



# Program Information Document (PID)

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Concept Stage | Date Prepared/Updated: 28-Jan-2020 | Report No: PIDC210443



**BASIC INFORMATION**

**A. Basic Program Data**

Country Brazil	Project ID P171977	Parent Project ID (if any)	Program Name Brazil: Primary Health Care Financing and Organization Reforms
Region LATIN AMERICA AND CARIBBEAN	Estimated Appraisal Date 04-May-2020	Estimated Board Date 09-Jul-2020	Does this operation have an IPF component? Yes
Financing Instrument Program-for-Results Financing	Borrower(s) Ministério da Economia	Implementing Agency Ministério da Saúde - Secretaria de Atenção Primária à Saúde	Practice Area (Lead) Health, Nutrition & Population

**Proposed Program Development Objective(s)**

The Project Development Objective is to support the Brazilian government to improve access, quality and efficiency of public health services by reforming the Sistema Único de Saúde (SUS) Primary Health Care (PHC) financing and organization.

**COST & FINANCING**

**SUMMARY (USD Millions)**

<b>Government program Cost</b>	2,975.35
<b>Total Operation Cost</b>	2,975.35
Total Program Cost	2,965.35
IPF Component	10.00
<b>Total Financing</b>	2,975.35
<b>Financing Gap</b>	0.00

**FINANCING (USD Millions)**

<b>Total World Bank Group Financing</b>	100.00
World Bank Lending	100.00



Total Government Contribution

2875.35

## B. Introduction and Context

### Country Context

- 1. After a decade of rapid growth and social progress up to 2013, Brazil's economy fell into a deep recession.** Between 2002 and 2013 Brazil's gross domestic product (GDP) grew at an average rate of 3.6 percent, with a peak of 7.5 percent in 2010. The deterioration in both the external environment and domestic policies led to a steady decline in growth after 2013. In 2014, GDP grew at 0.5 percent, and in 2015 and 2016, GDP contracted by more than 3 percent. The scenario has recently improved, and since 2016 GDP has grown around 1 percent a year.
- 2. While the decade of a favorable external environment contributed to fast poverty reduction, improvements in poverty indicators have stagnated or reversed in recent years.** Between 2001 and 2015 more 24 million Brazilians were lifted from poverty. Most of this reduction was explained by the creation of formal sector jobs, with sharp decline in the unemployment rate to a low of 6.8 percent in 2014. Inequality also declined in the beginning of the 21st century. Between 2009 and 2015, the Gini coefficient of household incomes fell from 0.59 to 0.51. However, the economic crisis precipitated a rapid rise in unemployment with job losses of 2.6 million only in 2015-16. The unemployment rate peaked 13.6 percent in March 2017 and has only slowly declined to 11.2 percent in November 2019. In 2018, 16,9 million of Brazilians were living with less than R\$179 per person per month. The economic downturn also reverted the reduction of inequalities, the Gini coefficient increased to 0.54 in 2016, and then declined to 0,53 in 2017 – still higher than in 2015.
- 3. A large structural fiscal imbalance lies at the heart of Brazil's present economic difficulties.** The primary balance deteriorated from a surplus of nearly 3 percent of GDP in 2012 to a deficit of 1.3 percent in 2019. Because of high interest expenditures, the overall fiscal deficit is considerably larger and reached 6.4 percent of GDP in 2019. While revenues are cyclical and have declined during the recession, spending is rigid and driven by constitutionally guaranteed social commitments (including pension benefits), high percentage of earmarking of resources and rigid labor market contracts, especially in the public service. In fact, government has little room for staff adjustments, since civil servants enjoy job stability and rigid contracts. Current government estimates suggest that the so-called "forced expenditures" (that is, expenditures that cannot be reduced) represent over 90 percent of all expenditures. As a result of the increased spending and stringent and inflexible legal framework, fiscal adjustments are hard to implement.
- 4. Since 2016, the government has adopted a series of measures aimed at controlling the seemingly unsustainable debt dynamics.** Among the most important reforms are the Constitutional Amendment 95 (*Teto dos Gastos, or EC95*) and the recently approved pension reform. The EC95 introduced ceiling for government spending until 2024. It states that government spending cannot be higher than previous year's spending adjusted by inflation. It is estimated that the amendment will bring down primary spending from 23.5 percent of GDP in 2016 to 20.8 percent of GDP by 2026. However, even after accounting for savings from the recent pension reform, maintaining public expenditure within the spending limit will require additional 1.2 percent of GDP in savings that are yet to be identified.



