Brazilian Federation: Composed by three distinct political entities (Federal, States and Municipalities), each of them with administrative autonomy (without hierarchical submission).

- **Area**: 8.511.996 km².
- Five Geographical macro regions: North, northeast, southeast, south and central-west.
- Number of states: 26 states and a Federal District.
- Number of municipalities: 5.562.

Federal Health Management: Ministry of Health
State Health Management: State Health Secretariat
Municipal Health Management: Municipality Health Secretariat

Per capita income at municipal level, 2000

*Per capita income:*

- **Lowest**: $0-$299
- **16.6-299**: $300-$599
- **500-799**: $600-$899
- **1000**: $900-$1499
- **Highest**: $1500+
Regional differences
Life expectancy average Brazil, Alagoas State and Rio Grande do Sul state

![Graph showing life expectancy in Brazil, Alagoas, and Rio Grande do Sul over years.]

<table>
<thead>
<tr>
<th>Year</th>
<th>Brazil</th>
<th>Alagoas</th>
<th>Rio Grande do Sul</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
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<tr>
<td>1992</td>
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<td>2002</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td></td>
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</tr>
</tbody>
</table>

Unified Health System - SUS

- 90% of the Brazilian population uses services offered by SUS
  - publicly owned and operated
  - privately owned but publicly funded
- 61.5% of the population uses SUS exclusively
- 28.6% of the population uses SUS as well as private health care
- 8.7% never use health care delivered or financed by SUS

• Brazilian Unified Health Care System
  - organized under principles of:
    ✓ Regionalization
    ✓ hierarchy of care and
    ✓ comprehensiveness
    ✓ according to the level of complexity of health care needs
To focus the strategies developed to articulate the Mental Health and Primary care policies through strategies such as the current Family Health Program.
**Mental Health Policy**

- Four main points:
  - to guarantee civil rights for people with mental disorders
  - to protect patients under treatment in the existing hospitals
  - to develop a diverse network to provide access, efficacy and efficiency for people with mental disorders
  - to decentralize psychiatric care through the creation of a mental health network regulated by the Psychosocial Community Centers as the gateway for the system

---

**Mental Health Policy**

- 1990– Creation of the first Psychosocial Community Centers and Day Hospitals
- 2001- Approved the Mental Health Law
- progressive substitution of psychiatric beds for
  - Community Social Psychiatric Centres, labelled “Centros de Atenção Psicosocial-CAPS”

---

**Mental Health Policy**

**Reduction of psychiatric beds 2002-2008**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>51393</td>
</tr>
<tr>
<td>2003</td>
<td>48303</td>
</tr>
<tr>
<td>2004</td>
<td>45814</td>
</tr>
<tr>
<td>2005</td>
<td>42076</td>
</tr>
<tr>
<td>2006</td>
<td>39567</td>
</tr>
<tr>
<td>2007</td>
<td>37988</td>
</tr>
<tr>
<td>2008</td>
<td>36797</td>
</tr>
</tbody>
</table>
Reduction of psychiatric beds since the beginning of the MHS Reorganization

Annual Expansion of the number of Psychosocial Attention Centres (Services) - CAPS
Period: between late 80’s and 2006

The Brazilian mental health network supported by a psychosocial centered care approach

- Supported Adult Education
- Sheltered Workshops
- Clubhouse
- Drop-in centres
- Psychiatric Unit Care in General Hospitals
- Family Health Care team
- Psychosocial Care Centres: The CAPS (for adults with severe mental illness)
  - The CAPS-AD (for addiction)
  - The CAPS-I (for children)
- Psychosocial Supportive housing and Boarding homes: The SRTs

Sheltered Workshops

- Supported Adult Education
- Sheltered Workshops
Patients in a sheltered workshop in Campinas-SP-Brazil

Patient interviewing a man for the CAPS' newspaper

The expansion of the Community Psychiatric Social Centers-CAPS

Coverage of Psychosocial Attention Services for 100,000 inhabitants
Professionals and users in the Carnaval, the most known Brazilian celebration

Spending a day in the Hopi Hari Park

Demanding for respecting their rights about delivery care

2002 2007

Extra – hospitalar
Programs and actions

Hospitalar programs and actions

Table 4- Expansion of CAPS according type, 2003-2006

Tabela 4 – Expansão dos Centros de Atenção Psicossocial por tipo
(décembro de 2003 – dezembro de 2006)

<table>
<thead>
<tr>
<th>Tipo de Ativo</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPS I</td>
<td>140</td>
<td>173</td>
<td>216</td>
<td>233</td>
<td>432</td>
</tr>
<tr>
<td>CAPS II</td>
<td>106</td>
<td>200</td>
<td>220</td>
<td>276</td>
<td>336</td>
</tr>
<tr>
<td>CAPS III</td>
<td>75</td>
<td>245</td>
<td>326</td>
<td>246</td>
<td>377</td>
</tr>
<tr>
<td>CAPS IV</td>
<td>32</td>
<td>37</td>
<td>44</td>
<td>56</td>
<td>77</td>
</tr>
<tr>
<td>CAPS V</td>
<td>45</td>
<td>55</td>
<td>70</td>
<td>102</td>
<td>136</td>
</tr>
<tr>
<td>Total</td>
<td>348</td>
<td>702</td>
<td>980</td>
<td>1402</td>
<td>1811</td>
</tr>
</tbody>
</table>

