

Brazilian National Primary Care Policy (2006-2026): Induction layers and a future agenda

Política Nacional de Atenção Básica (2006-2026): camadas de indução e agenda futura

Política Nacional de Atención Básica (2006-2026): capas de inducción y agenda futura

Aline Gonçalves Pereira¹, Dirceu Ditmar Klitzke², Ana Cláudia Cardozo Chaves³, Hannah Carolina Tavares Domingos¹, Ana Júlia Tomasini², José Félix de Brito Júnior³, Luciana Gonzaga de Oliveira¹

DOI: 10.1590/2358-28982026151118251

ABSTRACT This qualitative study analyzes the trajectory of Brazil's National Primary Care Policy (PNAB) from 2006 to 2026 by linking normative revisions, policy-induction instruments, political-fiscal conditions, and public health emergencies. Federal acts and institutional documents were examined through documentary analysis, complemented by narrative synthesis. 'Induction layers' were defined as incremental sets of regulatory, financial, organizational, informational, and relational instruments that operationalize Primary Health Care (PHC). Documents were classified into ten dimensions: care organization; professional practice; care modalities; oral health; equity; workforce provision and training; infrastructure and digital transformation; co-financing; management and governance; relationships, participation, and co-responsibility; and emergency response. Findings indicate that the PNAB remains a core norm, accompanied by institutional layering and conversion. The 2017 revision increased organizational flexibility amid fiscal constraint, while later instruments intensified induction through financing, information, and equity. The future agenda depends on coherence among equitable financing, workforce stability, regional coordination, digital transformation, continuous care, social participation, and protection of PHC attributes.

KEYWORDS Primary Health Care. Health policy. Unified Health System. Health equity. Continuity of patient care.

RESUMO Este estudo qualitativo analisa a trajetória da Política Nacional de Atenção Básica (PNAB) no Brasil entre 2006 e 2026, articulando revisões normativas, instrumentos de indução, condicionantes político-fiscais e emergências em saúde pública. Realizou-se uma análise documental de atos federais e de documentos institucionais, complementada por uma síntese narrativa da literatura. As 'camadas de indução' foram definidas como conjuntos incrementais de instrumentos regulatórios, financeiros, organizacionais, informacionais e relacionais que operacionalizam a Atenção Primária à Saúde (APS). Os documentos foram classificados em dez dimensões: organização do cuidado; atuação profissional; modalidades assistenciais; saúde bucal; equidade; provimento e formação; infraestrutura e transformação digital; cofinanciamento; gestão e governança; relações, participação e corresponsabilização; e resposta a emergências. Os resultados indicam a permanência da PNAB como norma-núcleo, acompanhada de processos de adição e conversão institucional. A revisão de 2017 ampliou a flexibilidade organizativa em contexto de restrição fiscal, enquanto instrumentos posteriores intensificaram a indução por cofinanciamento, informação e equidade. Conclui-se que a agenda futura depende da coerência entre cofinanciamento, força de trabalho, coordenação regional, transformação digital, continuidade do cuidado e proteção dos atributos da APS.

PALAVRAS-CHAVE Atenção Primária à Saúde. Política de saúde. Sistema Único de Saúde. Equidade em saúde. Continuidade da assistência ao paciente.

RESUMEN Este estudio cualitativo analiza la trayectoria de la Política Nacional de Atención Básica (PNAB) en Brasil entre 2006 y 2026, articulando revisiones normativas, instrumentos de inducción, condicionantes político-fiscales y emergencias de salud pública. Se realizó un análisis documental de actos federales y de documentos institucionales, complementado por síntesis narrativa. Las 'capas de inducción' fueron definidas como conjuntos incrementales de instrumentos regulatorios, financieros, organizativos, informacionales y relacionales que operacionalizan la Atención Primaria de Salud (APS). Los documentos se clasificaron en diez dimensiones: organización del cuidado; actuación profesional; modalidades asistenciales; salud bucal; equidad; provisión y formación; infraestructura y transformación digital; cofinanciamiento; gestión y gobernanza; relaciones, participación y corresponsabilidad; y respuesta a emergencias. Los resultados indican la permanencia de la PNAB como norma-núcleo, acompañada de adición y conversión institucional. La revisión de 2017 amplió la flexibilidad organizativa en un contexto de restricción fiscal, mientras que instrumentos posteriores intensificaron la inducción mediante financiamiento, información y equidad. La agenda futura depende de la coherencia entre financiamiento, fuerza de trabajo, coordinación regional, transformación digital, cuidado continuo, participación social y atributos de la APS.

PALABRAS CLAVE Atención Primaria de Salud. Política de salud. Sistema Único de Salud. Equidad en salud. Continuidad de la atención al paciente.

¹Ministério da Saúde (MS), Secretaria de Atenção Primária à Saúde (Saps), Gabinete da Secretaria de Atenção Primária à Saúde – Brasília (DF), Brasil.

²Ministério da Saúde (MS), Secretaria de Atenção Primária à Saúde (Saps), Departamento de Estratégias, Acreditação e Componentes da Atenção Primária à Saúde (Deaps) – Brasília (DF), Brasil. anajulia.tomasini@gmail.com

³Ministério da Saúde (MS), Secretaria de Atenção Primária à Saúde (Saps), Departamento de Saúde da Família (Desf) – Brasília (DF), Brasil.

Introduction

Primary Health Care (PHC) is the cornerstone of health systems because it combines first-contact access, longitudinality, comprehensiveness, and care coordination, together with derived attributes related to family and community orientation and cultural competence¹. In Brazil, the Family Health Strategy (ESF) consolidated a territory-based, multiprofessional arrangement consistent with this framework², with effects associated with reductions in infant mortality and deaths from cardiovascular and cerebrovascular diseases^{3,4}.

