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# National Primary Care Policy

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# National Primary Care Policy

Brasília, Federal District
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MINISTRY OF HEALTH
Secretariat of Health Care
Department of Primary Care

# National Primary Care Policy

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# Table of Contents



[1]Annexes III and IV to Rule No. 650/GM of March 28, 2006 were replaced by Annexes I and II of Rule No. 822/GM of April 17, 2006, which can be found at www.saude.gov.br/dab

# Introduction

The document National Primary Care Policy (PNAB) is guided by the values of ethics, professionalism, and participation and expresses the Ministry of Health's correct decision to revitalize Primary Health Care in Brazil.

It was only possible to pave the road to reconstruction through a process that involved different political actors at the municipal, state, and federal levels. In addition to these agents involved, we were supported by members of academic institutions, health professionals, SUS (Unified Health System) employees and users, and health system entities.

Before the new PNAB was reached, based on the principles and guidelines outlined in the Pact for Life, Pact in Defense of the SUS, and Management Pact, the Secretariat of Health Care, through the Department of Primary Care, submitted a draft of the new National Primary Care Policy to the Tripartite Commission of Managers. The experience gained at the different management levels served as a supplementary strategy to facilitate the Primary Care regulation.

The discussions leading to the final PNAB were based on the transversal themes of universality, comprehensiveness, and equity, in a context of decentralization and social control of the administration, and the SUS care and organizational principles established by law. Thus, the new policy reflects a redefinition of the general principles, responsibilities of each government level, required infrastructure and resources, characteristics of the work process, duties of the professionals, and funding standards, including the specificities of the Family Health strategy.

In this historic process, Primary Care has strengthened gradually and must become the preferred access route to the Unified Health System (SUS), as a starting point to structure local health systems. Upon approval and publication, it can be said that the year of 2006 was marked by the maturity of Primary Health Care. This is so because the Pact for Life set as a priority: to strengthen and qualify the Family Health strategy as a model for Primary Care and coordinating center for the health care networks within the Unified Health System (SUS).

**THE MINISTER OF HEALTH**

# Rule No. 648/GM of March 28, 2006

Approves the National Primary Care Policy an provides a review of guidelines and standards for the organization of Primary Care under the Family Health Program (PSF) and the Community Health Agent Program (PACS).

The MINISTER OF HEALTH, in the exercise of his duties and

Considering the need to review and adapt the national standards to the current development stage of primary care in Brazil;

Considering the expansion of the Family Health Program (PSF), which has become a priority strategy for the reorganization of primary care in Brazil;

Considering that the PSF has become a nationwide strategy, which reveals the need to adapt its standards based on the experience gained in the various Brazilian states and municipalities;

Considering the principles and guidelines proposed in the Pact for Life, Pact in the Defense of the SUS, and Management Pact to strengthen the SUS across the government levels, which include defragmentation of the funding of Primary Care;

Considering the Federal Government's goal to implement public administration with measurable results; and

Considering the pact made at the Meeting of the Tripartite Commission of Managers held on March 23, 2006,

RESOLVES:

Article 1. To approve the National Primary Care Policy in order to review the current regulations for implementation and operation, as provided in the Annex to this Rule.

Sole Paragraph. The Department of Primary Care within the Ministry of Health (SAS/MS) shall publish manuals and guides

describing operational details and providing specific guidance on this Policy.

Article 2. To establish that the budget funds referred to in this Rule shall come from the Ministry of Health's budget and shall charge the following Work Programs:

I. 10.301.1214.0589 – Financial Incentive to Municipalities Eligible for the Variable Part of the Primary Care Baseline funding;

II. 10.301.1214.8577 – Primary Care Service in Brazilian Municipalities; and

III. 10.3011214.8581 – Structuring of the Primary Health Care Service Network.

Article 3. This Rule shall become effective on the date of publication.

Article 4. The following Rules are revoked: No. 1882/GM of December 18, 1997, published in Federal Gazette No. 247 of December 22, 1997, Section 1, page 10; No. 1884/GM of December 18, 1997, published in Federal Gazette No. 247 of December 22, 1997, Section 1, page 11; No. 1885/GM of December 18, 1997, published in Federal Gazette No. 247 of December 22, 1997, Section 1, page 11; No. 1886/ GM of December 18, 1997, published in Federal Gazette No. 247 of December 22, 1997, Section 1, page 11; No. 59/GM of January 16, 1998, published in Federal Gazette No. 14-E of January 21, 1998, Section 1, page 2; No. 157/GM of February 19, 1998, published in Federal Gazette No. 58 of March 26, 1998, Section 1, page 104; No. 2101/GM of February 27, 1998, published in Federal Gazette No. 42 of March 4, 1998, Section 1, page 70; No. 3.476/GM of August 20, 1998, published in Federal Gazette No. 160 of August 21, 1998, Section 1, page 55; No. 3.925/GM of November 13, 1998, published in Federal Gazette No. 22-E, February 2, 1999, Section 1, page 23; No. 223/GM of March 24, 1999, published in Federal Gazette No. 57 of March 25, 1999, Section 1, page 15; No. 1348/GM of November 18, 1999, published in Federal Gazette No. 221 of November 19, 1999, Section 1, page 29; No. 1013/GM of

September 8, 2000, published in Federal Gazette No. 175-E of September 11, 2000, Section 1, page 33; No. 267/GM of March 6, 2001, published in Federal Gazette No. 46 of March 7, 2001, Section 1, page 67; No. 1502/GM of August 22, 2002, published in Federal Gazette No. 163 of August 23, 2002, Section 1, page 39; No. 396/GM of April 4, 2003, published in Federal Gazette No. 104 of June 2, 2003, Section 1, page 21; No. 673/GM of June 3, 2003, published in Federal Gazette No. 106 of June 4, 2003, Section 1, page 44; No. 674/ GM of June 3, 2003, published in Federal Gazette No. 106 of June 4, 2003, Section 1, page 44; No. 675/GM of June 3, 2003, published in Federal Gazette No. 106 of June 4, 2003, Section 1, page 45; No. 2081/GM of October 31, 2003, published in Federal Gazette No. 214 of November 4, 2003, Section 1, page 46; No. 74/GM of January 20, 2004, published in Federal Gazette No. 15 of January 23, 2004, Section 1, page 55; No. 1432/GM of July 14, 2004, published in Federal Gazette No. 157 of August 16, 2004, Section 1, page 35; No. 1434/GM of July 14, 2004, published in Federal Gazette No. 135 of July 15, 2004, Section 1, page 36; No. 2023/GM of September 23, 2004, published in Federal Gazette No. 185 of September 24, 2004, Section 1, page 44; No. 2024/GM of September 23, 2004, published in Federal Gazette No. 185 of September 24, 2004, Section 1, page 44; No. 2025/GM of September 23, 2004, published in Federal Gazette No. 185 of September 24, 2004, Section 1, page 45; No. 619/GM of April 25, 2005, published in Federal Gazette No. 78 of April 26, 2005, Section 1, page 56; No. 873/GM of June 8, 2005, published in Federal Gazette No. 110 of June 10, 2005, Section 1, page 74; and No. 82/SAS of July 7, 1998, published in Federal Gazette No. 128 of July 8, 1998, Section 1, page 62

SARAIVA FELIPE

# Annex

# National Primary Care Policy

## CHAPTER I
## Primary Care

### 1 - GENERAL PRINCIPLES

Primary Care means a set of individual and collective health care actions, which include health promotion and protection, injury prevention, diagnosis, treatment, rehabilitation, and health maintenance. It is delivered by democratic and participative administrative and sanitary practices in teamwork directed towards people living in well-defined territories of sanitary responsibility, considering the dynamics of the territories where those people live. It uses highly complex low-density technologies, which are expected to resolve the most frequent and relevant health problems in its territory. It is the preferred point of contact of users with health systems. It is guided by the principles of universality, accessibility, care coordination, interpersonal relationship and longitudinality, comprehensiveness, accountability, humanization, equity, and social participation.

Primary Care considers the individuality, complexity, comprehensiveness, and socio-cultural environment of the subjects and seeks the promotion of their health, disease prevention and treatment, reduction of any harm or suffering likely to compromise their ability to live healthily.

Primary Care uses Family Health as a priority strategy for its organization in accordance with the standards of the Unified Health System.

The foundations of Primary Care are:

I - to allow universal and continuous access to quality and effective health care services, characterized as the preferred access route to the health system, within an assigned territory to enable decentralized planning and programming consistent with the principle of equity;

II - to promote comprehensiveness in its various aspects, to wit: integration of programmatic actions and spontaneous demand; articulation of health promotion actions, injury prevention, health

surveillance, treatment and rehabilitation, interdisciplinary and team work, care coordination in the service network;

III - to create interpersonal relationship and accountability between the teams and the assigned population to ensure continuous health care actions and longitudinal care;

IV - to value health professionals through encouragement and continuous monitoring of their education and training;

V - to systematically assess and monitor the results achieved as part of the planning and programming process; and

VI - to encourage people's participation and social control.

In order to put Primary Care into operation, the following are defined as strategic areas of activity throughout the national territory: elimination of hanseniasis, control of tuberculosis, control of hypertension, control of diabetes mellitus, elimination of child malnutrition, child health, women's health, health of the elderly, oral health, and health promotion. Other areas will be defined regionally according to priorities and pacts agreed by the CIBs (Bipartite Commissions of Managers).

In the pact-making process for primary care, a Pact on Primary Care Indicators shall be reached and signed based on the annual goals to be achieved according to agreed health indicators. The pact-making process for Primary Care shall follow specific regulations under the Management Pact. Managers may agree at the CIBs on state Primary Care indicators to be monitored in their territories.

