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PRIMARY CARE AND SUPPLEMENTARY HEALTH IN BRAZIL: AN INTEGRATIVE REVIEW

ATENÇÃO PRIMÁRIA E SAÚDE SUPLEMENTAR NO BRASIL: REVISÃO INTEGRATIVA

ATENCIÓN PRIMARIA Y SALUD COMPLEMENTARIA EN BRASIL: UNA REVISIÓN INTEGRADORA

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ABSTRACT

To synthesize knowledge about the incorporation of initiatives based on Primary Health Care by the Brazilian Supplementary Health sector. This is an integrative review, which followed six phases: elaboration of the guiding question, literature search, data collection, critical analysis of the articles, discussion, and synthesis. Brazilian publications were searched, in the SciELO, Pubmed, CAPES Periodicals, EBSCOHost, and Google Scholar databases, between 2009 and 2019. 22 publications were analyzed. The articles were about concepts and experiences of Primary Care by private health plan operators. The results point to more effective management with greater beneficiary satisfaction. The resistance of specialist physicians, lack of professional qualification, political motivation, and cultural bias constitute obstacles to this care reorganization. The Primary Care model impacts both the quality of health services and the economic sustainability of the Supplementary Health sector, providing users with comprehensive care, disease prevention, and health promotion.

Descriptors: *Supplemental Health; Prepaid Health Plans; Primary Health Care; Review Literature.*

RESUMO

Sintetizar o conhecimento sobre a incorporação de iniciativas baseadas na Atenção Primária à Saúde pela Saúde Suplementar brasileira. Trata-se de uma revisão integrativa que seguiu seis fases: elaboração da pergunta norteadora, busca na literatura, coleta de dados, análise crítica dos trabalhos, discussão e síntese. Foram buscadas publicações brasileiras nas bases SciELO, Pubmed, Periódicos CAPES, EBSCOHost e Google Scholar, entre os anos 2009 e 2019. Foram analisadas 22 publicações. Os trabalhos versavam sobre conceitos e experiências de Atenção Primária por operadoras de planos de saúde. Os resultados apontam uma gestão mais efetiva com maior satisfação dos beneficiários. A resistência de médicos especialistas, falta de qualificação profissional, motivação política e viés cultural configuram empecilhos para essa reorganização assistencial. O modelo de Atenção Primária impacta tanto na qualidade dos serviços quanto na sustentabilidade econômica da Saúde Suplementar, proporcionando aos usuários o cuidado integral, com prevenção de doenças e promoção de saúde.

Descritores: *Saúde Suplementar; Planos de Saúde; Atenção Primária à Saúde; Revisão.*

RESUMEN

Sintetizar conocimientos sobre la incorporación de iniciativas basadas en Atención Primaria por la Salud Complementaria Brasileña. Se trata de una revisión integradora, que siguió seis fases: elaboración de la pregunta orientadora, búsqueda bibliográfica, recolección de datos, análisis crítico, discusión y síntesis. Se buscaron publicaciones brasileñas, en las bases SciELO, Pubmed, CAPES Periodicals, EBSCOHost y Google Scholar, entre 2009 y 2019. Se analizaron 22 publicaciones. Los trabajos versaron sobre conceptos y experiencias de Atención Primaria. Los resultados apuntan a una gestión más eficaz con mayor satisfacción de los beneficiarios. La resistencia de médicos especialistas, la falta de cualificación profesional, la motivación política y el sesgo cultural constituyen obstáculos para esta reorganización asistencial. El modelo de Atención Primaria impacta tanto en la calidad como en la sostenibilidad económica de la Salud Complementaria, brindando a los usuarios una atención integral, con prevención de enfermedades y promoción de la salud.

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Descriptores: *Salud Complementaria; Planes de Salud de Prepago; Atención Primaria de Salud; Revisión.*

INTRODUCTION

Compared to several developed countries, Brazil had its social security system created belatedly through the 1988 Constitution, with the institution of the Unified Health System (SUS), with the State being solely responsible for regulating, inspecting and controlling it. SUS' principles are universal access, equality and comprehensive care; while its guidelines are decentralization, hierarchization and community participation. This model breaks with the logic of health insurance that existed until then for social security[1].

Despite the institution of the SUS as a universal, free and public system, the constitutional text also states that health is free to the private sector, in a complementary way. Thus, Brazil has a model considered “duplicate”, in which the public-private mix coexists with the provision, financing, demand and use of health services. The private segment is called Supplementary Health[1–3].