The National Primary Health Care Policy (PNAB) is the main federal regulatory framework guiding PHC within the Brazilian Unified Health System (SUS). Established in 2006 and revised in 2011 and 2017, it sets guidelines, responsibilities, and organizational parameters while interacting with programs, incentives, and cofinancing arrangements that shape its implementation across territories⁵⁻⁷. Although the legal designation remains 'Primary Care', the contemporary agenda requires recognition that PHC has assumed broader responsibilities for coordinating care trajectories and integrating surveillance, health promotion, prevention, treatment, rehabilitation, oral health, continuous care, and social participation.

The 2017 revision was accompanied by intense technical and political dispute. The literature describes controversies regarding the care model, team composition, national minimum standards, local autonomy, Community Health Workers, and ESF's sustainability in a context of political and fiscal constraints⁸⁻¹⁵. The establishment of the New Fiscal Regime through Constitutional Amendment N° 95/2016 set long-term limits on federal primary expenditures, with potential effects on the share of public health expenditure in Gross Domestic Product and on its availability in per capita terms^{16,17}. This controversy cannot be reduced to textual comparisons among ministerial ordinances: the policy also changes through adjacent policy

instruments, such as cofinancing, information systems, workforce provision, digitalization, thematic health care networks, and emergency responses^{18,19}.

In this study, 'policy-steering layers' refer to incremental sets of regulatory, financial, organizational, informational, and relational instruments that operationalize PHC, shape the behavior of managers and teams, and condition the actual delivery of care. The matrix engages with the debate on policy mix, which focuses on coherence among instruments²⁰, and with gradual institutional change, particularly layering, understood as the addition of new rules and arrangements to a preexisting structure²¹. The layers were organized into ten dimensions: care organization; professional practice; care delivery modalities; oral health; equity; workforce provision and training; infrastructure and digital transformation; cofinancing; management and governance; relationships, participation, and shared responsibility; and emergency response.

PNAB was retained in the title because it is the official designation used in the ministerial ordinances analyzed and reflects a historical construction specific to the SUS. At the same time, the article recognizes that the future policy agenda is situated within the broader debate on PHC, given the contemporary expansion of its functions within the health system: care coordination, network integration, surveillance, health promotion, social participation, equity, and longitudinal follow-up of people's care trajectories. This distinction avoids reducing the debate to a terminological change and allows it to be situated within the systemic responsibilities of the Brazilian PHC.

This study aimed to analyze the trajectory of the PNAB from 2006 through June 2026, identifying the policy-steering mechanisms incorporated into its implementation and examining their implications for the care model, territorial equity, regional coordination, continuous care, and the future PHC agenda within the SUS.

Materials and methods

Study design

This qualitative study comprised documentary analysis and a narrative synthesis of regulations, federal acts, and publicly available institutional documents. Documentary analysis was adopted to rebuild policy trajectories through systematic reading, extraction, organization, and thematic interpretation of content²². Narrative synthesis was used to integrate controversies and evidence from heterogeneous fields, following guidance on transparency, logical coherence, and assessment of interpretive robustness²³.

Documentary *corpus* and analytical strategy

The *corpus* covered the period from March 2006 to June 2026 and included 48 documents: the 2006, 2011, and 2017 versions of the PNAB; federal acts and regulations establishing programs, strategies, teams, and initiatives with a direct interface with PHC; frameworks for regionalization, health care networks, regulation, cofinancing, digital health, oral health, and emergency response; and political-fiscal documents with potential implications for SUS sustainability.

The narrative literature included 26 studies addressing PHC attributes, the 2017 PNAB revision, cofinancing, equity, crisis response, and institutional change. For presentation of the findings, the period was organized into four historical windows grouping federal government cycles identified by letters, without personalizing the analysis of governments: 2006-2011 (Cycles A-B; onset of C), 2011-2017 (Cycles C-D), 2017-2022 (end of Cycle D; Cycle E), and 2023-2026 (Cycle F, considered through June 2026).

Document selection was purposive and theory-oriented, prioritizing acts that could potentially alter PHC operational capacities

– access, longitudinality, comprehensiveness, coordination, community orientation, oral health, participation, and care continuity – and their integration with specialized care. Documents were located in official federal government repositories, the Brazilian Ministry of Health Virtual Health Library, and institutional webpages of the agencies responsible for the acts analyzed.

For purposes of historical organization, neutral terminology was adopted for federal government cycles: Cycle A (2003-2006, included in the *corpus* from March 2006); Cycle B (2007-2010); Cycle C (2011-2014); Cycle D (2015-2018); Cycle E (2019-2022); and Cycle F (2023-2026, included in the *corpus* through June 2026). This terminology enables us to situate the period's political-institutional inflections without personalizing the analysis.

The following information was extracted for each document: object, purpose, predominant mechanism – regulation, incentive or cofinancing, information, organization of care, intersectoral action, or relational policy steering – the corresponding layer, and potential implications for PHC attributes. The layers were defined based on recurring dimensions across the PNAB versions and refined through cross-cutting synthesis of the findings, particularly regarding care relationships, user participation, shared responsibility, and care continuity trajectories. The second author reviewed extraction, classification, and synthesis; disagreements were discussed until consensus was reached.

After the findings were aggregated by layer, a cross-cutting synthesis was conducted to identify recurring structural tensions across different federal government cycles or instruments, as supported or problematized by the literature. The future agenda was developed from these tensions, distinguishing dimensions that depend predominantly on regulatory changes from those requiring implementation, regional governance, cofinancing, information infrastructure, and stronger care relationships.

Use of artificial intelligence

OpenAI® ChatGPT was used exclusively to support language review and grammatical correction. The definition of the study object, source selection, documentary analysis, interpretation of results, and conclusions were developed by the authors, who assume full responsibility for the final content.

Ethical considerations

Submission to a Research Ethics Committee was not required because this study was based on public documents and scientific literature and involved no identifiable human participants.

Results

The analysis showed that the trajectory of the PNAB between 2006 and 2026 combines a core regulatory framework with policy-steering layers that accumulate, shift in relative weight, and produce practical effects on PHC. The findings were organized into three tables for presentation: *Table 1* presents the key regulatory milestones; *table 2* gathers programs, strategies, and policy-steering instruments; and *table 3* integrates the political-fiscal context, institutional changes, and critical events.