Sectoral (or multi-sectoral) and Institutional Context of the Program

**5. The Unified Health System (SUS) is one of the main achievements in terms of social policies in Brazil.** The creation of SUS in 1988, establishing universal health coverage (UHC), has been associated with the expansion of the health service delivery with remarkable improvements in access, financial protection and health outcomes. The SUS network expanded considerably, particularly outpatient services driven by the expansion of the family health strategy (FHS) (*Estratégia de Saúde da Família*).<sup>1</sup> Between 1998 and 2019, FHS teams increased from 4,000 to over 43,000 and enrollment expanded from 10.6 million to over 84 million people, or 40 percent of the population.<sup>2</sup> Access to health increased sharply, the number of individuals seeking primary health care (PHC) services increased by about 85 percent between 1998 and 2013 and the number of medical consultations per capita rose by 70 percent between 1990 and 2009.<sup>3</sup> In terms of financial protection, the most recent evidence shows that Brazil has one of the lowest levels of catastrophic spending in the Latin America and Caribbean Region.<sup>4</sup>

**6. The expansion of access to health services contributed to improving the quality of life of Brazilians.** This advance is reflected in the evolution of the country's main health indicators over time. For example, life expectancy at birth for Brazilians increased by 8.2 years between 1991 and 2018 (from 66.9 to 75 years). However, this rate remains much lower than it should be expected considering Brazil's level of spending in health as percentage of GDP. Between 1990 and 2018, infant mortality rate declined more than 70 percent (from 52.5 to 12.8 per 1,000 live births) and maternal mortality rate dropped by more than 50 percent between (from 104 to 44 per 100,000 live births). However, this level is three times the average rate among the Organization for Economic Cooperation and Development (OECD) countries (14 per 100,000 live births), but one third of Brazil's structural peers (135 per 100,000 live births) and lower than its regional peers (52 per 100,000 live births).<sup>5</sup>

**7. The gradual expansion of the health system and entitlements to services has been accompanied by the debate about the appropriate level of government spending and how efficiently health systems' resources are used.** In 2017 Brazil spent 9.3 percent of its GDP on health while the average for OECD countries in the same year was 8.8 percent.<sup>6</sup> However, two factors should be noted: first, unlike most the OECD countries, health spending in Brazil is dominated by private spending. The private sector accounts for more than half of the total health expenditures (THE), and spending with private health insurance, which covers approximately 25 percent of the population, accounts for 58 percent of the total private spending. Second, health indicators in Brazil are still below the average among OECD countries and, in many cases, worse than its regional and economic peers.

**8. Despite the efforts to establish a public universal health system, Brazil struggles to achieve a right balance between an appropriate level of (public) spending and to obtain better value for the resources invested in its health system.** Public health spending in Brazil has grown steadily over the last decades, often exceeding the growth rate of public revenue and gross domestic product (GDP). Between 2008 and 2017, public health spending increased by 0.51 percent of GDP. At federal level, health spending increased from 6.7 percent to 8.3 percent in relation to current revenue (*receita corrente líquida*) and from 1.6 percent to 1.8 percent as a proportion to GDP. The discussion on the sustainability of public

<sup>1</sup> The FHS are multi-professional health teams (composed of a physician, a nurse, a nurse assistant and 4-6 community health workers) organized by geographic regions to provide primary care to approximately 1,000 families (or about 3,500 people).

<sup>2</sup> Administrative records, Ministry of Health.

<sup>3</sup> Pesquisa Nacional de Saude (PNS, 2013) and Pesquisa Nacional por Amostra de Domicílios (PNDA, 1998).

<sup>4</sup> Knaul et al. (2011). Household catastrophic health expenditures: A comparative analysis of twelve Latin American and Caribbean Countries. *Salud Pública de México*, Vol. 53(2).