## 2 - RESPONSIBILITIES OF EACH GOVERNMENT LEVEL

Municipalities and the Federal District, as managers of the local health systems, are responsible for complying with the Primary Care principles, organizing, and implementing actions in their territory.

2.1 - It is the responsibility of Municipal Departments of Health and the Federal District:

I - to organize, implement, and manage Primary Care services and actions universally, within their territory, including facilities of their own and assigned by the state or the Federal Government;

II - to include in municipal and Federal District Health Plans a proposal for the organization of Primary Care and method of use of the fixed and variable PAB (Primary Care) funding;

III - to insert, preferably according to their institutional capacity, the Family Health strategy in their service network for a systemic health care organization;

IV - to organize the flow of users to ensure referrals to health services and actions beyond Primary Care level;

V - to ensure the necessary infrastructure for the operation of the Primary Care Centers and provide them with material resources, equipment, and inputs sufficient for the set of proposed actions;

VI - to select, hire, and pay professionals that compose multi-professional Primary Care teams, including Family Health professionals, in accordance with the applicable laws;

VII - to program Primary Care actions from its territory, using a national or equivalent local programming instrument;

VIII - to feed national databases with data produced by the municipal health system and update the database of professionals, services, and public and private outpatient facilities managed by them;

IX - to prepare methodologies and instruments to monitor and assess Primary Care at the municipal level;

X - to develop technical mechanisms and organizational strategies to qualify human resources for the management, planning, monitoring, and assessment of Primary Care;

XI - to define strategies for articulation with health care services to institutionalize Primary Care assessment;

XII - to determine, monitor, and assess the indicators under the Primary Care Pact in their territory and annually announce the results achieved;

XIII - to verify the quality and consistency of the data entered into the national information systems to be sent to other administration levels;

XIV - to consolidate and analyze data of interest to the local teams,

regional teams, and municipal administration available on the information systems and announce the results obtained;

XV - to follow and assess the Primary Care work with or without Family Health Strategy and announce information and results achieved;

XVI - to encourage and enable training and continuous education of team professionals; and

XVII- to seek partnerships with governmental and non-governmental organizations and the private sector to strengthen Primary Care within their territory.

2.2 - It is the responsibility of State Departments of Health and the Federal District:

I - to contribute to reorienting the health care model by supporting Primary Care and encouraging the adoption of the Family Health strategy by municipal health care services in substitution of the current Primary Care practices;

II - to agree with the Bipartite Commission of Managers on strategies, guidelines, and standards to implement Primary Care in the state, subject to the general principles set forth by this Rule;

III - to set, under the State and Federal District Health Plan, goals and priorities for the organization of Primary Care in their territory;

IV - to allocate state funds as part of the tripartite funding of Primary Care;

V - to agree with the Bipartite Commission of Managers and inform the Tripartite Commission of Managers on the use of the funds for Compensation of Regional Specificities;

VI - to provide technical advice to municipalities in the process of Primary Care qualification and expansion and strengthening of the Family Health strategy, including guidance on the organization of services considering new epidemiological scenarios;

VII - to prepare methodologies and instruments to monitor and assess Primary Care at the state level;

VIII - to develop technical mechanisms and organizational strategies to qualify human resources for the management, planning, monitoring, and assessment of Primary Care;

IX - to define strategies for articulation with municipal SUS administrations to institutionalize Primary Care assessment;

X - to determine, monitor, and assess the indicators under the Primary Care Pact in the state territory and annually announce the results achieved;

XI - to establish other mechanisms for control and regulation, monitoring and assessment of Primary Care actions and the Family Health strategy at the state or Federal District level;

XII - to be jointly responsible with the Ministry of Health for monitoring the use of Primary Care funds transferred to municipalities and the Federal District;

XIII - to submit to the CIB for resolution any inconsistencies found in the implementation of the fixed and variable PAB to:

a) give time for the municipal manager to correct the inconsistencies;

b) notify the Ministry of Health; and

c) block the transfer of funds or other measures deemed necessary as specified by the CIB;

XIV - to advise the municipalities on the implementation of Primary Care information systems as tools to monitor the actions performed;

XV - to consolidate, analyze, and transfer information system files sent by the municipalities to the Ministry of Health in accordance with the flows and times specified for each system;

XVI - to verify the quality and consistency of the data sent by the municipalities using information systems and return information to municipal managers;

XVII - to analyze data of state interest generated by the information system, announce the results obtained, and use them in planning;

XVIII - to advise municipalities on the analysis and management of the information systems to strengthen the municipal planning capacity;

XIX - to provide municipalities with technical and educational tools to facilitate the process of training and continuous education of the team members;

XX - to seek institutions, in partnership with Municipal Departments of

Health, to train and ensure continuous education of health professionals of the Primary Care teams and family health teams;

XXI - to promote exchange of experience among the various municipalities to disseminate technologies and knowledge and improve Primary Care services; and

XXII - to seek partnerships with governmental and non-governmental organizations and the private sector to strengthen Primary Care within the state and Federal District.

2.3 - It is the responsibility of the Ministry of Health:

I - to contribute to reorienting the health care model in Brazil by supporting Primary Care and encouraging the adoption of the Family Health strategy as the basis for the organization of municipal health systems;

II - to ensure sources of federal funds as part of the funding of the fixed and variable Primary Care Baseline funding - PAB;

III - to provide technical advice to the states, Federal District, and municipalities in the process of qualification and strengthening of Primary Care and the Family Health strategy;

IV - to set national guidelines and provide technical and educational tools to facilitate the process of training and continuous education of Primary Care professionals;

V - to seek contact with institutions, in partnership with State, Municipal and Federal District Departments of Health, to train and ensure continuous education of Primary Care professionals;

VI - to articulate with the Ministry of Education strategies to induce changes in the curriculum of undergraduate programs in the field of health, especially medicine, nursing, and dentistry, to train professionals with a profile consistent with Primary Care;

VII - to advise states, municipalities, and the Federal District on the implementation of Primary Care information systems;

VIII - to analyze data of national interest related to Primary Care generated by the health information systems and announce the results obtained;

IX - to prepare methodologies and instruments to monitor and assess Primary Care at the national level;

X - to develop technical mechanisms and organizational strategies to qualify human resources for the management, planning, monitoring, and assessment of Primary Care;

XI - to define strategies for articulation with state and municipal SUS administrations to institutionalize Primary Care assessment;

XII - to monitor and assess indicators under the Primary Care Pact at the national level and annually announce the results achieved, in accordance with the pact-making process agreed by the Tripartite Commission of Managers;

XIII - to establish other mechanisms for control and regulation, monitoring and assessment of Primary Care actions and the Family Health strategy at the national level;

XIV - to promote exchange of experience and encourage preparation of studies and research to enhance and disseminate technologies and knowledge related to Primary Care; and

XV - to seek partnerships with governmental and non-governmental organizations and the private sector to strengthen Primary Care in Brazil.

## 3 - NECESSARY INFRASTRUCTURE AND RESOURCES

The following items are required for the implementation of Primary Care actions in municipalities and in the Federal District:

I - Primary Health Center(s) (UBS), with or without Family Health Teams, registered in the Ministry of Health's National Database of Health Care Institutions, in accordance with the applicable sanitary standards;

II - UBSs with or without Family Health Teams, which offer, according to the actions they perform:

III - a multi-professional team composed of a doctor, nurse, dentist, dental office assistant or dental hygiene technician, nursing assistant or nursing technician, and community health agent, among others;

IV - a medical office, dental office, and nursing office for Primary Care professionals;

V - a reception area, a storage place for files and records, a primary care nursing room, a vaccination room, and bathrooms, per unit;

VI - appropriate equipment and materials according to the list of proposed actions to ensure effectiveness of Primary Care;

VII - guarantee of flows of referrals and counter referrals to specialized services, diagnostic and therapeutic, outpatient and hospital support; and

VIII - existence and regular maintenance of an inventory of inputs necessary for the operation of primary health centers, including dispensing of nationally approved medications.

For a Primary Health Center (UBS) without Family Health Teams in big cities, it is recommended to use the parameter of a UBS for up to 30,000 inhabitants, located within the territory of sanitary responsibility, to ensure the Primary Care principles.

For a UBS with Family Health Teams in big cities, it is recommended to use the parameter of a UBS for up to 12,000 inhabitants, located within the territory of sanitary responsibility, to ensure the Primary Care principles.

## 4 - REGISTRATION OF CENTERS PROVIDING PRIMARY HEALTH CARE SERVICES

The registration of Primary Health Centers shall be performed by municipal and Federal District managers in conformity with the standards for the National Database of Health Care Institutions.

## 5 - WORK PROCESS OF PRIMARY CARE TEAMS

The characteristics of the work process of Primary Care teams are:

I - definition of the territory of activity of the UBS;

II - programming and implementation of activities, with priority to the resolution of more frequent health problems, considering the responsibility of effective care to the spontaneous demand;

III - implementation of educational actions likely to influence the

health/disease process and increase social control for the improvement of the quality of life;

IV - implementation of actions focused on risk groups and behavioral, dietary, and/or environmental risk factors to prevent the appearance or maintenance of avoidable diseases and injuries;

V - comprehensive and continuous primary care organized to the assigned population with guaranteed access to diagnostic and laboratory support;

VI - implementation of the guidelines of the National Humanization Policy, including inpatient care;

VII - provision of first aid for medical and dental emergencies;

VIII - participation of teams in the planning and assessment of actions;

IX - implementation of intersectorial actions to integrate social projects and related sectors designed for health promotion; and

X - support to strategies to strengthen the local administration and social control.

