BUILDING A NETWORK WITH PRIMARY CARE TO PROVIDE QUALITY MENTAL HEALTH CARE: Challenges for the Brazilian Unified System

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Brazil

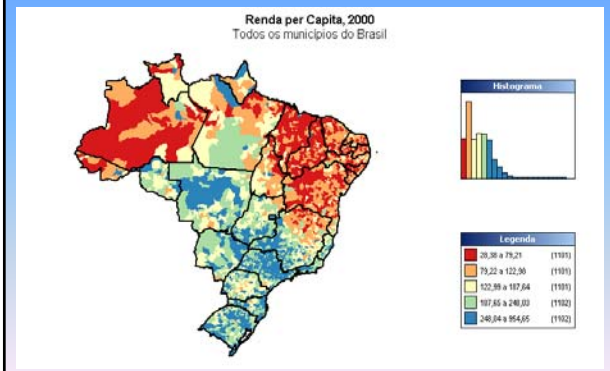
Brazilian Federation: Composed by three distinct political entities (Federal, States and Municipalities), each of them with administrative autonomy (without hierarchical submission).

Area : 8.511. 996 km².

Five Geographical macro regions: North, northeast, southwest, south and central-west
Number of states: 26 states and a Federal District
Number of municipalities: 5.562

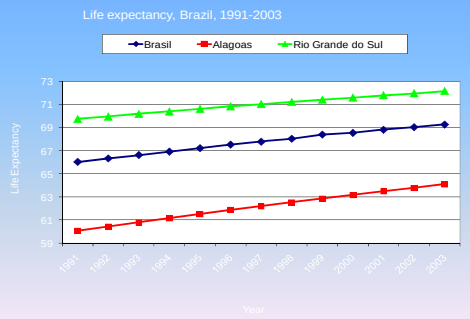
Federal Health Management : Ministry of Health
State Health Management : State Health Secretariat
Municipal Health Management: Municipality Health Secretariat

Per capita income at municipal level, 2000



Regional differences

Life expectance average Brazil,
Alagoas State and Rio Grande do Sul state



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

Unified Health System - SUS

Principles

Federative Pact

NATIONAL LEVEL

STATES

27

DECENTRALIZATION

MUNICIPALITIES

5.562

System Organization

Mental Health Policy	Primary Health Care	Family Health Program

Purpose

- 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

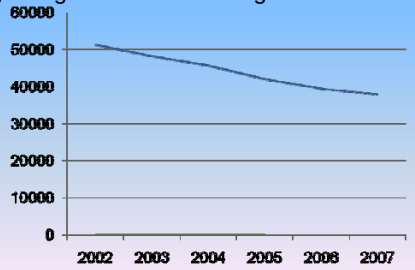
- 1990– Creation of the first Psychosocial Community Centers and Day Hospitals
- 2001- Approved the Mental Health Law
- progressive substitution of psychiatric beds for
- Community Social Psychiatric Centres, labelled "Centros de Atenção Psicosocial-CAPS"

Mental Health Policy
Reduction of psychiatric beds 2002-2008

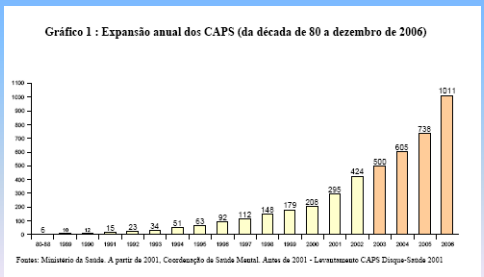
Year	Number
2002	51393
2003	48303
2004	45814
2005	42076
2006	39567
2007	37988
2008	36797

Mental Health Policy

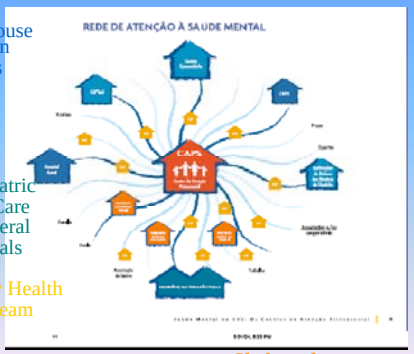
- Reduction of psychiatric beds since the beginning of the MHS Reorganization



Annual Expansion of the number of Psycosocial Attention Centres (Services) – CAPS
Period: between late 80's and 2006



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



Clubhouse
Drop-in centres

Psychiatric Unit Care in General Hospitals

Family Health Care team

Supported Adult Education
Schools

Sheltered Workshops

Psychosocial Care Centres The CAPS
(for adults with severe mental illness)
The CAPS-AD
(for addiction)
The CAPS-I
(For children)

Supportive housing and Boarding homes
The SRTs

CAPS-reabilitation activities developed for nurses in the mental health services

Patients in a sheltered workshop in Campinas-SP-Brazil

Patient interviewing a man for the CAPS' newspaper

Products made in the Sheltered workshops

The expansion of the Community Psychiatric Social Centers-CAPS

Tabela 1 – Expansão dos Centros de Atenção Psicossocial por UF: serviços existentes (dezembro de 2002 a dezembro 2006)

UF	Número de Centros de Atenção Psicossocial				
	2002	2003	2004	2006	2009
Região Norte					
AM	0	0	0	1	3
AC	0	1	1	1	2
AP	1	1	2	2	2
PA	12	15	15	20	24
TO	4	5	5	5	6
RR	0	1	1	1	1
RO	2	3	4	7	8
Região Nordeste					
AL	6	9	9	13	20
BA	14	32	37	42	55
CE	24	28	29	35	51
MA	4	8	8	19	26
PB	2	4	12	16	24
PE	11	17	20	24	31
PI	1	1	5	15	21
RN	6	7	9	12	21
SE	3	6	11	16	20
Região Centro-Oeste					
DF	2	2	2	3	3
GO	6	11	13	16	19
MT	5	12	17	24	29
MS	4	4	5	8	12
Região Sudeste					
ES	5	7	9	11	19
MG	35	57	69	91	125
RJ	51	52	55	63	72
SP	105	113	127	143	166
Região Sul					
PR	15	16	22	31	54
RS	55	61	70	78	97
SC	23	25	33	44	55
TOTAL	424	609	806	1.098	1.511

Fonte: Coordenação de Saúde Mental.