<sup>5</sup> World Development Indicators, 2018.

<sup>6</sup> IBGE (2019). *Contas-Satelite de Saude 2010 – 2017*.



health expenditures in Brazil involves recognizing that, on the one hand, there is a relative under-financing of the public system and, on the other, that there is scope to achieve better results with the current level of spending.

#### Relationship to CAS/CPF

**9. The proposed operation is consistent with the emerging priorities of World Bank Group’s Country Partnership Framework (CPF) for the Federative Republic of Brazil, for the period FY18-FY23 (Report #113259-BR), discussed by the Executive Directors on May 16, 2017,** more specifically within the first Focus Areas - fiscal consolidation and government effectiveness.<sup>7</sup> It is particularly aligned with the CPF objective 1.4 “Increase effectiveness of service delivery in health”, which emphasizes the need to focus on activities that strengthen government capacity and promote improved service delivery through improving the targeting of policies, increasing accountability for results, and thereby supporting the shift from expanding access to increasing quality. The PHC reform at the federal level, to be implemented across all municipalities, has been an important step towards achieving these goals. The proposed operation is also consistent with the World Bank’s twin goals of eliminating extreme poverty and boosting shared prosperity by supporting a program targeted at improving PHC coverage, which benefits most the poor.

#### Rationale for Bank Engagement and Choice of Financing Instrument

**10. The World Bank engagement in the SUS PHC reform is justified mainly by: (i) World Bank’s technical expertise; (ii) focus on institutional strengthening; and (iii) mitigation of risks of discontinuity of programs due government transitions.** The World Bank projects have helped to implement the main reforms of the SUS over the past decades, both at the federal and at sub-national levels. Projects such as Family Health Extension (phases I and II) helped to establish and expand the family health program (*Programa de Saúde da Família*, PSF) in the Brazilian municipalities with more than 100,000 inhabitants. The AIDS-SUS Project (after three other AIDS and STDs-related operations) helped to consolidate one of the pioneering programs for the treatment and control of HIV/AIDS infection in Brazil. The Health Network Formation and Quality Improvement Project (QUALISUS-Rede) sought to implement health care networks through subprojects all over the country. More recently, the World Bank provided technical assistance to the Ministry of Health (MOH) in the design of the PHC financing reform, which will be implemented with the support of the proposed Program.

**11. The proposed operation would support the design and implementation of SUS PHC reforms.** These reforms would have strong focus on results, by linking federal transfers to municipalities to results, which would require strengthening capacity at federal and municipal levels. The operation would provide support over time, seeking to ensure the continuity of programs even during government transitions. The Program-for-Results (PforR) financing instrument is more adequate for such an operation given the focus on achieving results for a well-established government program (SUS PHC). Additionally, the PforR provides the necessary fiduciary flexibility to implement such a complex reform, which involves thousands of municipalities. The Technical Assistance (TA) component would be financed through an Investment Project Financing (IPF) loan in the amount not to exceed US\$10 million. This TA will provide support to improve technical capacity at the MOH and municipal health secretariats (*Secretarias Municipais de Saúde*, SMS) to implement and monitor the PHC reforms. The TA component would allow contracting of consultancies, studies and assessments which, using the World Bank’s procurement rules, allows access to national and international expertise to contribute to the implementation of the reforms.

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<sup>7</sup> Brazil: Country Partnership Framework (2017). World Bank Report #113259-BR; Approved by the World Bank’s Board of Directors on May 16, 2017.



### C. Program Development Objective(s) (PDO) and PDO Level Results Indicators

#### Program Development Objective(s)

**12.** The Project Development Objective is to support the Brazilian government to improve access, quality and efficiency of public health services by reforming the Sistema Único de Saúde (SUS) Primary Health Care (PHC) financing and organization.

#### PDO Level Results Indicators

**13.** The proposed PDO level indicators are:

- Number of people registered in family health teams;
- Percentage of municipalities that have reached the population PHC registration target;
- Rate of hospital admission for PHC-sensitive conditions;
- Percentage of municipalities that have reached pay-for-performance indicators targets.