## 6 - DUTIES OF PRIMARY CARE TEAM MEMBERS

Specific duties of Primary Care professionals shall be described in the municipality and Federal District's regulations, in accordance with the priorities set by its administration and the agreed national and state priorities.

## 7 - CONTINUOUS EDUCATION PROCESS

Continuous education of Primary Care professionals is joint responsibility of the SMS (Municipal Departments of Health) and SES (State Departments of Health) in the states and of the Department of Health in the Federal District.

The minimum contents of Continuous Education shall give priority to the strategic areas of Primary Care as agreed by the CIT, in addition to state, municipal and Federal District priorities.

Funding of Continuous Education shall be composed of funds from the three government levels as agreed by the CIT and CIBs.

Primary care services shall be adapted to teaching/learning integration in accordance with the processes agreed by the CIT and the CIBs.

## CHAPTER II
## Specificities of the Family Health Strategy

### 1 - GENERAL PRINCIPLES

The Family Health strategy is intended to reorganize Primary Care in Brazil in accordance with the standards of the Unified Health System. In addition to the general principles of Primary Care, the Family Health strategy shall:

I - substitute the traditional Primary Care network in the territories in which Family Health Teams work;

II - act in the territory by performing household registration, situational diagnosis, actions directed towards health problems as agreed with the community where it works, promoting long-term care of individuals and families, and maintaining always a proactive attitude to people's health problems/diseases;

III - perform activities in accordance with the planning and programming based on the situational diagnosis and focusing on the family and community;

IV - seek integration with social institutions and organizations, specially those within its area of coverage, to promote partnerships; and

V - be a space for the construction of citizenship.

### 2 - RESPONSIBILITIES OF EACH GOVERNMENT LEVEL

In addition to the responsibilities proposed for Primary Care, the various Federation entities shall have the following responsibilities with regard to the Family Health strategy:

2.1 - It is the responsibility of Municipal Departments of Health and the Federal District:

I - to insert the Family Health strategy in their service network for the organization of the local health system;

II - to define, in the Health Plan, the characteristics, objectives, goals, and mechanisms to monitor the Family Health strategy;

III - to ensure the necessary infrastructure for the operation of the

Family Health and Oral Health teams and primary health centers for referral of Community Health Agents and provide them with material resources, equipment, and inputs sufficient for the set of proposed actions;

IV - to ensure full-time work – 40 weekly working hours – for all professionals in the family health, oral health, and community health agent teams, except for those who must devote at least 32 working hours to activities in the SF (Family Health) team and up to 8 hours of all their working hours to multi-professional residence and/or family and community medicine activities or work at small hospitals, in accordance with specific regulations under the National Policy for Small Hospitals;

V - to prepare and update the database of ACSs (Community Health Agents), nurses of the PACS team, and professionals of the Family Health and Oral Health teams, as well as the population living in the area covered by the Family Health, Oral Health and ACS teams, in the National Health Information Systems designed for that purpose; and

VI - to encourage and enable specific training of Family Health team professionals.

2.2 - It is the responsibility of State Departments of Health:

I - to agree with the Bipartite Commission of Managers on strategies, guidelines, and rules to implement and manage Family Health in the state, subject to the general principles set forth by this Rule;

II - to set, under the State Health Plan, goals and priorities for Family Health;

III - to submit to the Bipartite Commission of Managers (CIB), within 30 days after the date of filing of the case, a proposal for setting up or expansion of ESFs (Family Health Teams), ESBs (Oral Health Teams), and ACS teams prepared by the municipalities and approved by the municipalities' Boards of Health;

IV - to submit to the CIB for resolution, the flow of monitoring of the

registration of professionals of the Family Health, Oral Health, and ACS teams on the national information systems designed for that purpose;

V - to submit to the CIB for resolution the flow of deregistration and/or blocking of funds due to inconsistencies found in the setting up and operation of the Family Health, Oral Health, and ACS teams, to be published as a resolution rule of the CIB to correct any teams working inappropriately;

VI - to analyze and consolidate information sent by the municipalities on the setting up and operation of the Family Health, Oral Health, and ACS teams;

VII - to monthly send to the Ministry of Health consolidated information sent by the municipalities to authorize the transfer of federal financial incentives to the municipalities;

VIII - to be responsible before the Ministry of Health for monitoring, controlling, and assessing the use of the Family Health incentive funds transferred to the municipalities within the state;

IX - to provide technical advice to the municipalities on the process of implementation and extension of SF;

X - to articulate with human resource training institutions in the state strategies for expansion and qualification of graduate programs, medical and multi-professional residences in Family Health and continuous education, according to the demands and needs identified in the municipalities as agreed by the CIBs; and

XI - to follow, monitor, and assess the development of the Family Health strategy in the municipalities and identify situations in violation with the regulations, ensure support to necessary adaptations, and announce the results achieved.

2.3 - It is the responsibility of the Federal District:

I - to set, under the Federal District's Health Plan, goals and priorities for Family Health;

II - to analyze and consolidate information on the setting up and operation of the Family Health, Oral Health, and ACS teams;

III - to be responsible before the Ministry of Health for monitoring, controlling, and assessing the use of the Family Health incentive funds transferred to the Federal District; and

IV - to follow, monitor, and assess the development of the Family Health strategy in the Federal District, identify and adapt situations in violation with the regulations, and announce the results achieved.

2.4 - It is the responsibility of the Ministry of Health:

I - to define and revise, as agreed by the Tripartite Commission of Managers, the guidelines and standards for Family Health;

II - to ensure sources of federal funds as part of the funding of Primary Care organized through the Family Health strategy;

III - to seek contact with institutions, in partnership with State, Municipal and Federal District Departments of Health, to train and ensure specific continuous education of Family Health professionals;

IV - to articulate with the Ministry of Education strategies for expansion and qualification of graduate programs, medical and multi-professional residences in Family Health and continuous education;

V - to analyze data of national interest related to the Family Health strategy generated by the health information systems and announce the results obtained; and

VI - for the analysis of indicators, result valuation indices, and other parameters, the calculation of the population covered by ESF, ESB, and ACS will be performed based on the population registered in the current information system.

## 3 - NECESSARY INFRASTRUCTURE AND RESOURCES

The following items are necessary for the setting up of Family Health Teams:

I - existence of a multi-professional team in charge of not more than 4,000 inhabitants, with a recommended average of 3,000 inhabitants, with all its members working 40 weekly hours, composed of at least a doctor, nurse, nursing assistant or nursing technician and Community Health Agents;

II - number of ACSs sufficient to cover 100% of the enrolled population, with a maximum of 750 people per ACS and 12 ACS per Family Health team;

III - existence of a Primary Health Center registered in the Ministry of Health's National Database of Health Care Institutions, within the area to assist the Family Health Teams, which can offer at least;

a) a medical and nursing office for the Family Health Team, according to the needs of the actions to be performed under its responsibility;

b) a reception area/room, a storage place for files and records, a primary care nursing room, a vaccination room, and bathrooms, per center;

c) appropriate equipment and materials according to the list of programmed actions to ensure effectiveness of Primary health Care;

IV - guarantee of the flows of referrals and counter referrals to specialized services, diagnostic and therapeutic, outpatient and hospital support; and

V - existence and regular maintenance of an inventory of inputs necessary for the operation of the UBS.

The following items are necessary for the incorporation of oral health professionals into Family Health Teams:

I - in case of Oral Health Teams (EBS) type 1: existence of a multi-professional team composed basically of a dentist and a dental office assistant, working together with one or two ESFs, having sanitary responsibility for the same population and territory as the related ESFs, with all its members working 40 weekly hours;

II - in case of EBS type 2: existence of a multi-professional team composed basically of a dentist, a dental office assistant, and a dental hygiene technician working together with one or two ESFs, having sanitary responsibility for the same population and territory as the related ESFs, with all its members working 40 weekly hours;

III - existence of a Primary Health Center registered in the Ministry of Health's National Database of Health Care Institutions, within the area to assist the Oral Health teams, which can offer at least:

a) a dental office for the Oral Health Team, according to the needs of the actions to be performed under its responsibility; and

b) appropriate equipment and materials according to the list of programmed actions to ensure effectiveness of Primary health Care.

The strategy of Community Health Agents is planned to be implemented as a possibility for initial reorganization of Primary Care. The following items are necessary for the implementation of this strategy:

I - existence of a Primary Health Center, registered in the Ministry of Health's National Database of Health Care Institutions, for referral to the ACSs and the supervising nurse;

II - existence of a nurse for up to 30 ACS, which constitutes an ACS team;

III - the supervising nurse and the ACS must devote 40 weekly working hours to the ACS team;

IV - definition of micro-areas of responsibility of each ACS, with not more than 750 people; and

V - exercise of the duty of Community Health Agent as regulated by Law No. 10507/2002

## 4 - WORK PROCESS IN FAMILY HEALTH

In addition to the characteristics of the work process of Primary Care teams, the following are characteristics of the work process in Family Health:

I - to keep the registration of families and individuals updated and systematically use the data to analyze the health situation considering social, economic, cultural, demographic, and epidemiological characteristics of the territory;

II - precise definition of the territory of activity, mapping and recognition of the defined area comprising the determined population segment, with continuous update;

III - diagnosis, programming and implementation of activities according to health risk criteria, with priority to the resolution of more frequent health problems;

IV - practice of broad family care, based on the knowledge of family structure and functionality to propose interventions that influence the health/disease processes of the individuals, families, and community;

V - interdisciplinary and team work integrating different technical and professional areas;

VI - promotion and implementation of intersectorial actions to seek partnerships, integrate social projects and related sectors designed for health promotion, in accordance with the priorities and under the coordination of the municipal administration;

VII - valuation of different types of knowledge and practices in an comprehensive and effective approach to enable the creation of relationships of trust with ethics, commitment, and respect;

VIII - promotion and encouragement of community's participation in social control, planning, implementation, and assessment of actions; and

IX - systematic monitoring and assessment of actions implemented to readjust the work process.