Coverage of Psychossocial Atention Services for 100.000 inhabitants

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

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

Tipo de Serviço CAPS	Ano 2002	2003	2004	2005	2006
CAPS I	145	173	218	283	439
CAPS II	186	268	236	271	328
CAPS III	19	24	29	26	37
CAPSI	32	37	44	56	77
CAPSad	42	58	78	102	138
Total	424	560	605	738	1011

Fonte: Coordenação Geral de Saúde Mental

CAPS- reabilitation activities

Professionals and users in the celebration Carnaval the most known brazilian

Spending a day in the Hopi Hari Park

Demanding for respecting their rights about delivery care

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

	2002	2007
Extra – hospitalar Programs and actions	153,31	760,47
Hospitalar programs and actios	465, 98	439, 40

Types of CAPS and their coverty

Types of CAPS	Population assisted
CAPS- I	50.000
CAPS - II	100.000
CAPS -III	150.000
CAPS-ad CAPS-i	100.000 100.000

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

Table 5-Outpatient services

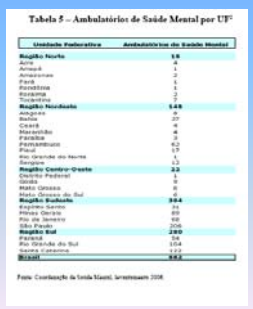


Tabela 5 – Ambulatórios de Saúde Mental por UF[1]

Unidade Federativa	Ambulatórios de Saúde Mental
Região Norte	**16**
Acre	1
Amapá	1
Amazonas	2
Pará	1
Rondônia	1
Roraima	2
Tocantins	8
Região Nordeste	**148**
Alagoas	9
Bahia	37
Ceará	4
Maranhão	4
Paraíba	3
Pernambuco	62
Piauí	17
Rio Grande do Norte	1
Sergipe	13
Região Centro-Oeste	**33**
Distrito Federal	1
Goiás	5
Mato Grosso	6
Mato Grosso do Sul	6
Região Sudeste	**354**
Espírito Santo	31
Minas Gerais	89
Rio de Janeiro	98
São Paulo	206
Região Sul	**280**
Paraná	104
Rio Grande do Sul	154
Santa Catarina	122
Brasil	**833**

Fonte: Coordenação de Saúde Mental, levantamento 2006

Family Health Program

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

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

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

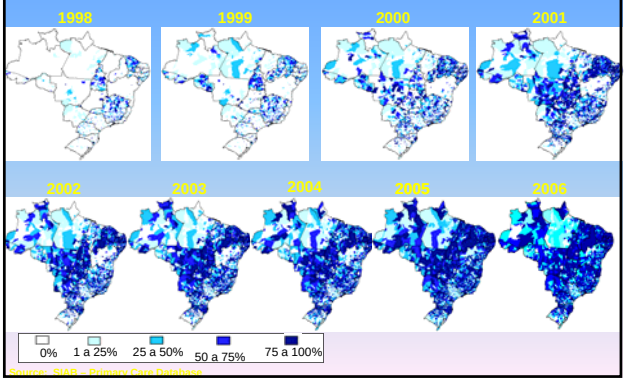
1. Women´s health
   pre-natal care, prevention of cervical cancer, family planning
2. Child health
   growth & development, nutrition, immunization, treatment of prevalent illnesses
3. Control of hypertension
4. Control of diabetes
5. Control of tuberculosis
6. Elimination of leprosy
7. **Mental Health**
8. Oral health
9. Health promotion activities
10. Public Health activities

Nowadays the teams have 14 working areas

Outcomes in the Brazilian PHC Strategy

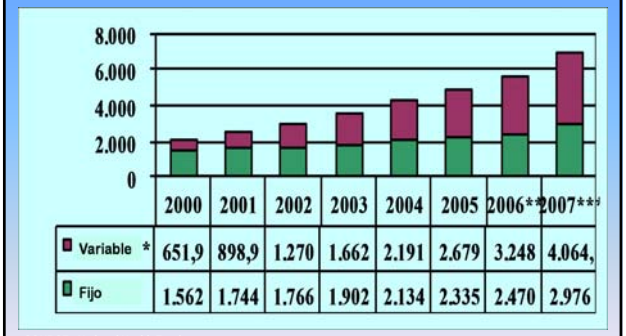
- PHC is part of the political agenda of government (evidence: budget growth, subject in political campaigns).
- Growth in access and coverage with broad popular support.
- Studies show evidence in reducing gaps in the utilization of health services by historically marginalized groups (African Brazilian 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 on the Implementation of Family Health Teams - BRASIL, 1998/2006



Source: SIAB - Primary Care Database

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



	2000	2001	2002	2003	2004	2005	2006**	2007***
Variable *	651,9	898,9	1.270	1.662	2.191	2.679	3.248	4.064,
Fijo	1.562	1.744	1.766	1.902	2.134	2.335	2.470	2.976

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 inservice training for health professionals.

6 – Advocacy and growth in political importance of PHC.