Table 1. Historical timeline of the National Primary Health Care Policy (PNAB) and key regulatory milestones shaping Primary Health Care (PHC) (2006-2026), by federal government cycle

Historical window (federal cycles)	Foundational regulatory frameworks	What has changed for PHC	Coordination with induction-hardened layers
2006-2011 (Cycles A: 2003-2006; B: 2007-2010; onset of C: 2011-2014)	PNAB 2006 (Ordinance nº 648/2006)	Consolidates national guidelines and reaffirms the Family Health Strategy (ESF) as the organizing axis of Primary Health Care, strengthening territorialization, population assignment, longitudinal relationships, and accountability for population health. During this period, the expansion of PHC fostered complementary instruments and the progressive incorporation of oral health into territory-based care.	Creates room for complementary policy instruments – intersectoral action, matrix support, care technologies, oral health, and strengthened teamwork – which gained greater prominence during this period.
2011-2017 (Cycles C: 2011-2014; D: 2015-2018)	PNAB 2011 (Ordinance nº 2.488/2011); Decree nº 7.508/2011; PNAB 2017 (Ordinance nº 2.436/2017)	The 2011 PNAB further developed organizational parameters and strengthened care coordination, longitudinality, and network-based integration. The 2017 revision increased regulatory flexibility and reframed the debate on minimum standards, team composition, and equity, while preserving the ESF as the priority model. Territory-specific care modalities were also consolidated, including Street Clinic teams, riverside and river-based teams, and prison-based primary care.	Consolidates and expands policy instruments related to quality improvement/performance, information, workforce provision, care delivery modalities, equity, oral health, and integration within health care networks, with greater requirements for care coordination in specific territories.
2017-2022 (end of Cycle D; Cycle E: 2019-2022)	2017 PNAB as the current policy framework, with implementation amid changes in policy instruments	The policy remains in force, but sublegal and programmatic instruments – particularly cofinancing and health information mechanisms – have assumed greater importance in guiding priorities and monitoring. Oral health and territory-specific care modalities remain integrated into PHC but have been affected by changes in financing arrangements, indicators, and programmatic priorities.	A shift toward policy steering primarily through financial and information instruments became consolidated, accompanied by the restructuring of programs and priorities and greater demands for data management. In parallel, participatory bodies were weakened and social oversight was undermined – as exemplified by Decree Nº 9.759/2019 – reducing opportunities for deliberation and social consensus-building.

Table 1. Historical timeline of the National Primary Health Care Policy (PNAB) and key regulatory milestones shaping Primary Health Care (PHC) (2006-2026), by federal government cycle

Historical window (federal cycles)	Foundational regulatory frameworks	What has changed for PHC	Coordination with induction-hardened layers
2023-2026 (Cycle F: 2023-2026)	Recalibration of federal cofinancing (GM/MS Ordinance Nº 3.493/2024); SUS Digital Program (GM/MS Ordinance No. 3.232/2024); Alyne Network (GM/MS Ordinance No. 5.350/2024); incentives for specific teams and vulnerable territories (GM/MS Ordinance Nº 7.799/2025; GM/MS Ordinance Nº 9.572/2025).	Strengthens operational governance and implementation criteria, bringing regulatory guidelines into closer alignment with cofinancing, quality, and data instruments. It increases the centrality of network-based care coordination, integration with specialized care, and the rebuilding of PHC institutional capacities, including oral health, home care supported by eMulti teams, riverside and river-based teams, Street Clinic teams, mobile units, border-area teams, prison-based primary care, and incentives such as eQuilombola.	Increases the density of policy components –equity, multiprofessional care, home care, territory-specific care modalities, quality, infrastructure, digital health, and oral health – and intensifies operational coordination for populations and territories facing longstanding barriers to access.

Source: Prepared by the authors based on the study's documentary corpus (Brazil, 2006-2026).

In the 2006-2011 historical window, encompassing the end of Cycle A, Cycle B, and the onset of Cycle C, the PNAB consolidated national guidelines, reaffirmed the ESF as the organizing axis, and accompanied the expansion of teams, federal cofinancing, matrix support, and support technologies. Layering prevailed during this period: new initiatives were added to the core policy framework without altering its main orientation, expanding the scope of care, intersectoral action, clinical capacity, oral health, and territorial presence^{5,24}.

In the 2011-2017 historical window, encompassing Cycle C and Cycle D, the 2011 PNAB further developed organizational parameters and strengthened care coordination in conjunction with regionalization and health care networks^{6,15}. The National Program for Improving Access and Quality in Primary Care (PMAQ), the Health Information System for Primary Care (SISAB/e-SUS APS), the More Doctors Program (Programa Mais Médicos), the PHC Unit Requalification Program (Requalifica UBS), Home Care, and Street Clinic teams exemplify additions that strengthened evaluation, information, workforce provision, infrastructure, and care delivery modalities. This represents layering oriented toward expanding capacities and

formalizing quality standards.

The 2017 PNAB marked a regulatory inflection. The policy preserved the ESF as the priority model but increased organizational flexibility, recognized arrangements not equivalent to Family Health teams, and reopened disputes over Community Health Worker coverage, national standards, and equity⁷⁻¹⁴. The effect was not the immediate replacement of the ESF, but rather an expansion of the regulatory repertoire available to managers, creating conditions for gradual changes dependent on local capacities.

In the 2017-2022 historical window, corresponding to the end of Cycle D and Cycle E, sublegal, financial, and informational instruments gained greater weight. Previne Brasil, Informatiza APS, the PHC Service Portfolio, and institutional reorganizations shifted part of policy steering toward population registration, record-keeping, indicators, and data management²⁵⁻²⁸. This period reflects institutional conversion: existing instruments, especially cofinancing and information, began to steer new organizational behaviors even though the PNAB remained the current regulatory framework.