Duties of the various professionals of the Family Health, Oral Health Teams, and ACS teams, and nurses of the PACS teams are described in Annex I.

## 5 - TRAINING AND CONTINUOUS EDUCATION OF TEAMS

The training process must start simultaneously with the start of the work of the ESFs through an Introductory Course for the entire team.

It is recommended that:

I - the Introductory Course should be held within 3 months after setting up of the ESF;

II - the responsibility for the provision of the introductory course and/or continuous education courses for the teams in municipalities with less than 100,000 inhabitants should rest with the State

Department of Health in partnership with the Municipal Department of Health; and

III - the responsibility for the provision of the introductory course and/or continuous education courses for the teams in municipalities with more than 100,000 inhabitants should rest with the Municipal Department of Health, which may enter into partnership with the State Department of Health. In the Federal District, its Department of Health is responsible for providing the introductory program and/or continuous education courses for the teams.

Minimum contents of the Introductory Course and Continuous Education Course for the ESFs shall be specifically regulated by the Ministry of Health.

## 6 - SETTING UP PROCESS

I - The municipality and the Federal District shall prepare a proposal for setting up or expansion of ESF, ESB, and ACS in accordance with the state regulation approved by the CIB. If there is no specific regulation, the charts of Annex II to this Rule may be used. The proposal must define:

a) the territory to be covered, with the estimated resident population, definition of the number of teams to act, and mapping of the areas and micro-areas;

b) infrastructure, including physical area, equipment, and materials available at the UBSs where the teams will act, specifying the number and location of the centers where each of the teams will act;

c) Primary Care actions to be performed by the teams, especially in the priority areas defined at the national level;

d) management and supervision process for team work;

e) method of recruitment, selection, and hiring of team professionals, based on the 40 weekly working hours;

f) implementation of the Primary Care Information System (SIAB), including human and material resources to operate it;

g) assessment process for the teams' work, method of monitoring of the Pact of Primary Care Indicators, and use of data from national information systems;

h) the counterpart funds from the municipality and Federal District.

II - The proposal prepared shall be approved by the Municipalities' Boards of Health and sent to the State Department of Health or its regional authority for review. The Federal District, after approval by its Board of Health, shall send its proposal to the Ministry of Health;

III - The State Department of Health or its regional authority shall have 30 days after the date of filing of the case to review and send it to the Bipartite Commission of Managers (CIB);

IV - Upon approval by the CIB, it is the responsibility of the Department of Health in the States and Federal District to notify the Ministry of Health, before the 15th of each month, of the number of ESF, ESB, and ACS that are entitled to receive financial incentives of the variable PAB;

V - The municipality, with the teams previously registered by the state, as decided by the CIB, will start to receive the incentive corresponding to the actual implemented teams, according to the from registration of professionals in the national information system designed for that purpose and the entry of data into the system proving the beginning of their activities;

VI - The Ministry of Health, states, and municipalities shall have a period of 180 days to implement the new registration flow and set up ESF, ESB, and ACS; and

VII - The flow of users to ensure referral and counter referral to specialized care in the medium-complexity outpatient care services, including laboratory and imaging - X-rays and ultrasound - diagnostic support, considering the minimum service delivery standards according to the protocols established by the Ministry of Health and the proposal to ensure primary pharmaceutical assistance must be included in the Municipal Health Plan.

## CHAPTER III
## Funding of Primary Care

### 1 - GENERAL

Funding of Primary Care shall have a tripartite composition.

The Primary Care Baseline funding (PAB) constitutes the federal component of the funding of Primary Care and is composed of a fixed and a variable portion.

The sum of the fixed and variable portions of the Primary Care Baseline funding (PAB) will compose the Financial limit for the Primary Care Block, as set forth in the guidelines of the Pact for Life, Pact in Defense of the SUS, and Management Pact.

The funds of the Financial limit for of the Primary Care Block shall be used to finance Primary Care actions described in the Health Plans of the municipality and Federal District.

### 2 - PRIMARY CARE BASELINE FUNDING

The Primary Care Baseline Funding – PAB consists of an amount of federal funds designed to enable Primary health Care actions and is part of the Financial limit for of the Primary Care Block.

The PAB is composed of a fixed part (fixed PAB) designed for all municipalities and a variable part (variable PAB), which consists of an amount of funds designed to encourage the implementation of the following national strategies for the reorganization of the health care model: Family Health – SF; Community Health Agents – ACS; Oral Health – SB; Compensation of Regional Specificities; Indians Peoples' Health – SI; and Penitentiary Health System.

Transfers of funds of the fixed and variable PABs to the municipalities are made into an account specially opened for that purpose in order to facilitate monitoring by the Boards of Health in the municipalities, states, and Federal District.

Funds are transferred into a specific account entitled "FMS – name of the municipality – PAB" in accordance with the Ministry of Health's general rules for fund-to-fund transfers.

The Ministry of Health shall define the codes of entries as well as their literal markers, which will be included in their credit notifications to clarify the purpose of each entry into the account. The credit notification shall be

sent to the Secretary of Health, the Health Fund, the Board of Health, the Legislature, and the Public Prosecution at each government level.

Accounting records and monthly management reports duly updated for the funds transferred to such accounts shall be at all times available to the Boards in charge of monitoring and controlling them in the Municipalities, States, and Federal District and to the federal, state, and municipal internal and external control agencies.

Municipalities shall electronically send the processing of the PAB-related services to the State Department of Health according to the schedule specified by it. The Departments of Health of the States and Federal District shall send the information to the DATASUS, subject to the schedule specified by the Ministry of Health.

Municipalities and the Federal District shall perform expenses in accordance with the legal requirements for any other public administration expenses (processing, commitment, settlement, and payment).

In accordance with Article 6 of Decree No. 1651/95, proof of application of the funds transferred from the National Health Fund to the State and Municipal Health Funds under Decree No. 1232/94, which deals with fund-to-fund transfers, shall be submitted to the Ministry of Health and the State through a management report approved by the relevant Board of Health.

Likewise, accounts for the amounts received and applied during the period shall be approved by the Municipal Board of Health and submitted to the Audit Court of the State or Municipality and the Municipal Legislature.

Proof of fund operation for each account shall be provided, whether upon Reporting or at the request of the controlling agencies, by presenting:

I – monthly reports on sources and applications of funds;

II – brief statement of budget execution;

III – detailed statement of major expenses; and

IV – management report.

The Management Report shall show how the application of the funds resulted in health care actions to the population, including monthly and annual quantities of Primary Care services.

2.1 - Fixed part of the Primary Care Baseline Funding

The funds of the PAB shall be regularly and automatically transferred from the National Health Fund to the Municipal and Federal District Health Funds on a monthly basis.

Exceptionally, the funds of the PAB corresponding to the population of municipalities not complying with the minimum requirements imposed by this Rule may be transferred temporarily to the State Health Funds, upon resolution of the Bipartite Commissions of Managers.

The fixed part of the PAB shall be calculated by multiplying a per capita amount specified by the Ministry of Health by the population of each municipality and the Federal District, and such amount shall be published by a specific rule. For the municipalities whose relevant amounts are already greater than the minimum per capita amount proposed, the greater amount shall be maintained.

The population of each municipality and the Federal District shall be the population measured by the IBGE and published by a specific rule of the Ministry of Health.

The municipalities that already receive incentives for teams under projects similar to the PSF, in accordance with Rule No. 1348/GM of November 18, 1999, and Incentives for Decentralization of Health Centers from FUNASA, in accordance with Rule No. 1502/GM of August 22, 2002, shall have the corresponding amounts incorporated into their fixed PAB from the date of publication of the financial limit for the Primary Care Block.

The actions described in the Groups of Primary Care Procedures, on the Outpatient Information System Table of the Unified Health System are maintained and remain as a reference to feed national databases.

2.2 - Variable Basic Care Baseline Funding

The funds of the variable PAB are an integral part of the Primary Care Block and shall be used as defined in the municipal health plans, within the scope of actions set forth in this Rule.

The variable PAB represents the portion of federal funds to finance national strategies for the organization of Primary Care, which is generally financed by a tripartite composition.

In order to be entitled to the specific funds of the variable PAB, the Federal District and the municipalities shall adhere to the following national strategies:

I - Family Health (SF);

II - Community Health Agents (ACS);

III - Oral Health (SB);

IV - Compensation of Regional Specificities;

V - Indian Peoples' Health (SI); and

VI - Penintentiary health system.

Transfer of the funds that compose the incentives related to the variable PAB for Indigenous Peoples' Health – SI shall be regulated by a specific rule.

Transfer of the funds that compose the incentives related to the variable PAB for Penitentiary health system shall comply with the provisions of Inter-ministerial Rule No. 1777 of September 9, 2003.

Transfer of the funds that compose the incentives related to the variable PAB for the SF, ACS, and SB is made based on the mandatory data entered into the SIAB, which is to maintained and updated by the managers of the Federal District and municipalities.