In Brazil, Supplementary Health began in 1970. This sector has undergone a great expansion since then, however, without having its activities standardized, oriented and supervised, being the target of several criticisms by the beneficiaries. In this context, Law No. 9,656 of 1998 emerged, which regulated private health care plans and insurance in the Brazilian territory[4].

In 2000, the National Supplementary Health Agency (ANS) was created by Law 9,961, aiming to promote the defense of the public interest in supplementary health care. Over time, ANS, which operated only in economic and financial regulation, incorporated the assistance focus in order to guarantee the quality of the service. Its role is to establish regulations in order to contribute to user satisfaction, financially balance companies in the sector, in addition to regulating values, products and coverage[4–6].

The Supplementary Health System is made up of the following types of assistance: self-management, medical cooperative, philanthropy, group medicine and specialized health insurance, group dentistry, dental cooperative and benefits administrator. The plans can be individual, when contracted directly by an individual, or collective, when contracted for employees of a company or class entity or institution (collective by adhesion)[7]. Until March 2020, corporate collective plans accounted for 65.9% of customers, while individual or family plans accounted for 12.7%8.

Most healthcare spending in Brazil is spent on the private sector (51%), with more than half paid for by Brazilian families. Due to increasing federal subsidies, the market for health plans and the concession of management of public establishments to the private sector expanded considerably. In 2013, these subsidies reached R$ 25.4 billion, equivalent to 30.6% of the Ministry of Health (MS) budget. In 2015, 26% of the population had health plans and the sector had a turnover of around R$132 billion[9.10].

Today, with more than 70 million beneficiaries, the private sector has become indispensable. According to the ANS, in December 2019, 47,031,980 people had contracts with 1,500 medical and dental operators across the country. In the absence of the private sector, the SUS would be responsible for 47 million more people in the queues in this period alone[8,11].

Due to the medical model that produces procedures, in the prescriptive act, fragmented into subspecialties, not considering the health-disease process, social and environmental conditions and longitudinal care[7], the Supplementary sector is in a process of structural crisis.

The World Health Organization (WHO) has been warning countries with fragmented health systems that they are failing to keep up with epidemiological trends, such as the rise of chronic problems. These systems have high costs with mass diagnostic methods, technological resources and medicines, generating inefficient and disconnected intervention actions for the patient[7].

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In order to counteract this crisis, in 2005 the ANS published Resolution No. 94, which addresses the adoption, by health plan operators, of health promotion and disease prevention programs (called PROMOPREV)[4]. Thus, there was a process of change from the care focus to care centered on comprehensive care for the individual. Thus, the adoption of Primary Health Care (PHC) practices and their integration with specialized care was encouraged. Other examples were Normative Resolutions No. 26,419 and 26,520, both of 2011, which provide for health promotion and prevention of risks and diseases, defining concepts and models of programs, and on incentives for the participation of beneficiaries, such as offering discounts and awards. This position was reaffirmed in 2018 by the recent institution by ANS of the Certification Program for Good Practices in Health Care, which aims to encourage Supplementary Health to adopt a system based on Primary Health Care (PHC)[12].

APS has four essential attributes: first contact access, coordination, longitudinality and completeness. It is responsible for the role of the healthcare system's gatekeeper, facilitating the path for the patient to find the right professional at the right time and in the right place, increasing the predictive value and efficiency of specialists. Several studies show that systems aimed at strong PHC are more effective, more satisfactory for users, have lower costs and are more equitable[7].

Based on the above, this article aims to synthesize knowledge, through an integrative review, on the reorganization of Brazilian Supplementary Health with the incorporation of PHC initiatives and their impact on the country's health sector.

METHODS

It is an integrative literature review, descriptive and bibliographical, which gathered studies to obtain a synthesis of the proposed theme. This review has a broad methodological approach, allowing the inclusion of experimental and non-experimental studies. In this type of work, the researcher synthesizes the results of published information, making expanded critical analyzes and interpretations of the chosen subject[13].

The study was based on data from secondary sources, through a bibliographic survey about PHC within the Supplementary Health care, following the steps: elaboration of the guiding question, literature search according to the inclusion and exclusion criteria, collection data from selected articles, critical analysis of the data found, interpretation and discussion of results, and synthesis of the integrative review[13].