In the 2023-2026 historical window, corresponding to Cycle F, multiprofessional care rebuilding, cofinancing recalibration, SUS Digital, the Alyne Network, and regulatory and quality

instruments increased the density of the policy mix²⁹⁻³⁴. Federal policy steering came to combine equity, patient-team relationships, quality, infrastructure, digital transformation, integration between PHC and specialized care, and continuous care. In this cycle, territory-specific care modalities and specific incentives – riverside and river-based teams, Street Clinic teams and mobile units, border-area teams, prison-based

primary care, and eQuilombola – show that equity requires differentiated arrangements for historically underserved territories. Oral health is a component of comprehensiveness and territorial equity.

Table 2. PHC institution-building initiatives by federal government cycle and policy-steering layers (2006-2026)

Historical window (federal cycles)	Institution-building initiatives (examples)	Prevailing policy-steering layer	PHC strategic function
2006-2011 (Cycles A-B; onset of C)	School Health Program (PSE); Guidelines for the Organization of the Health Care Network (RAS); Telehealth; Family Health Support Center (NASF)/matrix support; Health Pact; publication of the Bolsa Família Program's conditionalities; the Brazilian Popular Pharmacy Program; expansion of Oral Health Teams within the ESF.	Intersectoral action; technology; multiprofessional support; oral health.	Expands comprehensiveness, health education, intersectoral coordination, and the teams' clinical and care delivery capacity. Oral health strengthens the understanding of PHC as comprehensive, territory-based, and multiprofessional care.
2011-2017 (Cycles C-D)	PMAQ; SISAB/e-SUS APS; More Doctors Program (Programa Mais Médicos); thematic health care networks and care pathways; Requalifica UBS Program; Home Care; Street Clinic teams; riverside and river-based teams; prison-based primary care; Provab; PHC unit support sites and formal recognition of the PHC unit manager role; renaming of Nasf as Nasf-AB; integration of health surveillance and PHC; scope of PHC practices; minimum salary for Community Health Workers (ACS); inclusion of Oral Health Teams in quality improvement and monitoring instruments.	Quality improvement/performance; information; workforce provision; infrastructure; territory-specific care modalities; thematic health care networks; oral health; equity.	Standardizes assessments and incentives; strengthens monitoring; addresses workforce shortages; supports longitudinality; expands installed capacity; and requires integration between PHC and specialized care. Territory-specific care modalities expand PHC's capacity to reach populations experiencing homelessness, riverine and water-based populations, prison populations, and communities in hard-to-reach territories.
2017-2022 (end of Cycle D; Cycle E)	Saúde na Hora Program; Previne Brasil; greater flexibility in medical workload arrangements; Informatiza APS; Primary Health Care Service Portfolio (CaSAPS); Doctors for Brazil Program (Programa Médicos pelo Brasil); restructuring of incentives and monitoring parameters affecting teams, territory-specific care modalities, and Oral Health actions.	Access; cofinancing; digital transformation; information governance; service portfolio; oral health; care delivery modalities.	Reorganizes access and incentives; increases data's centrality, population registration, and monitoring; accelerates digitalization; and reframes priorities within PHC. Territory-specific care modalities and oral health remain comprehensive care dimensions but are increasingly shaped by financing, reporting, performance, and service delivery arrangements.
2023-2026 (Cycle F)	Rebuilding of workforce provision and multiprofessional care; eMulti and multiprofessional support for home care; new cofinancing arrangements; new PHC quality indicators; SUS Digital; Alyne Network; strategic infrastructure investments; relaunch of the Popular Pharmacy Program of Brazil; unification of workforce provision programs; strengthening of Brasil Sorridente and Mobile Dental Units; riverside and river-based teams; Street Clinic teams and affiliated mobile units; border-area teams; prison-based primary care; equity-oriented incentives, such as eQuilombola.	Cofinancing and governance; territorial equity; multiprofessional care; home care; territory-specific care modalities; digital transformation; network integration; quality; oral health.	Intensifies federal policy steering across multiple layers, strengthening local capacities, care coordination, and integration between PHC and specialized care. Home care supported by eMulti teams expands the capacity to provide continuous, shared, and territory-based care. Equity no longer appears solely as a general principle but is increasingly operationalized through differentiated arrangements for riverside populations, people experiencing homelessness, border territories, prison populations, Quilombola communities, and territories facing longstanding barriers to access.

Source: Prepared by the authors based on the study's documentary corpus (Brazil, 2006-2026).

Comparison across the groupings of federal government cycles indicates a qualitative change. The period comprising the end of Cycle A and Cycle B expanded basic capacities; Cycle C and the beginning of Cycle D refined evaluation, information, workforce provision, networks, and territory-specific care modalities; the end of Cycle D and Cycle E concentrated policy steering on cofinancing, population registration, and monitoring; and Cycle F diversified redistributive, multiprofessional, digital, structural, relational, and territory-based instruments. This trajectory shows that the policy does not operate only through ministerial ordinances: it takes shape through the interaction of rules, incentives, infrastructure, living labor in health care, patient-team

relationships, regional coordination capacity, and mechanisms capable of delivering care to riverside populations, people experiencing homelessness, border populations, people in the prison system, and Quilombola territories.

This periodization also shows that PHC's density increased without a new PNAB formally replacing the 2017 version. The shift occurs through the accumulation and reorientation of instruments: some expand capacities, such as workforce provision, multiprofessional teams, and infrastructure; others reorder priorities, such as cofinancing, indicators, and information systems; and still others place strain on the model, such as emergency responses that may suspend or weaken longitudinal care.