I - the data shall be transferred by the State Departments of Health and the Federal District's Department of Health to the SUS Information System Department - DATASUS electronically on or before the 15th of each month;

II - the data to be transferred are related to the period from the 1st to the 30th of the month immediately preceding the transmission.

III - transfer of the data to the SIAB National Database shall be made through the BBS/MS, via the Internet, or by diskette;

IV - the DATASUS shall send to the State Department of Health a receipt for entry of data into the SIAB National Database; and

V - the DATASUS shall update the SIAB National Database, located in the Primary Care Department of the Department of Health Care, on or before the 20th of each month.

The maximum number of Family Health, Oral Health, and ACS teams to be funded by the Ministry of Health every year shall be defined in a specific rule, according to the budget limits.

The number of components of the variable PAB shall be defined by a specific rule of the Ministry of Health.

## Family Health Team (ESF)

The amounts of financial incentives to the Family Health Teams set up shall be transferred every month based on the number of Family Health Teams (ESF) entered into the database of teams and professionals in the Primary Care Information System – SIAB for the month preceding the current fiscal period.

The maximum number of ESFs for which the municipality and the Federal District may be entitled to receive specific funds shall be calculated using the following formula: population / 2400.

The source of population data to be used in the calculation shall be that applicable to the calculation of the fixed part of the PAB.

Two types of funding are available to the ESFs:

1 - ESF Type 1: means all ESFs that meet the following requirements:

I - are set up in municipalities with a Human Development Index (HDI) equal to or less than 0.7 and a population of up to 50,000 inhabitants in states of the "Legal Amazon" Region and up to 30,000 inhabitants in other Brazilian states; or

II - are set up in municipalities that are part of the National Program for the settlement of Health workers in rural areas (PITS) and that do not qualify under clause I of this item; and

III - are set up in municipalities not qualifying under clauses I and II and serving remnant "quilombo"* communities or settlements with at least seventy (70) people, subject to the maximum number of teams per municipality published by a specific rule.

2 - ESF Type 2: means all ESFs set up throughout the national territory not qualifying as Type 1.

The number of components of the variable PAB for ESFs Types I and II shall be defined by a specific rule of the Ministry of Health. Municipalities shall become entitled to receive the incentive after registration of the Family Health Teams responsible for serving these specific populations into the Primary Care Information System (SIAB).

## Community Health Agents (ACS)

The amounts of financial incentives to the ACS teams set up shall be transferred every month based on the number of Community Health Agents (ACS)



* Quilombos are specific communities composed by descendants of former african slaves, that mantain cultural and ethnic characteristics of their ancestors".

entered into the database of teams and professionals in the Primary Care Information System – SIAB for the current fiscal month.

An additional portion shall be transferred in the final quarter of each year, the amount of which shall be calculated based on the number of Community Health Agents entered into the database of teams and professionals in the Primary Care Information System – SIAB as in August of the current year.

The maximum number of ACSs for which the municipality and the Federal District may be entitled to receive specific funds shall be calculated using the following formula: IBGE population/ 400.

For municipalities in the Northern states, Maranhão, and Mato Grosso, the formula shall be: IBGE population in the urban area / 400 + IBGE population in the rural area / 280.

The source of population data to be used in the calculation shall be that applicable to the calculation of the fixed part of the PAB, as defined by the IBGE and published by the Ministry of Health.

### Oral Health Teams (ESB)

The amounts of financial incentives to the Oral Health Teams set up shall be transferred every month based on the number of Oral Health Teams (ESB) entered into the database of Teams and professionals in the Primary Care Information System – SIAB for the relevant fiscal month.

All teams set up on the SIAB shall be entitled to receive the financial incentives for Oral Health Teams (ESB), provided that they do not exceed the number of Family Health Teams and respect the logic of the Primary Care organization – Family Health.

Two types of funding are available to the ESBs:

I - Oral Health Team Type 1: composed of at least 1 dentist and 1 dental office assistant;

II - Oral Health Team Type 2: composed of at least 1 dentist, 1 dental office assistant, and 1 dental hygiene technician.

### Compensation of Regional Specificities

The amounts of the Compensation of Regional Specificities fund shall be defined by a specific Ministerial Rule for that purpose.

Use of the Compensation of Regional Specificities funds shall be periodically defined by the CIBs.

The CIB shall select the municipalities to receive it based on regional criteria and the method of use of such funds according to regional and/or municipal specificities of each state, such as seasonality, migrations, difficult to retain professionals, HDI, result indicators, continuous education, formation of ACSs.

The criteria defined shall be informed to the plenary CIT. In the case of the Federal District, the proposal for application of this fund shall be submitted to the Federal District's Board of Health for approval.

The State Departments of Health shall send a list of municipalities with the amounts and period of transfer of the funds agreed by the CIBs to the Primary Care Department of the Ministry of Health, so that the amounts may be transferred to the FNS and FMSs.

## 3 - MINIMUM REQUIREMENTS FOR MAINTENANCE OF THE PAB TRANSFER

The minimum requirements for maintenance of the PAB transfer are defined by the federal legislation on the SUS.

The municipal or Federal District Health Plan, approved by the relevant Board of Health and annually updated, shall specify the proposal for the organization of Primary Care and explain how the funds of the Primary Care Block shall be used. Municipalities and the Federal District shall keep these Plans for at least 10 years for assessment, monitoring, and audit purposes.

The Management Report shall show how the application of the funds resulted in health care actions to the population, including monthly and annual quantities of Primary Care services, and shall be annually submitted to the Municipal Board of Health for consideration and approval.

The amounts of the fixed PAB shall be annually adjusted upon achievement of agreed goals based on Primary Care indicators. Exceptionally, failure to achieve the goals may be assessed and justified by the State Departments of Health and by the Ministry of Health to ensure such adjustment.

The monitoring indicators for 2006 are:

I - Coverage determined by the municipal and Federal District manager for the previous year under the Primary Care Pact for:

a) annual average of medical visits per inhabitant in primary specialties*;

b) rate of live born infants from mothers with four or more pre-natal visits;

c) ratio between Pap smear tests in women between 25 and 59 years old and the female population in that age range; and

II - Coverage for the third dose of the tetravalent vaccine in infants under one year of age, equal to or greater than 95%;

The Ministry of Health shall annually publish, in a specific rule, the monitoring indicators for adjustment of the fixed PAB.

## 4 - REQUEST FOR RETROACTIVE CREDIT

Upon occurrence of problems in feeding the Primary Care Information System – SIAB by the municipalities and/or the Federal District, and in transferring files by the municipalities, the Federal District, and the states, the National Health Fund – FNS/SE/MS may extend retroactive credit of the financial incentives to Family Health teams, Oral Health teams, and Community Health Agents at the request of the Secretariat of Health Care – SAS/MS.

Such retroactivity is limited to six months prior to the current month.

In order to request retroactive credits, municipalities and the Federal District shall:

I - complete the sheet contained in Annex III to this Policy to inform the type of financial incentive that was not credited to the Municipal or Federal District Health Fund, specifying the relevant fiscal period and identifying the team, with its members, or the community health agent who did not generate incentive credit;

II - print the production report, in case of Family Health teams, for the team and the month worked that did not generate the fund transfer; and

III - send an official notice to the relevant state Department of Health claiming credit supplementation, together with the sheet referred to in item I and the related production report. In the case of the Federal District, the official notice shall be sent to the Department of Primary Care within the SAS/MS.

The State Departments of Health, upon reviewing the documentation received from the municipalities, shall send to the Department of Primary Care



* Primary medical specialties are ginecology/obstetrics, paediatrics and internal medicine.

within the SAS/MS a request for credit supplementation for the incentives under this Rule, together with the documents referred to in items I and II.

The Secretariat of Health Care– SAS/MS, through the Department of Primary Care, shall review the requests received by verifying the documentation sent for compliance and checking whether the credit was suspended due to any inconsistency found in the operation of the teams and whether the municipality or the Federal District is eligible for the transfer of the funds claimed during that period.

## 5 - SUSPENSION OF THE TRANSFER OF PAB FUNDS

The Ministry of Health shall suspend the transfer of PAB funds to the municipalities and the Federal District if:

I - the following national databases are not regularly fed by the municipalities and the Federal District:

a) Primary Care Information System (SIAB) – for the municipalities and the Federal District that have set up ACS and/or ESF and/or ESB;

b) Outpatient Information System – SIA;

c) Mortality Information System – SIM;

d) Live Born Infant Information System – SINASC;

e) Dietary and Nutritional Surveillance System – SISVAN;

f) Notifiable Injury Information System – SINAN; and

g) Information System of the National Immunization Program – SIS-PNI.

Failure to regularly feed means failure to send information for 2 consecutive months or any 3 months in a one-year period.

II - A federal or state audit detects any improper management or misapplication of the funds.

Suspension shall continue until the inconsistencies are resolved.

### 5.1 - Suspension of the transfer of the variable PAB funds

The Ministry of Health shall suspend the transfer of incentive funds to Family Health or Oral Health teams to the municipality and/or the Federal District if an examination and/or direct supervision of the Ministry of Health or State Department of Health or an audit of the DENASUS finds any of the following situations:

I - absence of any registered health center for the teams to work; and/or

II - absence of any of the team professionals for a period of more than ninety (90) days, except for the periods in which hiring of professionals is restricted by specific laws; and/or

III - failure by professionals of the Family Health or Oral Health Teams to comply with the working hours specified in this Policy.