The guiding question was elaborated: "What is known about the incorporation of PHC initiatives within the scope of Supplementary Health in Brazil in the last 10 years?". For the bibliographic survey, two researchers were independently searched in the following databases: Scientific Electronic Library Online (SciELO), MEDLINE (Medical Literature Analysis and Retrievel System Online) via PubMed, CAPES Journals (Coordination of Improvement of Higher Education Personnel) and EBSCOHost. Other sources, texts not published in scientific journals, for example, abstracts published in annals of scientific events, government reports, laws, decrees, theses, dissertations and articles published in non-indexed journals, were added according to the authors' experience, using also the Google Scholar search engine. In addition, a manual search of references cited in articles selected in the previous databases was performed.

The search strategies used specific indexing terms (Medical Subject Headings – MeSH and Descriptors in Health Sciences – DeCS) in Portuguese and English: "Primary Health Care", "Supplementary Health" and "Private Health", "Primary Care", "Supplemental Health" and "Private Health Care". Combinations were performed using the Boolean logical operator "AND", always crossing the first descriptor with one of the last two. In the MEDLINE database, descriptors in English were used. The search was also carried out with the publication date filter from 2009 to 2019, with restriction for

articles in Portuguese, with Brazil as the country related to the subject.

Information was selected on: year of publication, authors, database, keywords, title, journal, methodological design, results and level of evidence. For data collection, the titles and abstracts of the identified publications were read and, in the second stage, the texts were read in full. The inclusion criteria defined for the selection of articles were: Brazilian articles; articles in Portuguese, articles available online, articles in full that dealt with the topic addressed and articles published and indexed in the aforementioned databases in the established time frame.

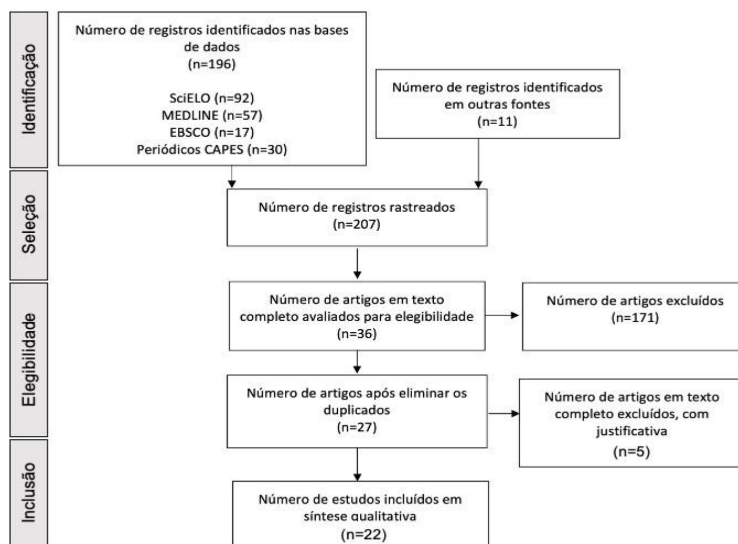
Then, the selected studies were organized into spreadsheets to aid in the analysis. The collected information was interpreted and analyzed through the systematization of thematic categories, when the following main themes were revealed: "conceptual aspects of PHC in Supplementary Health" and "experiences in the implementation of PHC initiatives by health plan operators".

RESULTS

Initially, 207 works on the subject were identified (Figure 1). At the end of the search in the databases, application of eligibility criteria, reading and elimination of duplicate files, 27 works were selected. Some works, even within the eligibility criteria, were excluded after the complete reading of the text, as they were considered of little relevance to the theme of the review. Thus, the final synthesis had 22 works.

The journal "Physis: Revista de Saúde Coletiva" was where the largest number of articles were located. As for the theme, it was observed that the works can be divided into two large groups: those dealing with conceptual aspects of PHC attributes in Supplementary Health, among which the large number of bibliographic reviews, opinion articles or projects stands out. of intervention, and those who reported experiences and results of the implementation of PHC initiatives in Brazilian Supplementary Health by plan operators, with the majority being case studies and a minority of qualitative studies and cross-sectional studies (Table 1).

Figure 1 - Flowchart for the selection of articles. Fortaleza – CE, Brazil, 2021.



Source – Author elaboration (2021). Based on: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi 10.1136/bmj.n71.

Table 1 - Description of publications selected by authors, year of publication, journal, methodological design and main results – Brazil (2009 – 2019).