Table 3. Political-fiscal and institutional context and critical events in the trajectory of PHC and the PNAB (2006-2026)

Historical window (federal cycles)	Political-fiscal and institutional contextual milestones	Public health emergencies / critical events	Implications for PHC and for interpreting the PNAB
2006-2011 (Cycles A-B; onset of C)	Expansion of PHC and incremental strengthening of local capacities; federal policy steering through complementary instruments; expansion of the ESF and Oral Health Teams as part of efforts to strengthen territorialization and comprehensive care.	Weak integration between PHC and health surveillance in responding to public health emergencies; the influenza A(H1N1)pdm09 pandemic as a critical event for surveillance, vaccination, and territory-based response.	The context of expansion supports the implementation of the PNAB as the core policy framework and the development of complementary policy-steering instruments. At the same time, it highlights the need to integrate clinical care, health surveillance, health promotion, oral health, and intersectoral actions at the territorial level.
2011-2017 (Cycles C-D)	Regionalization and health care networks gained institutional grounding with Decree No. 7.508/2011; instruments for quality improvement, workforce provision, infrastructure, information, territory-specific care modalities, and network organization were intensified.	Zika and microcephaly, with the declaration of a Public Health Emergency of National Importance and international recognition of the emergency.	PHC is increasingly expected to ensure network-based care coordination, integration with specialized care, and territory-based response capacity. These crises test the integration between health surveillance and care, including longitudinal follow-up, care for pregnant women, child development, oral health, family care, community support, and the capacity to reach specific territories.
2017-2022 (end of Cycle D; Cycle E)	Implementation of the 2017 PNAB under the effects of the New Fiscal Regime established by Constitutional Amendment N° 95/2016, with greater pressure for efficiency, monitoring, and the reconfiguration of policy-steering instruments; an intensified role for information, population registration, indicators, and cofinancing.	COVID-19, with the declaration of a Public Health Emergency of National Importance, and mpox, recognized as a Public Health Emergency of International Concern, with implications for surveillance, case reporting, organization of access, and continuity of care.	These crises require the maintenance of longitudinal care and the reorganization of access under conditions of system overload. They reinforce the need for resilient PHC, integrated health surveillance, network-based care coordination, and the preservation of care that cannot be interrupted, including care for chronic conditions, mental health care, vaccination, maternal and child health care, oral health, home care, and care for populations living in vulnerable territories.

Table 3. Political-fiscal and institutional context and critical events in the trajectory of PHC and the PNAB (2006-2026)

Historical window (federal cycles)	Political-fiscal and institutional contextual milestones	Public health emergencies / critical events	Implications for PHC and for interpreting the PNAB
2023-2026 (Cycle F)	Post-international emergency transition for COVID-19; recalibration of cofinancing; digital health as a structuring axis; rebuilding of multiprofessional care; expansion of investments; reorganization of thematic health care networks; and territorial targeting of incentives for vulnerable populations and specific contexts.	Persistent epidemic waves, including arboviral diseases; migration flows involving migrants, refugees, and stateless persons; flooding in Rio Grande do Sul and other extreme climate events; environmental, humanitarian, and social emergencies; and a growing need for territory-based preparedness and response.	The agenda shifts toward ensuring coherence among the regulatory framework, cofinancing, quality, digital health, the health workforce, and territorially appropriate infrastructure. Integration between PHC and specialized care becomes a practical requirement for care coordination. Resilience comes to be understood as a strategic capacity of PHC, requiring continuity of care, home care supported by eMulti teams, community-based approaches, social participation, integrated oral health care, crisis-ready physical, technological, and logistical configurations of PHC units, and the capacity to follow life trajectories in contexts of inequality.

Source: Prepared by the authors based on the study’s documentary corpus and the emergency response documents analyzed.

Public health emergencies acted as stress tests. Zika, COVID-19, mpox, arboviral diseases, migration flows involving migrants, refugees, and stateless persons, Rio Grande do Sul flooding, and other extreme climate events revealed that PHC depends on preestablished capacities to integrate surveillance, care, risk communication, vaccination, mental health, oral health, home care, and follow-up of chronic conditions. Resilience, therefore, is not an isolated attribute but a strategic capacity produced by cofinancing, the health workforce, interoperable information, community presence, care continuity, and infrastructure suited to territorial vulnerabilities.

This perspective shifts the PHC agenda beyond the organization of teams and care flows to include the physical, technological, and logistical configurations of Primary Health Care Units (UBS). Units capable of operating under climate instability, power outages, population displacement, access barriers, service overload, and the need for rapid territory-based response become essential to sustaining continuous, safe, and equitable care.

The cross-cutting synthesis identified five structural tensions: a comprehensive national model versus local flexibility; equity-oriented

policy steering versus unequal territorial capacities; quality improvement through cofinancing, indicators, and information versus the risk of administrative compliance; coordination assigned to PHC versus fragmented health care networks; and care continuity in the face of emergencies, chronic conditions, population flows, and social, technological, environmental, and climate transformations. These tensions underpin the discussion and the future agenda.

Discussion

This article primarily interprets the PNAB not merely as a succession of ministerial ordinances, but also as a policy in motion whose capacity to deliver PHC depends on coherence among policy-steering instruments, care relationships, regional coordination, and continuity of people’s care trajectories across territories. This perspective avoids reducing the policy to its regulatory text and makes it possible to understand how cofinancing, information, teams, networks, oral health, participation, and emergencies redefine implementation priorities.

PNAB 2017: Regulatory inflection and implementation conditions

The 2017 PNAB requires an ambivalent analysis: on the one hand, it maintained territorialization, population assignment, care coordination, and ESF's stated priority; on the other, it made parameters more flexible, recognized other team configurations, and differentiated essential and expanded standards⁷⁻¹⁴. The central issue is not flexibility itself, but the context in which it operates. In municipalities with adequate cofinancing, health professionals, connectivity, regulation, and specialized care support, adaptation may expand access. In vulnerable territories, it may legitimize limited service offerings and deepen segmentation.

Evidence indicates that the 2017 PNAB did not immediately replace the ESF with other arrangements, but it altered the field of institutional possibilities¹². Its most relevant effect is gradual: by shifting minimum standards, team composition, and local decision-making latitude, the policy began to interact with the New Fiscal Regime^{16,17}, as well as with changes in workforce provision, cofinancing, and information systems. This context does not, by itself, explain the regulatory revision. Still, it helps clarify the inflections that unfolded in the PNAB and its implementation instruments: greater regulatory flexibility, pressure for efficiency, monitoring's growing centrality, cofinancing reconfiguration, and disputes over national minimum standards, equity, and the sustainability of the ESF. Thus, criticism of the 2017 PNAB must be linked to concrete implementation conditions and to the capacity of the Brazilian federative system to protect essential PHC attributes.