The Ministry of Health shall suspend the transfer of incentive funds to Community Health Agents to the municipality and/or the Federal District if an examination and/or direct supervision of the Ministry of Health or State Department of Health or an audit of the DENASUS finds any of the following situations:

I - absence of any registered health center for referral of the population enrolled by the ACSs; and/or

II - absence of any supervising nurse for a period of more than ninety (90) days, except for the periods in which electoral laws prevent hiring of professionals, during which the absence of professional shall be considered improper; and/or

III - absence of an ACS for a period of more than ninety (90) consecutive days; and/or

IV - failure by professionals to comply with the working hours specified in this Policy.

## 6 - FUNDS FOR STRUCTURING

When setting up the Family Health and Oral Health Teams, municipalities and/or the Federal District shall receive specific funds to structure the Health Centers of each Family Health Team and for Oral Health Teams in order to improve the physical infrastructure and equipment of the Primary Health Centers for the teams to work.

These funds shall be transferred during the fiscal month following the setting up of the teams.

If the team set up is dissolved within less than twelve (12) months after receipt of the incentive for structuring, then the amount received shall be deducted from future amounts to be transferred to the Health Funds of the Federal District, state, or municipality.

In case of reduction in the number of Family Health or Oral Health Teams, the municipality or the Federal District shall not be entitled to new funds for setting up until the number of teams previously set up is reached.

Every year, the Ministry of Health shall provide funds designed to structure the primary service network in accordance with the budget availability. The CIT shall agree on the criteria for selection of the municipalities and/or Federal District.

For the year 2006, funds shall be provided to the municipalities:

I - That have medical residence in family and community medicine registered by the CNRM; and

II - That receive at their Primary Health Centers students from Undergraduate Programs participating in the PROSAUDE.

The Ministry of Health shall publish a specific rule specifying the amount provided, the transfer method, the list of participants, and the disbursement schedule.

Such funds shall be transferred fund to fund to the municipalities that meet these criteria and shall be deposited into a specific account.

# Annex I

## Duties of the professionals of the Family Health, Oral Health and ACS Teams

The general duties described below may be supplemented by guidelines and standards from the local administration.

1 - THE FOLLOWING DUTIES ARE COMMON TO ALL PROFESSIONALS:

I - to participate in the process of territorialization and mapping of the team's area of activity by identifying groups, families, and individuals exposed to risks, including occupational risks, and continuously update such information, giving priority to situations to be monitored in the local planning;

II - to provide the assigned population with health care, preferably at the health center, household, and other community spaces (schools, associations etc.) when necessary;

III - to perform comprehensive care actions according to the local population's health needs and as provided in the local administration's priorities and protocols;

IV - to ensure comprehensiveness of the care by performing health promotion, injury prevention, and curative actions; and ensure that the spontaneous demand is met by performing programmatic and health surveillance actions;

V - to perform active search and notification of diseases and injuries required to be notified and other injuries and situations of local importance;

VI - to pay careful attention to the users' needs in all actions, provide humanized service, and promote an interpersonal relationship;

VII - to be responsible for the assigned population and continue to coordinate the care, even when the population needs care from other levels of the health system;

VIII - to participate in activities of planning and assessment of the team's actions using the data available;

IX - to promote mobilization and participation of the community to enhance social control;

X - to identify partners and resources in the community that may boost intersectorial actions with the team under the coordination of the SMS;

XI - to ensure quality in the registration of activities in the national Primary Care information systems;

XII - to participate in continuous education activities; and

XIII - to perform other actions and activities to be defined in accordance with local priorities.

2 - THE FOLLOWING ARE SPECIFIC DUTIES:

In addition to the defined duties, the following are minimum specific duties of each professional category, and it is the responsibility of the municipal or Federal District manager to expand such duties according to local specificities:

Of the Community Health Agent:

I - to perform actions to promote integration between the health team and the population assigned to the UBS, considering the characteristics and purposes of the monitoring work for individuals, social groups, or community;

II - to work with the assignment of families by defined geographic area - micro-area;

III - to continuously contact the families by performing educational actions to

promote health and prevent diseases according to the team's planning;

IV - to register all people in their micro-area and keep registrations up to date;

V - to guide families on the use of the health care services available;

VI - to perform health promotion, disease and injury prevention, and health surveillance activities through household visits and individual and collective educational actions at the households and community, and keep the team informed, especially on any risk situations;

VII - to monitor through household visits all families and individuals under their responsibility according to the needs defined by the team; and

VIII - to perform the duties currently assigned to the ACS with respect to malaria and dengue prevention and control, in accordance with Rule No. 44/GM of January 3, 2002

Note: ACS is authorized to perform activities at the primary health centers if such activities are related to the above duties.

Of the Nurse under the Community Health Agent Program:

I - to plan, manage, coordinate, and assess the actions performed by the ACSs;

II - to supervise, coordinate, and perform training and continuous education activities for the ACSs in connection with the performance of their duties;

III - to facilitate the relationship between the professionals of the Primary Health Center and the ACSs by helping organize the referred demand;

IV - to see patients and conduct nursing procedures at the Primary Health Center and, when necessary, at households and community;

V - to request additional examinations and prescribe medications based on the protocols or other technical standards specified by the municipal or Federal District manager, subject to the legal provisions for the profession;

VI - to organize and coordinate specific groups of individuals and families under risk situation in the area of activity of the ACSs; and

VII -to participate in the management of the inputs necessary for the proper operation of the UBS.

Of the Nurse:

I - to provide comprehensive care to the people and families at the USF and, when advisable or necessary, at the households and/or other community spaces;

II - to see nursing patients, request additional examinations and prescribe medications, subject to the legal provisions for the profession and based on the protocols or other technical standards specified by the Ministry of Health, state managers, municipal or Federal District managers; (NR)

III - to plan, manage, coordinate, and assess the actions performed by the ACSs;

IV - to supervise, coordinate, and perform training and continuous education activities for the ACSs and the nursing team;

V - to contribute to and participate in Continuous Education activities for the Nursing Assistant, ACD, and THD; and

VI - to participate in the management of the inputs necessary for the proper operation of the USF.

(Items I and II were amended by Rule No. 1625 of July 10, 2007)

Of the Doctor:

I - to provide comprehensive care (health promotion and protection, injury prevention, diagnosis, treatment, rehabilitation, and health maintenance) to individuals and families during all stages of human development: childhood, adolescence, adulthood, and old age;

II - to see patients clinically and conduct procedures at the USF and, when advisable or necessary, at the households and/or other community spaces (schools, associations etc.);

III - to perform activities of spontaneous and programmed demand in general practice, pediatrics, gynecology & obstetrics, outpatient surgeries, minor clinical/surgical emergencies, and diagnostic procedures;

IV - to refer users, when necessary, to medium and high-complexity services, subject to the local flows of referral and counter referral, and assume continuous responsibility for monitoring the user's therapeutic plan proposed by the referral professional;

V - to determine the need for hospitalization or home care and assume continuous responsibility for monitoring the user;

VI - to contribute to and participate in Continuous Education activities for ACSs, Nursing Assistants, ACD, and THD; and

VII - to participate in the management of the inputs necessary for the proper operation of the USF.

VIII - it is the responsibility of the doctor to monitor the performance of the Protocols and change the medical routine based on clinical indications and scientific evidence;

IX - in case of review of Protocols or creation of new Protocols, the Federal Medical and Nursing Boards and other Boards, when necessary, shall also participate in their preparation. (NR)

(Items VIII and IX were added by Rule No. 1625 of July 10, 2007).

Of the Nursing Assistant and Technician:

I - to participate in primary care activities by conducting regulated procedures in the exercise of their profession at the USF and, when advisable or necessary, at households and/or other community spaces (schools, associations etc.);

II - to perform health education actions to specific groups and families under risk situation, according to the team's planning; and

III - to participate in the management of the inputs necessary for the proper operation of the USF.

Of the Dentist:

I - to make a diagnosis to obtain an epidemiological profile for oral health planning and programming;

II - to conduct clinical procedures for Primary oral health Care, including emergencies and minor outpatient surgeries;

III - to effectively provide comprehensive oral health care (health promotion and protection, injury prevention, diagnosis, treatment, rehabilitation, and health maintenance) individually and collectively to all families, individuals, and specific groups, according to the local planning;

IV - to refer and guide users, when necessary, to other assistance levels and assume continuous responsibility for monitoring the user and the treatment progress;

V - to coordinate and participate in collective actions for health promotion and oral disease prevention;

VI - to monitor, support, and perform activities for oral health with the other members of the Family Health Team to bring together and integrate health actions in a multidisciplinary manner.

VII - to contribute to and participate in Continuous Education activities for

the THD, ACD, and ESF;

VIII - to perform technical supervision of the THD and ACD; and

IX - to participate in the management of the inputs necessary for the proper operation of the USF.

Of the Dental Hygiene Technician (THD):

I - to provide comprehensive oral health care (promotion, prevention, assistance, and rehabilitation) individually and collectively to all families, individuals, and specific groups, according to the programming and their technical and legal competences;

II - to coordinate and perform the maintenance and conservation of dental equipment;

III - to monitor, support, and perform activities for oral health with the other members of the Family Health Team to bring together and integrate health actions in a multidisciplinary manner.

IV - to support the activities of the ACDs and ACSs in prevention and oral health promotion actions; and

V - to participate in the management of the inputs necessary for the proper operation of the USF.

Of the Dental Office Assistant (ACD):

I - to perform oral health promotion and prevention actions for the families, groups, and individuals according to local planning and health care protocols;

II - to disinfect and sterilize materials and instruments used;

III - to prepare and organize the necessary tools and materials;

IV - to provide instruments and assist the dentist and/or THD in clinical procedures;

V - to ensure maintenance and conservation of dental equipment;

V - to organize the clinic schedule;

VII - to monitor, support, and perform activities for oral health with the other members of the Family Health Team to bring together and integrate health actions in a multidisciplinary manner; and

VIII - to participate in the management of the inputs necessary for the proper operation of the USF.

