limited evidence that the productivity of health providers has increased due to performance incentives and new forms of management. In both models, personnel costs have however increased, although this would perhaps have been required in the alternative models as well in order to attract staff. There is currently very little information on administrative costs associated with the respective models. However, it is clear that both the foundation and the OSs incur nontrivial administrative costs, and there are also transaction costs to be considered in state and municipal administration related to monitoring and oversight of contracts.

What will future look like? By now, the OS model has a relatively long history in Brazil, and is increasingly used for staffing and managing health care provision in different parts of Brazil. Experiences to date have shown that it takes time for the approach to mature, with the need for significant capacity on both the OS and government side (management of services, design of contracts, monitoring of costs and performance, oversight, etc.). Nonetheless, as OSs with a focus on health care become more plentiful and experienced, and with continued pressures to contain civil service wage bills at state and municipal level, the approach will likely continue to grow, in particular in larger municipalities. The state foundation model brings some important strengths, but has suffered from significant implementation problems. Some of these are related to the complex governance and contracting arrangements that arise between the foundation, the state and the municipalities. However, the foundation model has also, for better or worse, been undermined by federal initiatives such as *Mais Médicos*, which emerged to address some of the same problems that the FESF was expected to help solve. The future of the foundation model for primary care in Bahia and elsewhere hence depends in large part how it relates to federal human resource initiatives, and on how efforts to diversify into other areas will permit the foundation to maintain a significant focus on primary care.

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ANNEX 1

Performance indicators related to Variable Part 1 of OS contracts

Action	Indicator	Source	Periodicity of the evaluation	Goal
Implementation of Medical File Committee in the PHC ¹ units	Proportion of PHC units with Medical File Committee implemented	SO ⁶ quarterly reports	Quarterly, from the 7th month of the contract	80%
Update of the PHC Units in the CNES ²	Proportion of professionals registered on CNES	CNES	Monthly	90%
Percentage of medical visits performed by the patient's own Family Physician	Percentage of medical visits performed by the patient's own Family Physician	EMR and SIA-SUS ⁷	Monthly, from the 3rd month	60-80%
Follow up on the oral health work plan	Proportion of discharges in dental treatments	Local information system	Monthly, from the 6th month of dental clinic implementation	80%
Annual planning of activities	Proportion of PHC units with annual planning submitted	SO annual report	Annual	80%
Percentage of schools in the territory covered by promotion, prevention and healthcare activities	Proportion of PHC units with school health planning submitted	SO quarterly reports	Quarterly	80%
Computerization of workstations	Proportion of medical offices and other rooms with EMR ⁵	SO quarterly reports	Quarterly	70%
Percentage of oral health kits distributed in community or individual activities	Percentage of oral health kits distributed	SO quarterly reports	Quarterly	10%

1. PHC = primary health care. 2. CNES = *Cadastro Nacional de Estabelecimentos de Saúde* (National Cadastre of Healthcare Facilities). 3. BPA = *Boletim de Produção Ambulatorial* (Ambulatory Production Bulletin). SIAB = *Sistema de Informação sobre Atenção Básica* (Primary Care Information System). 5. EMR = Electronic Medical Record. 6. OS = Social Organization. 7. SIA-SUS = *Sistema de Informações Ambulatoriais do SUS* (SUS Ambulatory Information System)

Performance indicators related to the Variable Part 1 of the OS contracts (cont).

Action	Indicator	Source	Periodicity of the evaluation	Goal
Regular supply of PHC units	Proportion of PHC units attesting being regularly supplied by the manager	SO reports	Monthly	80%
Average cost of medications prescribed by user	Average cost of medications prescribed by user	EMR	Quarterly, from the 7th month of the contract	Max = (variable)
Average cost of diagnostic and therapeutic services prescribed by user	Average cost of diagnostic and therapeutic services prescribed by user	EMR	Quarterly, from the 7th month of the contract	Max = (variable)
Decentralization of insuline provision	Proportion of PHC units that provide insuline	SO quarterly reports	Quarterly	90%
Decentralization of asthma medication provision	Proportion of PHC units that provide asthma medication	SO quarterly reports	Quarterly	80%
Decentralization of anti-retroviral medication provision	Proportion of PHC units that provide anti-retroviral medication	SO quarterly reports	Quarterly	80%
Regularity in the submission of productivity (BPA ³ and SIAB ⁴ systems)	Proportion of PHC units that inform the BPA and SIAB systems on time	SO reports	Monthly	100%