### D. Program Description

#### PforR Program Boundary

**14. The strengthening of the PHC network has been defined by the Brazilian government as a fundamental strategy to reform SUS.** The proposed reforms aim at expanding PHC coverage, improve quality of services at primary and secondary care, and to improve efficiency of SUS health service delivery. The program would have two complementary components: the first component would support the implementation of the SUS PHC reforms, with a focus on the implementation of the new PHC financing mechanism (results area 1) and the reorganization of PHC service delivery model (results area 2). It will support programs and budget lines existing in the Pluriannual Plan (2020 – 2023) and in the Annual Budget Law (LOA). The second component would provide technical assistance to strengthen the institutional capacity of the MOH and the state and municipal health secretariats to implement the PHC reforms. This component is estimated at 10 percent of the total loan amount and will finance studies, impact evaluations, training and other expenses to support Program implementation.

**15. Component 1, Results Area 1 - Implementation of the new PHC financing model.** The program will support the MOH and municipal health secretariats to implement the *Previne Brasil* program. Following international best practices to financing PHC, the *Previne Brasil* introduces a new mechanism to transfer federal resources to municipalities and it represents a major shift in how the federal government allocates resources in the health sector. In the previous mechanism, federal transfers to municipalities were distributed mainly on per capita basis, with little incentives to improved quality and patient follow-up. In the new program, a significant share of resources to PHC is linked to performance indicators, which focus on priority areas defined by the MOH. The program also introduces weighted capitation, which provides additional resources to municipalities registering vulnerable populations (beneficiaries of social assistance programs such as *Bolsa Família* or *Benefício de Prestação Continuada - BPC*), children under five years old, and the elderly (over 65 years) in PHC teams.

**16. Component 1, Results Area 2 – reorganization of PHC service delivery model.** The MOH defined key strategies to reform PHC service delivery to improve access and effectiveness of PHC services, these strategies include: (i) the *Informatiza APS*, the program of informatization of PHC units; (ii) the *Saúde na Hora* (SnH), a program that introduces the provision of extended hours in PHC centers; and (iii) PHC benefits package, which is a list of essential services that should



be offered to the population in all PHC health units. The Informatiza SUS is one key actions of the Government of Brazil's to implement its digital health strategy (Conecte SUS), it will provide incentives to each PHC center upon the transfer of data through a single MOH platform that concentrates PHC data. These incentives will vary from R\$1,700 to R\$2,300 depending on the municipality rural-urban geographical classification as defined by the IBGE.<sup>8</sup> The SnH Program provide incentives to municipalities that extend PHC centers hours of operation to 60 hours or 75 hours per week (these extended hours can be at night, lunch hours and/or during weekends). The financial incentives range from R\$44,200 for those opting for 60 hours (an increase of 106,7 percent of the federal transfer) to R\$ 109,300 for those opting for 75 hours (121percent increase in monthly transfers).

**17.** The preliminary Disbursement-linked Indicators (DLIs) associated to Results Areas 1 and 2 would be:

- Percentage of PHC centers opening at extended hours;
- Percentage of municipal health secretariats adopting PHC costs management tools;
- Percentage of PHC centers showing improvements in pay-for-performance indicators;
- Percentage of Brazilian municipalities with program to expand the scope of practices of nurses and community health workers;
- Percentage of municipalities adopting clinical protocols to guide PHC referrals to other levels of care;
- Percentage of family health teams computerized and sending data regularly to the MOH.

**18. Component 2 - TA to strengthen the institutional capacity for a sound implementation of the PHC reforms.** The TA would offer specialized consultancy services to the MOH and the municipal health secretariats, including to: (i) develop and implement a monitoring and evaluation strategy to assess the implementation and impacts of the reforms; (ii) support collaboration between MOH and municipal health secretariats; and (iii) implement studies and assessments to support the design and implementation of PHC-related interventions (such as management practices, costing exercises, changes in health workers scope of practice, etc.). The TA would support the MoH to:

- Implement analytical work to identification, assess, and disseminate best practices in cost management at PHC across Brazilian municipalities;
- Implement analytical work and policy debate (seminars, stakeholders' consultation, etc.) to define a new regulatory framework for public-private partnerships in the provision of PHC services;
- Develop a monitoring and evaluation strategy, including: (i) support the partnership between the MoH and IBGE, including the application of PHC assessment instruments validated in Brazil – PCATool and PDRQ-9;<sup>9</sup> and (ii) define a M&E strategy using predictive models (data science techniques) to simulate the impacts of the proposed PHC interventions;
- Establish clinical/referral protocols to other levels of care, to facilitate coordination of care across PHC and other settings;
- Expand the scope of practice for nurses and community health workers, including the provision of training on new competences and skills;
- Conduct field studies, exchange of experiences with other countries, among others.