AUTHORS AND YEAR	SOURCE	DESIGN	RESULTS	NÍVEL DE EVIDÊNCIA
REIS E PÜSCHEL (2009)[14]	JOURNAL OF THE USP SCHOOL OF NURSING	QUALITATIVE STUDY. INTERVIEWS WITH PROFESSIONALS AND CONTENT ANALYSIS.	CONTRADICTIONS IN THE CONCEPT OF FAMILY HEALTH THAT HINDER THE IMPLEMENTATION OF PROPOSALS BASED ON HEALTH PROMOTION IN THE SUPPLEMENTARY SECTOR.	NÍVEL 4
PEREIRA *ET AL.* (2012)[3]	HEALTH IN DEBATE CASE STUDY.	COMPARISON IN THE ORGANIZATION OF APS* FROM BRAZIL, VENEZUELA, BOLIVIA AND URUGUAY.	IMPLEMENTATION OF UNIVERSALIZATION POLICIES AND PHC ASSISTANCE MODELS. CHALLENGES REMAIN RELATED TO THE HISTORICAL CONTEXT OF EACH COUNTRY.	NÍVEL 4
ZIROLDO *ET AL.* (2013)[11]	THE WORLD OF HEALTH	LITERATURE REVIEW.	SUPPLEMENTARY HEALTH HAS BECOME INDISPENSABLE FOR THE BRAZILIAN STATE TO SUPPORT THE EXPENSES OF THE	NÍVEL 6

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			HEALTH SECTOR	
FONTES (2013)[15]	FEDERAL UNIVERSITY OF PARANÁ	REVIEW AND INTERVENTION DESIGN	THE NEED TO PROPOSE A PROJECT OF CONTINUING HEALTH EDUCATION FOR ESF⁺ PROFESSIONALS WAS IDENTIFIED.	NÍVEL 6
LIMA-COSTA *ET AL.* (2013)[16]	PUBLIC HEALTH NOTEBOOKS	CROSS-SECTIONAL STUDY, COMPARING DATA ON INDICATORS OF USE AND QUALITY OF HEALTH SERVICES..	USAGE INDICATORS SHOWED BETTER PERFORMANCE AMONG REGULAR USERS OF THE ESF AND MEMBERS OF A PRIVATE PLAN COMPARED TO THOSE COVERED BY THE UBS§. QUALITY INDICATORS WERE BETTER AMONG PRIVATE PLAN AFFILIATES.	NÍVEL 4
OGATA (2014)[4]	PAN AMERICAN HEALTH ORGANIZATION (PAHO)	REPORTS ON THE RESULTS OF THE LABORATORY FOR INNOVATIONS IN SUPPLEMENTARY HEALTH PAHO AND ANS**.	-	NÍVEL 5
BARBOSA *ET AL.* (2015)[5]	INTERFACE – COMUNICAÇÃO, SAÚDE, EDUCAÇÃO	CASE STUDY OF A PLAN OPERATOR IN JOÃO PESSOA, RECIFE AND NATAL. INTERVIEWS WITH MANAGERS AND PROFESSIONALS, WITH CONTENT ANALYSIS	THE ESF INITIATIVE IS AN ADVANCE IN THE SECTOR AND IS CAPABLE OF IMPROVING THE HEALTH OF USERS..	NÍVEL 4
RODRIGUES *ET AL.* (2015)[17]	INTERFACE – COMMUNICATION, HEALTH, EDUCATION	STUDY OF MULTIPLE CASES WITH A QUALITATIVE APPROACH, IN BELO HORIZONTE/MG (BRAZIL).	THERE IS A NEED TO SUPPORT OPERATORS ON HEALTH PROMOTION MODELS TO INDUCE CHANGES AND INNOVATIONS.	NÍVEL 4
SILVA E RODRIGUES (2015)[18]	HEALTH AND SOCIETY	STUDY OF MULTIPLE CASES WITH A QUALITATIVE APPROACH, IN BELO HORIZONTE/MG (BRAZIL)	OPERATORS AIM TO REDUCE COSTS AND ATTRACT CUSTOMERS. BENEFICIARIES SEEK COMPREHENSIVE CARE BUT FACE RESTRICTIONS ON ACCESS.	NÍVEL 4
DAROS *ET AL.* (2016)[19]	PHYSIS: JOURNAL OF PUBLIC HEALTH	CONTENT ANALYSIS OF E-MAILS SENT BY BENEFICIARIES TO THE RELATIONSHIP CENTER ON THE ANS WEBSITE, AND FOCUS GROUPS WITH TECHNICIANS AND SPECIALISTS IN ANS REGULATION.	REPORTS POINT TO DENIAL OF ACCESS TO SERVICES AND PROCEDURES AND RESTRICTION OF CONTINUITY OF CARE.	NÍVEL 4
ZIELINSKI (2016)[20]	FEDERAL UNIVERSITY OF RIO GRANDE DO SUL	LITERATURE REVIEW.	THERE IS FEASIBILITY FOR MODELING PHC AND ITS ATTRIBUTES IN SUPPLEMENTARY HEALTH, WITH MINIMAL IMPEDIMENTS TO IMPLEMENTATION.	NÍVEL 6
NUNES *ET AL.* (2016)[21]	JOURNAL OF PUBLIC HEALTH	CROSS-SECTIONAL STUDY WITH 1,593 ELDERLY PEOPLE FROM BAGÉ/RS. ASSESSMENT OF THE ASSOCIATION OF MULTIMORBIDITY, PRIMARY CARE MODEL AND POSSESSION OF A HEALTH PLAN WITH HOSPITALIZATION.	MULTIMORBIDITY INCREASED THE OCCURRENCE OF HOSPITALIZATIONS. ELDERLY PEOPLE WITH HEALTH INSURANCE AND RESIDENTS IN FHS AREAS WERE HOSPITALIZED MORE OFTEN, REGARDLESS OF THE PRESENCE OF MULTIPLE DISEASES.	NÍVEL 4
OLIVEIRA (2016)[22]	PHYSIS: JOURNAL OF PUBLIC HEALTH	OPINION ARTICLE/BIBLIOGRAPHIC REVIEW.	IMPORTANCE OF RISK IDENTIFICATION AND INTEGRALITY IN THE DIFFERENT POINTS OF THE ASSISTANCE NETWORK.	NÍVEL 6
OLIVEIRA E KORNIS (2017)[2]	PHYSIS: JOURNAL OF PUBLIC HEALTH	BIBLIOGRAPHIC REVIEW.	THE SUPPLEMENTARY HEALTH PERFORMANCE INDEX PLAYED A MARKET-CONCENTRATING ROLE, MEETING ANS STANDARDS.	NÍVEL 6
BATISTA (2017)[23]	FEDERAL UNIVERSITY OF RIO GRANDE DO SUL	REVIEW AND INTERVENTION DESIGN.	INSERTION OF THE APS AS AN ALTERNATIVE ASSISTANCE FOR HEALTH PLAN OPERATORS AND PERFORMANCE OF THE SANITARIST AS A PROFESSIONAL IN THE SUPPLEMENTARY SECTOR..	NÍVEL 6