Intergovernmental tension is decisive for interpreting this inflection. The 2017 PNAB increased municipalities' latitude for adaptation, but local autonomy does not have the same meaning in every territory. Where there are workforce shortages, limited administrative capacity, or heavy dependence on

federal transfers, flexibility may operate less as innovation and more as authorization for minimum standards. This is where regulation, cofinancing, and intergovernmental inequality intersect.

The PHC Service Portfolio may support transparency and planning³⁵, including by explicitly defining oral health services, care for chronic conditions, mental health care, and preventive actions. However, without an adequate workforce, supplies, continuing professional development, regulation, and integration with specialized care, the scope may be appropriated as a checklist of procedures detached from longitudinality, community orientation, and shared clinical responsibility.

Territorial equity, the Equity and Sizing Index, and the risk of unequal implementation

The risk that uniform instruments may widen inequalities stems from municipal heterogeneity. Identical rules apply to territories with markedly different capacities for record-keeping, connectivity, workforce provision, infrastructure, rurality, population dispersion, logistics, specialized care availability, and organization of oral health services. Equity, therefore, depends not only on the formal design of the incentive but, above all, on the adequacy of funding levels, updated underlying databases, and institutional support enabling vulnerable municipalities to meet operational requirements.

The new cofinancing methodology introduced in 2024 partially addressed this problem by incorporating the Equity and Sizing Index (ESI), which combines social vulnerability and population size^{29,30}. This represents an advance over strictly uniform incentives because it recognizes that social needs and provision costs are not evenly distributed. However, its criteria still capture only incompletely rurality, territorial dispersion, Amazonian specificities, migration flows, specialized care access barriers, service

availability gaps, and registration capacity inequalities.

The subsequent expansion of the equity and quality component to riverside teams, Street Clinic teams, and prison-based primary care suggests a progressive correction of the design³¹. The incorporation of border-area teams, mobile units linked to the care of people experiencing homelessness, and specific incentives such as eQuilombola further advances this direction by shifting equity from an abstract principle to operational mechanisms targeting territories and populations facing longstanding barriers to access.

Even so, the ESI should be understood as a necessary, but not sufficient, layer. Its effectiveness will depend on distributive evaluation, database updates, specific incentives, regionalized workforce provision, institutional support, and protection of a stable universal cofinancing base.

In the 2023-2026 historical window, corresponding to Cycle F, the analytical question shifts from whether equity is incorporated into the design of the financial component to whether the overall set of instruments enables unequal municipalities to achieve comparable outcomes. Quality indicators, patient-team relationships, and territorial follow-up can strengthen care when supported by stable teams and useful data; however, they may indirectly penalize territories with greater workforce turnover, poorer connectivity, and wider population dispersion. This tension indicates that the ESI must be linked to institutional support, digital health, workforce provision, and regional integration so that differences in capacity are not converted into differences in performance²⁹⁻³¹.

Cofinancing, digital transformation, and relational policy steering

The Previnhe Brasil Program increased the centrality of population registration, performance, and information quality. Still, it was criticized for shifting part of policy steering away from

territories and toward registered individuals and a limited set of indicators²⁵⁻²⁸. SUS Digital and digitalization expand opportunities for clinical continuity, telehealth, and regional integration^{28,32}, but may also widen inequalities when equipment, connectivity, interoperability, and technical support are insufficient.

The relational layer makes explicit a limitation of administrative instruments. No ministerial ordinance produces care on its own: relationships, trust, communication, collaborative work, active user participation, family support, and shared responsibility bring the policy to life. These elements do not replace cofinancing, information, or regulations; rather, they indicate that their effectiveness depends on sufficient team time, workforce stability, continuing professional development, community-based approaches, and governance that recognizes living labor in health care.

In this regard, digital transformation should support clinical and community decision-making rather than merely increase recordkeeping requirements. Useful information is information that supports follow-up, active outreach, shared care plans, patient safety, oral health care, remote monitoring when appropriate, and communication across points of the health care network. Digitalization weakens PHC's relational capacity when it becomes an exercise in administrative compliance.

Future agenda: From regulations to care trajectories

The literature and the documentary *corpus* suggest that the future agenda should not begin by rejecting previous versions of the PNAB, but by critically selecting their achievements and inconsistencies^{5-14,24,29-35}. The 2006 version established the centrality of the ESF, territorialization, and accountability for population health. The 2011 revision further developed PHC organization and strengthened network integration, multiprofessional care, evaluation, oral health, and care delivery modalities. The 2017 PNAB, in turn, recognized

territorial diversity and the need for local adaptation while also making more visible the risks of flexibility without protection of national standards, segmented access, and weakened federal coordination.

Thus, the future agenda requires a policy that can combine a strong universal foundation, equitable cofinancing, differentiated territory-specific care modalities, integrated oral health, continuous care, home care with multiprofessional support, social participation, digital transformation that is useful for care, and resilient infrastructure to address contemporary inequalities and emergencies.

The future agenda cannot be reduced to issuing a new ministerial ordinance. Part of it depends on regulatory changes, such as explicitly defining national parameters that protect the ESF, updating cofinancing rules, and strengthening integration among PHC, regulation, and specialized care. Another part depends on implementation: workforce provision, connectivity, infrastructure, continuing professional development, institutional support, regional negotiation and agreement, and social participation mechanisms. The central tension lies in combining stable principles with territorial adaptation without legitimizing unequal standards.

In the short term, the greatest political-institutional feasibility lies in improving existing instruments: refining the ESI, evaluating its distributive effects, reducing the recordkeeping burden, improving indicators, and strengthening eMulti teams, oral health, telehealth, and regional regulation. More profound changes, such as reorganizing the PNAB around care trajectories, require intergovernmental negotiation and broader social debate. This means shifting the policy focus toward people's concrete experiences within the health care network: how they access services, keep relationships with teams, move between PHC and specialized care, and receive continuous care in the face of chronic conditions, vulnerabilities, and emergencies.