<sup>8</sup> In 2017 the IBGE proposed a new typology to characterize urban and rural areas in Brazil. The new typology considers demographic density, localization in relation to the main urban centers and population size to classify municipalities into five categories: urban, adjacent Intermediary, remote Intermediate, adjacent rural and rural remote (IBGE, 2017).

<sup>9</sup> Primary Care Assessment Tool (PCAT) and patient-doctor relationship questionnaire (PDRQ-9).



## **E. Initial Environmental and Social Screening**

**19.** The Program would support the expansion of an already established and growing PHC network, improve quality of services at primary and secondary care, and improve efficiency of the SUS health service delivery through reforms that do not include any infrastructure works. The Program includes a TA component. Environmental and social risks of this operation are rated Moderate since no infrastructure works will be supported and potential risks are restricted to downstream implications of the envisaged reforms.

**20.** According to the scope of the PforR component, environmental risks would be indirect well understood and are expected to be limited. Environmental risks consider the possibility of not adequately management/supervision and control of the health services waste generated in the health centers. Risks related with biomedical waste management, pest management, occupational health and safety, and community health and safety that could be associated to any study for regulation or policy changes and the Borrower's capacity to adequately manage and monitored them, particularly at municipal level, will be further assessed during project's preparation. Social risks are based on the need: (i) to engage transparently with many key stakeholders of the reforms, among them some sensitive, so envisaged changes occur. Some of main actors to be considered are federal and states legislatures, municipalities, primary health system units, related private sector, among others; and (ii) to clearly identify reasons and most disadvantaged or vulnerable social groups excluded of these PHC system – among them indigenous peoples may be included – that could be excluded of access to project benefits.

**21.** The management of these risks would not require significant changes to the borrower's overall management approaches. The Borrower's institutional capacity in managing environmental and social risks that may be associated to this PforR operation is broadly considered as adequate. The Brazilian Government has advanced environmental and social laws and regulations that include robust standards to ensure overall adequate management of waste generated in health centers and promote social inclusion and accessibility approaches in related policies, among them those that will be supported by the project. Meanwhile, during project preparation, the Bank team will carry out an Environmental and Social Systems Assessment (ESSA), reviewing exclusionary criteria, risk screening and program systems assessing in what degree the Program's system. This assessment will consider the six core principles set by the PforR Policy, emphasizing (a) the capacity to manage environmental impacts related with biomedical waste, pest management, occupational health and safety as well as community health and safety issues and (b) due consideration to the cultural appropriateness of, and equitable access to, Program benefits, paying special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

**22.** The TA component of the operation was also initially screened taking into consideration the World Bank Environmental and Social Framework (ESF) for IPF operations. The Project concept notes Environmental and Social Review Summary (ESRS) identifies the relevant Environmental and Social Standards and the environmental and social risk management instruments that might be prepared. The TA of up to 10 percent of total loan proceeds is focused on straight forward institutional capacity building of the Ministry of Health and the state and municipal health secretariats to implement the PHC reforms without a physical footprint. The TA would allow contracting of consultancies, studies and assessments. Products include among others the proposal of a regulation for public-private partnerships or private sector in the provision of primary health care, protocols for transferring from the units of primary health care to higher levels of health care, among others. These TA activities are classified as moderate risk. Addressing issues related with the TA component, the client will prepare (a) a tailored stakeholder's engagement plan; (b) a social risk and impacts analysis that could serve as inputs to improve proposed project's activities that may constitute barriers to access and uses of PHC services by most vulnerable groups; and (c) a labor management procedure for the consultancies to be carried out.



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Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts of the IPF Component

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