SILVA (2018)[24]	GETÚLIO VARGAS FOUNDATION	REVIEW AND INTERVENTION DESIGN.DE INTERVENÇÃO.	THE APS MODEL IS FINANCIALLY VIABLE AND TENDS TO INCREASE ITS RESULTS IN THE MEDIUM AND LONG TERM, BRINGING COMPETITIVE ADVANTAGE.	NÍVEL 6
ANS (2018)[12]	PAN AMERICAN HEALTH ORGANIZATION	REPORTS OF RESULTS FROM THE LABORATORY OF INNOVATIONS IN SUPPLEMENTARY HEALTH PAHO AND ANS.	-	NÍVEL 5
MACHADO (2019)[25]	PUBLIC HEALTH NOTEBOOKS	OPINION ARTICLE/BIBLIOGRAPHIC REVIEW..	EVIDENCED RISKS OF THE SUS[§§] LOSING MFC[++] PROFESSIONALS TO THE PRIVATE SECTOR, AND OF DOCTORS THEMSELVES NOT CONSIDERING THE ESF AS A SPACE FOR ACTION.	NÍVEL 6
ALVES *ET AL.* (2019)[26]	SCIENTIFIC JOURNAL OF UNIMED FACULTY	OPINION ARTICLE/BIBLIOGRAPHIC REVIEW..	THE INSERTION OF THE COMPREHENSIVE HEALTH CARE STRATEGY IN HEALTH SUPPLEMENTARY IN BRAZIL HAS BEEN CAUSING GREAT CHANGES.	NÍVEL 6
RIBEIRO (2019)[27]	FEDERAL UNIVERSITY OF MINAS GERAIS	REVIEW AND INTERVENTION DESIGN	THE ADVANCED ACCESS MODEL CAN IMPROVE THE LINK BETWEEN PATIENTS AND HEALTHCARE PROFESSIONALS.	NÍVEL 6
AVELAR (2019)[28]	READ. ELECTRONIC MAGAZINE OF ADMINISTRATION (PORTO ALEGRE)	QUANTITATIVE, DESCRIPTIVE AND CAUSAL STUDY. ANALYSIS OF SECONDARY FINANCIAL DATA OF SELF-MANAGEMENT TYPE HEALTH OPERATORS OVER THE PERIOD 2010 TO 2016 PUBLISHED BY ANS.	IT WAS FOUND THAT THE PROPORTION OF OLD CONTRACTS, THE AVERAGE AGE OF BENEFICIARIES, THE SIZE OF THE OPERATOR AND THE REGION OF OPERATION INFLUENCED THE LEVEL OF INDEBTEDNESS.	NÍVEL 4