# Annex II

## National primary care policy

### Charts for Project Implementation Plans – ACS/SF/SB

General Characteristics

| Name or No. of the SF/SB | Geographic area of activity (Name of the municipality / neighborhood / community) | Estimated population |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Infrastructure

| Name or No. of the ESF | | Permanent Material | | | |
|---|---|---|---|---|---|
| | | Existing | Qty. | To be purchased | Qty |
| | | | | | |
| | | | | | |
| | | | | | |

## Method of hiring human resources

| Profesional | Recruitment method | Selection method | Hiring method | Working pattern |
|---|---|---|---|---|
| Doctor | | | | |
| Nurse | | | | |
| Nursing assistant | | | | |
| Community health agent | | | | |
| Dentist | | | | |
| Dental Office Assistant (ACD) | | | | |
| Dental Hygiene Technician (THD) | | | | |
| Other professionals (specify) | | | | |

## Chart of Goals for Actions in Strategic Areas

| Name or No. of the ESF | Strategic area of activity | Actions proposed for the ESF | Number of actions programmed per year, per ESF |
|---|---|---|---|
| | Children's Health | | |
| | Women's Health | | |
| | Diabetes Control | | |
| | hypertension Control | | |
| | Elimination of hanseniasis | | |
| | Tuberculosis Control | | |
| | Oral Health | | |
| | Elimination of child malnutrition | | |
| | Health promotion | | |
| | Health of the Elderly | | |

## Assessment and monitoring of actions

| Assessment Instrument | Proposed monitoring method |
|---|---|
| SIAB | |
| Primary Care Pact | |
| Management Pact | |
| Others (specify) | |

Summary chart for funding of implementation areas

| Expenses | Personnel expenses | Material/maintenance expenses | Structuring | TOTAL |
|---|---|---|---|---|
| Current | | | | |
| Proposal with SF/SB | | | | |

| Revenues | Municipal funds | State funds | Ministry of Health's Incentive | TOTAL |
|---|---|---|---|---|
| Current | | | | |
| Proposal with SF/SB | | | | |

Definition of Medium Complexity Referrals

| Areas of Referral | Name and location of the Referral Center | Referral Method |
|---|---|---|
| Specialized services | | |
| Emergency services | | |
| Laboratory tests | | |
| Radiodiagnosis | | |
| Ultrasound | | |
| Rehabilitation | | |
| Inpatient care at Primary Specialities | | |

# Annex III

## National Primary Care Policy

### Retroactive request for complementary transfer of financial incentives - year _____

Family health teams, oral health teams, and community health agent teams.

Municipality _____ State _____

IBGE Code _____ Period _____

Type of incentive: Funding ◯ additional ◯

ESF ◯ ACS ◯ ESB type I ◯ ESB type II ◯

Identification of the team _____

Reason for non-registration in the SIAB _____

_____

_____

_____

| NAME OF THE PROFESSIONALS | PROFESSIONAL CATEGORY | PROFESSIONAL REGISTRATION / IDENTIFICATION |
|---|---|---|
| | | |
| | | |

NAME OF THE TEAM: Identification of the team by it's name.

TYPE OF INCENTIVE: Identify first whether the incentive is funded (monthly transferred) or additional. Next, check if it refers to family health teams, community health agents, or oral health teams type I or II.

LIST OF PROFESSIONALS: Full name of each professional in the team who did not generate incentive.

PROFESSIONAL CATEGORY: Identify the category of each professional listed in the preceding column.

PROFESSIONAL IDENTIFICATION / REGISTRATION: Inform the professional registration number for the doctor, nurse, and dentist and the identification document number for the others,

Date _____

Municipal Secretary of Health _____

State Secretary of Health _____

# Rule No. 649/GM of March 28, 2006

Sets amounts for the year 2006 to fund the structuring of Primary Health Centers for the Family Health Teams as part of the National Primary Care Policy.

The MINISTER OF HEALTH, in the exercise of his duties and considering the National Primary Care Policy defined by Rule for Primary Care Guidelines and Standards, Rule No. 648/GM of March 28, 2006, which regulates the performance of primary health care actions in the Unified Health System (SUS) and defines criteria for the use of primary care funds,

RESOLVES:

Article 1. To determine, for the year 2006, the transfer of the sole amount of one hundred thousand reais (R$ 100,000.00) per undergraduate program to the municipalities that adhered have to the PROSAÚDE and are receiving nursing, medicine, and/or dentistry students at the municipal Primary Health Centers with Family Health teams.

Article 2. To set, for the year 2006, the amount to be transferred for structuring municipal Primary Health Centers of Family Health Teams to the municipalities receiving at these Centers residents in Family and Community Medicine, registered in the National Medical Residence Commission (CNRM), at the sole amount of thirty thousand reais (R$ 30,000.00) per resident student.

Article 3. To determine that the funds referred to in Articles 1 and 2 of this Rule be transferred from the National Health Fund to the Municipal Health Funds for renovations, adaptation of physical area and equipment.

Article 4. To determine that it is the responsibility of the Secretariat of Health Care (SAS/MS), jointly with the Secretariat for the Management of Health Labor and Education (SGTES/MS) to

publish a list of municipalities that meet the criteria of this Rule with their amounts.

Article 5. To determine that the budget funds referred to in this Rule shall come from the Ministry of Health's budget and shall charge the following Work Programs:

I - 10.846.1214.0587 – Primary Care Service in Brazilian Municipalities; and

II - 10.845.1214.0589 – Financial Incentive to Municipalities Eligible for the Variable Part of the Primary Care Baseline Funding – PAB for Family Health.

Article 6. This Rule shall become effective on the date of publication.

SARAIVA FELIPE

# Rule No. 650/GM of March 28, 2006

Sets amounts to fund the fixed and variable PAB upon review of guidelines and standards for the organization of Primary Care, the Family Health strategy, and the Community Health Agent Program, instituted by the National Primary Care Policy.

The MINISTER OF HEALTH, in the exercise of his duties and considering the National Primary Care Policy defined by Rule for Primary Care Guidelines and Standards, Rule No. 648/GM of March 28, 2006, which regulates the performance of primary health care actions in the SUS and defines criteria for transfer of the Primary Care Baseline Funding, fixed and variable portion,

RESOLVES:

Article 1. To determine that the minimum per capita amount of the Primary Care BaselineFunding – PAB, fixed portion (fixed PAB) shall be thirteen reais (R$ 13.00)/inhabitant per year.

Sole Paragraph. A greater per capita amount of the fixed PAB shall prevail in the municipalities whose reference levels are already greater than the minimum per capita amount proposed as of the date of publication of this Rule.

Article 2. To incorporate into the fixed PAB of the municipalities that receive incentives for teams with similar projects, in accordance with Rule No. 1348/GM of November 18, 1999 (Annex I), amounts corresponding to those paid by the health teams

under projects similar to the PSF and Incentives for Decentralization of Health Centers from the National Health Foundation (FUNASA), in accordance with Rule No. 233/GM of March 24, 1999 and Rule No. 1502/GM of August 22, 2002 (Annex II), from the fiscal period of march 2006.

Article 3. To create two types of Financial Incentive to the Family Health Teams set up in accordance with the criteria specified by the National Primary Care Policy.

Paragraph 1. The amount of the Financial Incentives for Family Health Teams Type 1 is eight thousand one hundred reais (R$ 8,100.00) per month per team.

Paragraph 2. All Family Health Teams of the municipalities listed in Annex III to this Rule and Family Health Teams of the municipalities listed in Annex IV to this Rule that serve populations residing in settlements or remnant quilombo communities are entitled to receive Type 1 funds, subject to the maximum number of teams specified in this Annex IV.

Paragraph 3. The amount of the Financial Incentives for Family Health Teams Type 2 is five thousand four hundred reais (R$ 5,400.00) per month per team.

Article 4. To determine that the amount of the Financial Incentives to Community Health Agents (ACS) shall be three hundred and fifty reais (R$ 350.00) per ACS per month, from the fiscal period of April 2006, calculated based on the number of ACSs entered into the database of teams and professionals in the Primary Care Information System (SIAB) for the relevant fiscal month.

Sole Paragraph. In the final quarter of each year, an additional portion shall be transferred, calculated based on the number of Community Health Agents entered into the database of teams and professionals in the Primary Care Information System (SIAB) for the month of August of the current year multiplied by the amount of the incentive set at the beginning of this Article.

Article 5. To set the following amounts of Financial Incentives for Oral Health Teams (EBS) Types 1 and 2, according to criteria specified by the National Primary Care Policy:

I – For EBSs Type 1, one thousand seven hundred reais (R$ 1,700.00) shall be transferred every month per team; and

II – For EBSs Type 2, two thousand two hundred reais (R$ 2,200.00) shall be transferred every month per team.

Sole Paragraph. All Oral Health Teams of the municipalities listed in Annex III to this Rule and Oral Health Teams of the municipalities listed in Annex IV to this Rule that serve populations residing in settlements or remnant quilombo communities shall be entitled to additional 50% of the amounts transferred for the ESBs set up of the types defined at the beginning of this Article, subject to the maximum number of teams specified in this Annex IV.

Article 6. To set the amount to be transferred to each Family Health Team set up at twenty thousand reais (R$ 20,000.00) in two monthly payments of ten thousand reais (R$ 10,000.00) each following the month of team implementation, as a fund to be invested in the Primary Health Centers and Introductory Course.