1. PHC = Primary Health Care. 2. CNES = *Cadastro Nacional de Estabelecimentos de Saúde* (National Cadastre of Healthcare Facilities). 3. BPA = *Boletim de Produção Ambulatorial* (Ambulatory Production Bulletin). SIAB = *Sistema de Informação sobre Atenção Básica* (Primary Care Information System). 5. EMR = *Eletronic Medical Record*. 6. SO = *Social Organization*. 7. SIA-SUS = *Sistema de Informações Ambulatoriais do SUS* (SUS Ambulatory Information System)

ANNEX 2

Performance indicators related to the Variable Part 2 of the OS contracts.

Indicator by dimension	Goal
<i>Access</i>	
Percentage of medical visits performed by the patient's own Family Physician	70%
Percentage of spontaneous demand (reception of the nonprogrammed demand or referred by other PHC ¹ units) in relation to the programmed demand	40%
Rate of household visits per 1,000 registered users	0,25
Rate of educational groups performed per 1,000 registered users	0,010
Rate of items in the service portfolio implemented	80%
<i>Care Performance</i>	
Percentage of women aged 25 to 64 years with pap smear recorded over the past three years	80%
Percentage of diabetics with at least two recorded visits in last 12 months, in two different semesters	80%
Percentage of hypertensive patients with a blood pressure record in the last 6 months	80%
Percentage of children up to 2 years with updated vaccination schedule	80%
Percentage of children up to 6 years with updated vaccination schedule	80%
Percentage of first consultation for prenatal care in the first trimester of pregnancy	80%
Percentage of first childcare consultation made in the first 28 days of life	80%
Proportion of discharges in dental treatments from registered patients	80%
<i>User Satisfaction</i>	
Percentage of satisfied and very satisfied users (<i>Note: If the goal for this indicator is not reached the others will not even be analyzed</i>)	Not defined
<i>Efficiency</i>	
Average cost of medications prescribed by user	Variable
Average cost of diagnostic and therapeutic services prescribed by user	Variable

Indicator by dimension	Goal
Percentage of drugs prescribed from the REMUME ² list (Appendix 4)	90%
Percentage of patients referred to other services	10%
Percentage of absenteeism of visits/procedures scheduled by the SISREG ³ system	30%

1. PHC = primary health care. 2. *REMUME* = *Relação Municipal de Medicamentos* (Municipal Medication List). 3. *SISREG* = *Sistema Nacional de Regulação* (National Regulation System).

ANNEX 3

Performance indicators related to the Variable Part 3 of the OS contracts

Indicator by Dimension	UC
Follow-up ('surveillance') in birth control planning of one woman in fertile age, per year	1
Follow-up ('surveillance') in birth control planning of one woman in fertile age, in the waiting list for IUD ¹ insertion or pre-surgical evaluation for tubal ligation	3
Follow-up ('surveillance') of one pregnancy	8
Follow-up ('surveillance') of one child over the first year of life, per year	7
Follow-up ('surveillance') of one child over the second year of life, per year	3
Follow-up ('surveillance') of one diabetic patient, per year	4
Follow-up ('surveillance') of one hypertensive patient, per year	2
Follow-up ('surveillance') of one tuberculosis patient discharged by cure, per year	8
Follow-up ('surveillance') of one leprosy patient discharged by cure, per year	10
Teams with undergraduate students or medical residents (preceptor teams)	10
Family physician registered as the technical responsible at the CREMERJ ² for the PHC ³ unit of work	10

1. IUD = intra-uterine device. 2. CREMERJ = *Conselho Regional de Medicina do Estado do Rio de Janeiro* (Rio de Janeiro State Regional Medicine Council). 3. PHC = primary health care.

This study presents two case studies, each on a current initiative of contracting for primary health services in Brazil, one for the state of Bahia, the other for the city of Rio de Janeiro. The two initiatives are not linked and their implementation has independently sprung from a search for more effective ways of delivering public primary health care. The two models differ considerably in context, needs, modalities, and outcomes.

This study does not attempt to evaluate the initiatives, but to identify their strengths and weaknesses, initially by providing a background to universal primary health care in Brazil, paying particular attention to the Family Health Strategy, the driver of the basic health care model. It then outlines the history of contracting for health care within Brazil, before analyzing the two studies.

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1818 H Street, NW
Washington, DC USA 20433

Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org