Fonte: Coordenação Geral da Saúde Mental

CAPS rehabilitation activities

Evolution of Expenses with Mental Health (million of R$), 2002-2007

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra – hospitalar</td>
<td>153,31</td>
<td>760,47</td>
</tr>
<tr>
<td>Programs and actions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalar programs</td>
<td>465,98</td>
<td>439,40</td>
</tr>
<tr>
<td>and actions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Types of CAPS and their covery

<table>
<thead>
<tr>
<th>Types of CAPS</th>
<th>Population assisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPS-I</td>
<td>50,000</td>
</tr>
<tr>
<td>CAPS-II</td>
<td>100,000</td>
</tr>
<tr>
<td>CAPS-III</td>
<td>150,000</td>
</tr>
<tr>
<td>CAPS-ad</td>
<td>100,000</td>
</tr>
<tr>
<td>CAPS-i</td>
<td>100,000</td>
</tr>
</tbody>
</table>

2009 - there are 39 CAPS III, concentrated mainly in the Southeastern region which means services that offer treatment 24 hours and provides intensive care during crisis events.

Table 5-Outpatient services

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family Health Program
Defining a New Model of PC: Traditional vs. FH Approach

<table>
<thead>
<tr>
<th>Model Feature</th>
<th>Traditional Basic Care (passive)</th>
<th>Family Health (pro-active)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit of intervention</td>
<td>Individual</td>
<td>Family</td>
</tr>
<tr>
<td>Main health intervention focus</td>
<td>Curative</td>
<td>Promotion and prevention</td>
</tr>
<tr>
<td>Package of health services provided</td>
<td>Fragmented / multiple providers</td>
<td>Integrated / one provider</td>
</tr>
<tr>
<td>Continuity of care with little duplication</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Knowledge of community health problems and conditioning factors</td>
<td>Low or medium</td>
<td>High</td>
</tr>
<tr>
<td>Census of households within responsibility area</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Outreach activities and home visits</td>
<td>Little</td>
<td>Significant</td>
</tr>
<tr>
<td>Team work among health professionals</td>
<td>Little</td>
<td>Strong</td>
</tr>
<tr>
<td>Ties with the community and community participation and control</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Multi-sector collaboration</td>
<td>Little</td>
<td>Strong</td>
</tr>
</tbody>
</table>

Implementation Process

- **Pre-step (early 1990s):** Community Health Agent Program supervised by well-trained nurses
- **First step (1994+):** Introduce Family Health Program in rural and urban for populations according to the following criteria:
  - Little or no access to PHC
  - Low-income
  - Poor health indicators
- **Second step (2000+):** Conversion of traditional model to Family Health approach (mostly in large cities)
- **Third step (2007+):** Formation of health network with family health as point of entry and follow-up

Family Health Team

- The team has to have at least a physician, a nurse, a nurse assistant and 4 to 12 community health agents. Most of the teams include dentists and social workers.
- Each team is assigned to a defined geographical area and is responsible for about 1,000 families.
- Teams enroll and monitor the health status of their defined populations, provide PHC, and make referrals to higher levels of care.
- Team must visit households . . . but have a base unit they work out of.
- Teams have to understand social processes and conditions in their catchment areas.
Family Health Team

- Teams work together on clinical, public health, health promotion, and social issues
- All staff work full time (40 hours per week)
- In general, salaries are good (ex: for a physician, salaries are equivalent to having two or three different part-time jobs involving much travel)
- Employment contracts are the responsibility of municipalities.
- User fees are not permitted and there is no evidence of informal payments.
- Some municipalities are starting use performance payments to the teams

Community Health Agent

- Live in the same area where they work (often elected)
- Must know their community’s problems
- Facilitate and improve the connection between the primary care professionals and the community (cultural competency)
- Are considered core members of the Brazilian primary health care program
- Eyes and ears of health system
- Do not just focus on illness: role is a general health and social professional as well as community activist

CORE PSF SERVICES

1. Women’s health
   - pre-natal care, prevention of cervical cancer, family planning
2. Child health
   - growth & development, nutrition, immunization, treatment of prevalent illnesses
3. Control of hypertension
4. Control of diabetes
5. Control of tuberculosis
6. Elimination of leprosy
7. Mental Health
8. Oral health
9. Health promotion activities
10. Public Health activities
Nowadays the teams have 14 working areas
Outcomes in the Brazilian PHC Strategy

• PHC is part of the political agenda of government (evidence: budget growth, subject in political campaigns).
• Growth in access and coverage with broad popular support.
• Studies show evidence in reducing gaps in the utilization of health services by historically marginalized groups (African Brazilian descendents, elderly, etc.).
• Improvement in selected health indicators (1998-2006) such as infant mortality, prenatal coverage, vaccination coverage.
• Professional development (specialized training courses, medical residencies, master degrees, PhD).


Evolution of PHC $$$ resources – Brasil (Millions of Reais)

SOURCE: National Health Fund
Summary of the six major points in PHC change

1. Definition of a national standard for Family Health Teams and their essential functions, including integration into a larger health network with a certain level of flexibility depending on the context (urban/rural/amazon, size of the city, and so on).

2. Definition of responsibilities for each government level in PHC management (federal, state, municipal).

3. Changes in funding mechanisms and growth of budget provisions for PHC, including performance-based financing.

4. Development of monitoring and evaluation systems, including a national database system.

5. Initiatives to change the content and approach to formation of and in-service training for health professionals.

6. Advocacy and growth in political importance of PHC.