Article 7. To set the amount to be transferred to each Oral Health Team set up at seven thousand reais (R$ 7,000.00) in a sole amount in the month following implementation as a fund to be invested in the Primary Health Centers and Introductory Course.

Article 8. To update the population database for calculation of the fixed and variable PAB based on the IBGE 2005 population and 2005 settled population, according to information from the Ministry of Agrarian Development, see Annex V to this Rule.

Article 9. To establish that the budget funds referred to in this Rule shall come from the Ministry of Health's budget and shall charge the following Work Programs:

I - 10.846.1214.0587 – Primary Care Service in Brazilian Municipalities; and

II - 10.845.1214.0589 – Financial Incentive to Municipalities Eligible for the Variable Part of the Primary Care Baseline Funding – PAB for Family Health.

Article 10. This Rule shall become effective on the date of publication, with financial effect from the fiscal month of April 2006.

SARAIVA FELIPE

# Rule No. 822/GM of April 17, 2006

Changes criteria for definition of types of ESFs provided by the National Primary Care Policy.

The ACTING MINISTER OF HEALTH, in the exercise of his duties,

Considering the provisions of the National Primary Care Policy defined by Rule No. 648/GM of March 28, 2006, which provides a review of guidelines and standards for the organization of Primary Care under the Family Health Program (PSF) and Community Health Agent Program (PACS).

Considering the provisions of Rule No. 650/GM of March 28, 2006, which sets amounts to fund the fixed and variable PAB; and

Considering the pact made at the Meeting of the Tripartite Commission of Managers – CIT, held on March 30, 2006, on the need to change criteria for definition of types of ESF provided in the National Primary Care Policy,

RESOLVES:

Article 1. To amend Rule No. 648/GM of March 28, 2006, published in Federal Gazette No. 61 of March 29, 2006, Section 1, page 71, the criteria for Family Health Teams – ESF to qualify under Type 1, as provided in item 2.2 of Chapter III of the National Primary Care Policy, which shall read as follows:

"Family Health Team _____

_____

I - ESF Type 1 means:

- All ESFs set up in municipalities:

a) with a population of up to 50,000 inhabitants in the states of the Legal Amazon Region; or

b) with a population of up to 30,000 inhabitants and a Human Development Index (HDI) equal to or less than 0.7, in the other Brazilian states; or

c) that are already entitled to receive the additional 50% of the amount of incentives for all ESFs and ESBs set up; and

The ESFs set up in municipalities not qualifying under clause I and serving remnant quilombo communities and/or settlements with at least seventy (70) people, subject to the maximum number of teams per municipality published by a specific rule." (NR)

Article 2. To amend Annexes III and IV to Rule No. 650/GM of March 28, 2006, published in Federal Gazette No. 61 of March 29, 2006, Section 1, page 76, which shall read with the wording contained in Annexes I and II to this Rule, respectively.

Article 3. This Rule shall become effective on the date of publication, with financial effect from the month of April 2006.

JOSÉ AGENOR ÁLVARES DA SILVA

# Rule No. 2133/GM of September 11, 2006

Sets the minimum amount of the fixed part of the Primary Care Baseline Funding – PAB for purposes of calculation of the amount of funds to be transferred from the National Health Fund to the municipalities and the Federal District and discloses the annual/monthly amounts of the fixed part of the PAB per municipality and Federal District.

The MINISTER OF HEALTH, in the exercise of his duties and

Considering Rule No. 648/GM of March 28, 2006, which approves the National Primary Care Policy and determines that it is the responsibility of the Ministry of Health to ensure funds to finance primary care;

Considering the need to adjust the amounts of the Primary Care Baseline Funding to boost changes in the organization of primary care in Brazil; and

Considering that all Brazilian municipalities are responsible for organizing and performing primary care actions in their territories to ensure access to quality health services,

RESOLVES:

Article 1. To set at fifteen reais (R$ 15.00) per inhabitant per year the minimum amount of the fixed part of the Primary Care Baseline Funding – PAB for purposes of calculation of the amount of funds to be transferred from the National Health Fund to the Municipalities and the Federal District.

Sole Paragraph. The per capita amount of the municipalities that currently receive a PAB greater than fifteen reais (R$ 15.00) shall be maintained.

Article 2. To disclose, in the Annex to this Rule, the annual and monthly amounts of the fixed part of the Primary Care Baseline Funding (PAB) per municipality based on the estimated population of states and municipalities for the year 2005, as set forth in Resolution No. 5 of August 30, 2005 from the Brazilian Foundation/Institute of Geography and Statistics (IBGE) and population settled between 2000 and 2005, according to information from the Ministry of Agrarian Development.

Article 3. To establish that the budget funds referred to in this Rule shall come from the Ministry of Health's budget and shall charge the following Work Program: 10.3011214.8577 – Primary Care Service in Brazilian Municipalities.

Article 4. This Rule shall become effective on the date of publication, with financial effect from the fiscal month of August 2006.

JOSÉ AGENOR ÁLVARES DA SILVA

Federal Gazette 175, Section 1, page 45/110 of 9/12/06

# Rule No. 1624/GM of July 10, 2007

Regulates the transfer, for the year 2007, of financial incentives to the Compensation of Regional Specificities – CER, a component of the variable part of the Primary Care Baseline Funding.

The MINISTER OF HEALTH, in the exercise of his duties and

Considering the National Primary Care Policy defined by Rule No. 648/GM of March 28, 2006, which regulates the performance of primary health care actions at the SUS;

Considering Rule No. 204/GM of January 29, 2007, which regulates the funding and transfer of federal funds to health actions and services in the form of financing blocks; and

Considering the joint responsibility of the Federal Government, States, Federal District, and Municipalities for funding the Unified Health System,

RESOLVES:

Article 1. To regulate the transfer, for the year 2007, of financial incentives for the Compensation of Regional Specificities – CER, a component of the variable part of the Primary Care Baseline Funding.

Article 2. To determine that the amount of federal funds referred to in Article 1 of this Rule shall correspond to a percentage of the minimum amount of the Fixed PAB multiplied by the population of each State and the Federal District.

Paragraph 1. The percentages referred to above in this Article shall be defined upon stratification of the levels of the Human Development Index – HDI of each Federation Unit, as described below:

I – 9% to Federation Units with an HDI of up to 0.7;

II – 7% to Federation Units with an HDI greater than 0.7 or equal to 0.755; and

III – 5% to Federation Units with an HDI greater than 0.755.

Paragraph 2. The population considered in calculating the CER incentive shall be used to calculate the fixed PAB as of the date of publication of this Rule.

Article 3. To publish, in accordance with the Annex to this Rule, the maximum amount of the CER incentive per State and for the Federal District.

Article 4. To determine that the Departments of Health of the States and Federal District shall send to the Department of Primary Care, Secretariat of Health Care of the Ministry of Health documentation containing the criteria for allocation of the funds referred to in this Rule, a list of Municipalities with the amounts and period of transfer of the funds, as well as the calculation sheet, as agreed by the relevant Bipartite Commission of Managers.

Article 5. To establish that the budget funds referred to in this Rule shall come from the Ministry of Health's budget and shall charge Work Program 10.3011214.8577 – Primary Care Service in Brazilian Municipalities.

Article 6. This Rule shall become effective on the date of publication, with financial effect from the fiscal month of June 2007.

JOSÉ GOMES TEMPORÃO

# Annex

| Federation Unit | Estimated Population IBGE 2006 | Annual incentive | Monthly incentive |
|---|---|---|---|
| DF | 2,383,784 | 1,787,838.00 | 148,986.50 |
| SC | 5,958,266 | 4,468,699.50 | 372,391.63 |
| SP | 41,055,734 | 30,791,800.50 | 2,565,983.38 |
| RS | 10,963,219 | 8,222,414.25 | 685,201.19 |
| RJ | 15,561,720 | 11,671,290.00 | 972,607.50 |
| PR | 10,387,378 | 7,790,533.50 | 649,211.13 |
| MS | 2,297,981 | 1,723,485.75 | 143,623.81 |
| GO | 5,730,753 | 4,298,064.75 | 358,172.06 |
| MG | 19,479,356 | 14,609,517.00 | 1,217,459.75 |
| MT | 2,856,999 | 2,142,749.25 | 178,562.44 |
| ES | 3,464,285 | 2,598,213.75 2 | 16,517.81 |
| AP | 615,715 | 646,500.75 | 53,875.06 |
| RR | 403,344 | 423,511.20 | 35,292.60 |
| RO | 1,562,417 | 1,640,537.85 | 136,711.49 |
| PA | 7,110,46 | 57,465,988.25 | 622,165.69 |
| AM | 3,321,050 | 3,487,102.50 | 290,591.88 |
| TO | 1,332,441 | 1,399,063.05 | 11 6,588.59 |
| PE | 8,502,603 | 8,927,733.15 | 743,977.76 |
| RN | 3,043,760 | 3,195,948.00 | 266,329.00 |
| CE | 8,217,085 | 11,093,064.75 | 924,422.06 |
| AC | 676,628 | 913,447.80 | 76,120.65 |
| BA | 13,950,146 | 18,832,697.10 | 1,569,391.43 |
| SE | 2,000,738 | 2,700,996.30 | 225,083.03 |
| PB | 3,623,215 | 4,891,340.25 | 407,611.69 |
| PI | 3,036,290 | 4,098,991.50 | 341,582.63 |
| AL | 3,050,652 | 4,118,380.20 | 343,198.35 |
| MA | 6,184,538 | 8,349,126.30 | 695,760.53 |

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