Source – Prepared by the authors (2021). *APS= Primary Health Care; +ESF= Family Health Strategy; §UBS= Basic Health Unit; **; ANS= National Supplementary Health Agency; ++MFC= Family and Community Medicine; §§SUS = Unified Health System.

DISCUSSION

THE ROLE OF PHC IN BRAZILIAN SUPPLEMENTARY HEALTH

The publications show that Supplementary Health in Brazil presents an increasing fragmentation and lack of coordination of medical specialties: biomedical logic with a focus on the disease, excessive medicalization, the privilege of using high technology in care practices and the predominance of hard technologies in relationships with the users; contrasting with the care model based on PHC already consolidated in the SUS. Customers end up taking responsibility for organizing the assistance they will receive, which also contributes to the generation of unnecessary or even repeated procedures, resulting in inefficiency, increased risk of iatrogenic events and increased costs and low user satisfaction[14].

In this scenario, with economic-financial sustainability threatened in the medium and long term, several health plans are undergoing a process of merger, purchase and incorporation between companies in the sector[3]. When analyzing the main causes of this crisis, there is a greater influence of the following factors: population aging, incorporation of technology, waste resulting from a care model based on the excessive consumption of more complex diagnostic and therapeutic resources and increasing "judicialization" of care health in the face of denial or lack of predictability of coverage[7]. Avelar et al.[28] highlight, as some of the determinants for the indebtedness of self-managed operators, the proportion of old contracts in their portfolios and the average age of beneficiaries.

According to ANS[12], Brazil has managed to make an epidemiological and demographic transition, but it has not yet achieved the transition in care. There is a chronicity of diseases, especially in the elderly, who have more disabilities and use health services more. Thus, several adversities arose, such as fragmentation in health care,

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inefficiencies, high costs and patient exposure to iatrogenic risks and effects[12]. Faced with this new scenario, PHC should be longitudinally oriented towards the care of chronic conditions, to control the most relevant diseases, through the adoption of clinical management technologies. Zielinski[20] – comparing the decree that regulates Law No. 8080, the text of the 2012 PNAB and the ANS legislation – states that there are no legal impediments to the implementation of PHC attributes in Brazilian Supplementary Health.

After 2 years of the ANS incentive policy, there was a sixfold increase in the number of health plan beneficiaries who participated in some PROMOPREV product. In 2011, there were around 198 thousand active beneficiaries in these programs and 127 programs registered with the ANS. In 2013, a total of 997 programs were observed, with a projected participation of 1,400,839 beneficiaries. The programs offer activities aimed at encouraging physical activity, healthy eating and preventing smoking and diseases – such as cancer and chronic conditions[12].

In 2012, ANS published the Care Plan for the Elderly in Supplementary Health, which covers the concepts of the care line and therapeutic project, also focusing on its risk stratification and functional status. In 2016, ANS listed three lines of care as priorities to be developed by operators: oncology, dentistry and elderly care. These projects propose care route designs under the logic of the hierarchy of services and highlight the importance of PHC as a point of attention[25,29].

In general, healthcare providers create care models by inserting the Family and Community physician in PROMOPREV programs, home care or PHC portfolios with a link to a list of patients. In this case, teams are usually formed, with nursing having a mainly managerial role, in addition to other professionals, such as psychologists and nutritionists[23].