Chronic conditions and multimorbidity make this shift visible. The challenge is no longer to coordinate services, but to follow people over years or decades by integrating professionals, technologies, supported self-management, oral health, mental health, specialized care, home care, family and community support, and palliative care when needed. Continuous care is not merely the persistence of a relationship; it is the capacity to sustain safe, comprehensive, and lifelong shared care trajectories.

The agenda also contains internal tensions. Expanding digital health may support continuity but can create new inequalities if not accompanied by connectivity, equipment, and support. Strengthening indicators may steer quality improvement but can reduce care to what is measurable. Expanding care modalities and teams may increase comprehensiveness but can fragment responsibilities in the lack of regional coordination. Therefore, the future agenda must be conceived as a coherent combination of instruments rather than as the sum of programs.

Social participation, community-based approaches, and intersectoral action cut across all these issues. Councils, intergovernmental negotiation, and mechanisms for listening to communities are needed to identify territorial effects, correct exclusionary instruments, and prevent the quality agenda from being reduced to what is measurable. PHC organized around care trajectories must combine technical quality, safety, equity, and health democracy.

Conclusions

PNAB's trajectory between 2006 and June 2026 reveals gradual institutional change. The policy remains the core regulatory framework, while regulatory, financial, organizational, informational, and relational layers redefine priorities, capacities, and implementation standards. The decisive issue is not only the policy text, but also the coherence of the policy mix that accumulates around it.

The 2017 PNAB was a relevant regulatory inflection, but its effects depend on its interaction with the New Fiscal Regime, workforce provision, cofinancing, information systems, and local capacities. The ESI is a redistributive advance, although it remains insufficient to capture the full complexity of territorial conditions. Public health, climate, and humanitarian emergencies have revealed that resilience depends on prior investments in the health workforce, interoperable information, integrated surveillance, community-based approaches, care continuity, and PHC unit infrastructure prepared to respond to environmental instability, population flows, and operational disruptions.

As a limitation, documentary analysis and narrative synthesis outline trajectories and policy-steering mechanisms but do not estimate causal effects or replace local implementation evaluative studies. The documentary selection may not cover all sublegal acts issued during the period. Even so, cross-validation among regulations, operational instruments, and critical literature supports the historical interpretation presented.

The future PHC agenda within the SUS should align equitable cofinancing, quality, digital health, multiprofessional care, oral health, regional regulation, and social

participation with the preservation of essential PHC attributes. More than organizing services, the policy must sustain continuous, comprehensive, safe, and shared care trajectories, especially in the face of chronic conditions, multimorbidity, aging, territorial inequalities, and critical events. A living PNAB depends on coherent instruments, strong care relationships, and effective integration of health care networks to reduce inequities and sustain a universal SUS.

Authorship contributions

Pereira AG (0000-0001-8231-8538)* contributed to the conception and design of the study, methodology, data analysis and interpretation, drafting, critical review, and approval of the final version of the manuscript. Klitzke DD (0009-0008-0138-9253)*, Chaves ACC (0000-0003-3711-3829), and Domingos HCT (0000-0002-5918-9333)* contributed to methodology, drafting, critical review, and approval of the final version of the manuscript. Tomasini AJ (0000-0002-7900-8878)*, Brito Júnior JF (0009-0008-4142-9889)*, and Oliveira LG (0000-0003-2399-3052)* contributed to critical review and approval of the final version of the manuscript. ■

References

1. Starfield B. Primary care: balancing health needs, services, and technology. New York: Oxford University Press; 1998.
2. Pinto LF, Giovanella L. Do Programa à Estratégia Saúde da Família: expansão do acesso e redução das internações por condições sensíveis à atenção básica. *Ciênc saúde coletiva*. 2018;23(6):1903-14. DOI: <https://doi.org/10.1590/1413-81232018236.05592018>
3. Aquino R, Oliveira NF, Barreto ML. Impact of the Family Health Program on infant mortality in Brazilian municipalities. *Am J Public Health*. 2009;99(1):87-93. DOI: <https://doi.org/10.2105/AJPH.2007.127480>

*Orcid (Open Researcher and Contributor ID).