INITIATIVES FOR THE IMPLEMENTATION OF PHC MODELS IN BRAZILIAN SUPPLEMENTARY HEALTH

The Banco do Brasil Employee Health Assistance Fund (CASSI) was a pioneer in reorganizing part of its services in 2001, focusing on PHC as an organizing axis, operationalized in its own services, the CliniCASSI, through the Family Health Strategy (ESF). Today the institution has 65 of these services in all Brazilian states. A Family Health team consists of a family doctor, a nursing technician, a nutritionist, a nurse, a psychologist and a social worker. Longitudinal and coordinated care aims to promote active and healthy aging. Currently, CASSI has 142 teams. The CASSI population registered in the ESF was 181,694 participants in 2015, representing about 25% of the beneficiaries, with the elderly being 28.9% of the participants[15,30]. Fontes[15] highlights that the differences between the CASSI and the SUS ESF are that self-management does not use its own services as a mandatory gateway and does not use the concept of territoriality, with patients choosing their family doctor[26].

According to a survey carried out in the cities of João Pessoa/PB, Natal/RN and Recife/PE on the implementation of CliniCASSI, it was found an increase in the bond and trust relationships between professionals and users, since the division of individuals in teams allowed greater continuity of care[4].

CASSI published in its newsletter in 2016 that the goals for the control of diabetics, hypertensives and dyslipidemics were achieved through the effective implementation of the PHC program, which demonstrated increased therapeutic adherence of monitored patients and self-care. However, the reach to beneficiaries is still precarious, with a restricted population using this service, demonstrating the difficulty of spreading the implementation of the ESF in the context of Supplementary Health[30].

UNIMED do Brasil's PHC proposal is called Comprehensive Health Care (AIS), which is encouraged through technical manuals and consulting from the Comprehensive Health Care Committee (CAS), initiatives discussed in the continuing

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and permanent education of the faculty. UNIMED, plenary meetings, congresses and production of scientific papers. The expansion proposed by the management of UNIMED do Brasil in 2017 pointed to a target of 80% of UNIMEDs with AIS by 2021. Currently, it exceeds sixty projects implemented, under different modalities[26].

AIS model products are called in different ways in different cities, such as "Pleno" in Belo Horizonte, "Fácil" in Florianópolis and "Personal" in Vitória[12]. UNIMED João Pessoa implemented the model in September 2016, with the plan called "Viver Mais", capturing its customers through lectures, intranet, hotsite, posters and text messages to telephones. After the plan was implemented, there was a 5% reduction in elective consultations and a 31% reduction in emergency care consultations, in addition to a reduction in referrals to specialists.

Silva[24] carried out an applied work that sought to analyze the financial feasibility of implementing a product based on APS (called "Personal") for UNIMED Leste Paulista, through a Business Plan. The project would initially serve employees and their dependents (about 1,100 beneficiaries) and then there would be expansion to the cooperative (present in 11 municipalities). According to the author, the results indicated that the model is financially viable and tends, gradually, to increase its results in the medium and long term, bringing a competitive advantage to the business[24].

Amil, after its acquisition by the United Health Group, in 2012, started offering care in PHC in its own and accredited units, with most of the portfolio concentrated in Rio de Janeiro and São Paulo, through the so-called Clubes Vida de Saúde, with Family and Community doctors. Registered patients are guaranteed access to appointments within 2 working days and have a nurse technician's telephone number 24 hours a day, 7 days a week, to answer questions about care, services and exams[12].

The expected result, from the implementation of PHC and the presence of the Family and Community doctor in Supplementary Health, is to ensure health care through promotion, prevention, recovery and rehabilitation, resulting in an improvement in the quality of life of its users. In addition, it offers care longitudinally, promotes comprehensive health care throughout all stages of life and reduces the chance of harm. Furthermore, it encourages the population's autonomy and self-care[23].

An analysis carried out by Rodrigues et al.[17] in six health plan operators that offered PROMOPREV programs and incorporated PHC services made clear common aspects in these programs, such as the adherence of non-medical health professionals, group activities and relevance of targeted themes – such as physical activity, the elderly, prevention and control of diseases and obesity. In addition, some services innovated by implementing socialization spaces – such as a memory workshop, dance and yoga[17].

A survey conducted in the Southeast region of Brazil on beneficiary satisfaction criteria in relation to the quality and comprehensiveness of care indicated the need to build new assessment indicators for Supplementary Health, such as links with care professionals, more explicit contracts, guarantee of access and continuity of care[19]. As an example, Ribeiro[27] analyzed indicators of use (longitudinality, demand for care and medical appointments) and quality (difficulty to obtain appointments, existence of queues, complaints about obtaining medication and appointments within 24 hours). This study, carried out in 2010, with 7,534 adults from Belo Horizonte/MG covered by a private plan, Family Health Strategy (ESF) and "traditional" Basic Health Unit (UBS), showed that quality indicators were higher in private plans[16] . It is noteworthy that scheduling models such as advanced access can contribute to the improvement of these indicators.

OBSTACLES TO THE REALIZATION OF PHC IN SUPPLEMENTARY HEALTH

The implementation of primary care in Supplementary Health faces some obstacles, both from

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the logistical and labor part of the operators, as well as from society and its beneficiaries.

Alves et al.[26] evaluated the challenges and trends faced by the implementation of AIS in the UNIMED system and highlighted the following obstacles: intrinsic factors such as acceptance by cooperating physicians, approval in the assembly, political motivation, engagement of leaders and choice of approach ; and extrinsic factors such as ANS regulation and the market.

According to Oliveira et al.[22], for the population to reach health means having unlimited access to procedures and not necessarily to organized and planned care. There is a cultural bias of the population whose perception of added value in health is in line with easy access to specialists, technology and the “immediate” resolution of problems, extolling image exams to the detriment of clinical reasoning and prevention, awaiting the disease as triggering factor of attention and care. These plans usually operate with the office model, out of step with the nature of health care dominated by chronic conditions. In addition, there are conflicts between specialists and primary care providers, due to the implementation of concepts of quaternary prevention, questioning excessive screening and unnecessary tests[25].

Nunes et al.[21], in a cross-sectional study carried out with 1,593 elderly people living in the urban area of the city of Bagé/RS, sought to assess the association of multimorbidity, primary care model (ESF or not) and having a health plan with hospitalization. on the last year. The results showed that elderly people with health insurance and residents of FHS areas were hospitalized more often, regardless of the presence of multiple diseases. The authors explain this fact with the hypothesis that probably elderly people with a health insurance plan were hospitalized more because they had easier access to hospitalization, even if the management of a health problem could be carried out at home or in an outpatient service. Thus, the work corroborates the problem of the lack of a gateway and coordinated care in Supplementary Health.

Reis and Püschel[14] highlight the gap in the training of health professionals and their continuing education on the Family Health Strategy, since many still have a biomedical-hospital-centric view, with a focus on curative medicine. As for health promotion, these professionals have only the theoretical concept, without conditions to work in the operationalization of the system. Oliveira et al.22 corroborate this idea, as they mention professional training based on an active search and meeting the individual's integral needs as an obstacle to the qualification of Supplementary Health.

On the other hand, the number of Family and Community medical professionals is still low in Brazil. Its performance in Supplementary Health has the benefits of decreasing referral rates and rationalizing complementary exams. However, it calls into question their community-oriented training, since community activities are not part of this system. Furthermore, its service is aimed at the market and not at a specific population demarcated in a territory[25].

Despite the interest in expanding these programs and breaking the biomedical-hospital-centric paradigm, these proposals are still little known and analyzed. In addition, there are large economic interests that support Supplementary Health, causing possible harm to health promotion and disease prevention actions, as they may be under strict surveillance to reduce costs[18].

Finally, based on the studies found, it is observed that, due to the SUS characteristic of being a mixed health system with complex public-private relationships, the strengthening of PHC could improve the efficiency and sustainability of the Supplementary Health sector, with reduction of expenses, financing and subsidies, generating a positive impact on Brazilian public health as a whole[31,32].

FINAL CONSIDERATIONS

This study has limitations in the systematization of the literature search, characteristic of the design of an integrative literature review. It is

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noteworthy that there are few publications on the topic addressed, even with the 10-year time span used in the research, including the predominance of works with low level of evidence, making it difficult to consolidate knowledge about the real impact of implementing initiatives of PHC in Brazilian Supplementary Health. Even with such limitations, it was observed that, despite the benefits, the implementation of PHC is still little used by private sector companies in Brazil. Thus, it is clear how much knowledge there is to be developed on this topic, such as the development of robust studies that use validated methods to assess the quality of health services.

It is concluded that Supplementary Health has sought to adhere to the PHC model, with person-centered medicine, promoting prevention and health promotion actions. However, the great fragmentation and specialization of this sector still represents a great challenge for the integral and longitudinal health model. The sustainability of the traditional model of health plans has been questioned by the challenge of the epidemiological change that occurred with the demographic transition, the incorporation of new technologies, existing shortages in the face of socioeconomic inequality and insufficient care, in addition to the waste of resources caused by its fragmentation. Investment in PHC by Supplementary Health contributes to a greater bond with the beneficiary, greater longitudinality of care and better therapeutic adherence.

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