4. Rasella D, Harhay MO, Pamponet ML, et al. Impact of primary health care on mortality from heart and cerebrovascular diseases in Brazil: a nationwide analysis of longitudinal data. *BMJ*. 2014;349:g4014. DOI: <https://doi.org/10.1136/bmj.g4014>
5. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 648, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS) [Internet]. Diário Oficial da União, Brasília, DF. 2006 mar 29 [acesso em 2026 jul 8]; Edição 61; Seção I:71. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/prtGM648_20060328.pdf
6. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS) [Internet]. Diário Oficial da União, Brasília, DF. 2011 out 24 [acesso em 2026 jul 8]; Seção I-48-55. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html
7. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Diário Oficial da União, Brasília, DF. 2017 set 22 [acesso em 2026 jul 8]; Seção I. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html
8. Morosini MVGC, Fonseca AF, Lima LD. Política Nacional de Atenção Básica 2017: retrocessos e riscos para o Sistema Único de Saúde. *Saúde Debate*. 2018;42(116):11-24. DOI: <https://doi.org/10.1590/0103-1104201811601>
9. Almeida ER, Sousa ANA, Brandão CC, et al. Política Nacional de Atenção Básica no Brasil: uma análise do processo de revisão (2015-2017). *Rev Panam Salud Publica*. 2018;42:e180. DOI: <https://doi.org/10.26633/RPSP.2018.180>
10. Melo EA, Mendonça MHM, Oliveira JR, et al. Mudanças na Política Nacional de Atenção Básica: entre retrocessos e desafios. *Saúde Debate*. 2018;42(Esp 1):38-51. DOI: <https://doi.org/10.1590/0103-11042018S103>
11. Mitros VMS, Rocha RN, Costa NGS, et al. Mudanças na Política de Atenção Básica à Saúde: consensos e contestações em espaços deliberativos do SUS. *Saúde Debate*. 2023;47(138):444-61. DOI: <https://doi.org/10.1590/0103-1104202313806>
12. Gomes CBS, Gutiérrez AC, Soranz D. Política Nacional de Atenção Básica de 2017: análise da composição das equipes e cobertura nacional da Saúde da Família. *Ciênc saúde coletiva*. 2020;25(4):1327-38. DOI: <https://doi.org/10.1590/1413-81232020254.31512019>
13. Giovanella L, Franco CM, Almeida PF. Política Nacional de Atenção Básica: para onde vamos? *Ciênc saúde coletiva*. 2020;25(4):1475-82. DOI: <https://doi.org/10.1590/1413-81232020254.01842020>
14. Mendonça FF, Lima LD, Pereira AMM, et al. As mudanças na política de atenção primária e a (in)sustentabilidade da Estratégia Saúde da Família. *Saúde Debate*. 2023;47(137):13-30. DOI: <https://doi.org/10.1590/0103-1104202313701>
15. Presidência da República (BR). Decreto nº 7.508, de 28 de junho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde – SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências [Internet]. Diário Oficial da União, Brasília, DF. 2011 jun 29 [acesso em 2026 jul 8]; Seção I:1. Disponível em: https://www.planalto.gov.br/ccivil_03/_ato2011-2014/2011/decreto/d7508.htm
16. Presidência da República (BR). Emenda Constitucional nº 95, de 15 de dezembro de 2016. Altera o Ato das Disposições Constitucionais Transitórias, para instituir o Novo Regime Fiscal, e dá outras providências [Internet]. Diário Oficial da União, Brasília, DF. 2016 dez 16 [acesso em 2026 jul 8]; Seção I:2. Disponível em: https://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc95.htm

17. Menezes APR, Moretti B, Reis AAC. O futuro do SUS: impactos das reformas neoliberais na saúde pública – austeridade versus universalidade. *Saúde Debate*. 2019;43(Esp 5):58-70. DOI: <https://doi.org/10.1590/0103-11042019S505>
18. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 1.813, de 11 de novembro de 2015. Declara Emergência em Saúde Pública de Importância Nacional por alteração do padrão de ocorrência de microcefalias no Brasil [Internet]. *Diário Oficial da União*, Brasília, DF. 2015 nov 12 [acesso em 2026 jul 8]; Seção I:51. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt1813_11_11_2015.html
19. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 188, de 3 de fevereiro de 2020. Declara Emergência em Saúde Pública de Importância Nacional em decorrência da infecção humana pelo novo Coronavírus (2019-nCoV) [Internet]. *Diário Oficial da União*, Brasília, DF. 2020 fev 4 [acesso em 2026 jul 8]; Edição 24-A; Seção I:1. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2020/prt0188_04_02_2020.html
20. Howlett M, Rayner J. Design principles for policy mixes: cohesion and coherence in new governance arrangements. *Policy Soc*. 2007;26(4):1-18. DOI: [https://doi.org/10.1016/S1449-4035\(07\)70118-2](https://doi.org/10.1016/S1449-4035(07)70118-2)
21. Mahoney J, Thelen K. A theory of gradual institutional change. In: Mahoney J, Thelen K, editores. *Explaining institutional change: ambiguity, agency, and power*. Cambridge: Cambridge University Press; 2010. p. 1-37.
22. Bowen GA. Document analysis as a qualitative research method. *Qual Res J*. 2009;9(2):27-40. DOI: <https://doi.org/10.3316/QRJ0902027>
23. Popay J, Roberts H, Sowden A, et al. Guidance on the conduct of narrative synthesis in systematic reviews [Internet]. Lancaster: Lancaster University; 2006 [acesso em 2026 jul 8]. Disponível em: <https://www.york.ac.uk/media/crd/Guidance%20on%20the%20conduct%20of%20narrative%20synthesis%20in%20systematic%20review.pdf>
24. Fernandez M, Tasca R, Klitzke DD, et al. O financiamento federal da Atenção Primária à Saúde: modelos, desafios e potencialidades. *Saúde Debate*. 2026;50(148):e10924. DOI: <https://doi.org/10.1590/2358-2898202614810924P>
25. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 2.979, de 12 de novembro de 2019. Institui o Programa Previne Brasil, que estabelece novo modelo de financiamento de custeio da Atenção Primária à Saúde no âmbito do Sistema Único de Saúde, por meio da alteração da Portaria de Consolidação nº 6/GM/MS, de 28 de setembro de 2017 [Internet]. *Diário Oficial da União*, Brasília, DF. 2019 nov 13 [acesso em 2026 jul 8]; Edição 220; Seção I:97. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2019/prt2979_13_11_2019.html
26. Massuda A. Mudanças no financiamento da Atenção Primária à Saúde no Sistema de Saúde Brasileiro: avanço ou retrocesso? *Ciênc saúde coletiva*. 2020;25(4):1181-8. DOI: <https://doi.org/10.1590/1413-81232020254.01022020>
27. Morosini MVGC, Fonseca AF, Baptista TWF. *Previne Brasil*, Agência de Desenvolvimento da Atenção Primária e Carteira de Serviços: radicalização da política de privatização da atenção básica? *Cad Saúde Pública*. 2020;36(9):e00040220. DOI: <https://doi.org/10.1590/0102-311X00040220>
28. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 2.983, de 11 de novembro de 2019. Institui o Programa de Apoio à Informatização e Qualificação dos Dados da Atenção Primária à Saúde – Informatiza APS, por meio da alteração das Portarias de Consolidação nº 5/GM/MS e nº 6/GM/MS, de 28 de setembro de 2017 [Internet]. *Diário Oficial da União*, Brasília, DF. 2019 nov 13 [acesso em 2026 jul 8]; Edição 220; Seção I:99. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2019/prt2983_12_11_2019.html
29. Ministério da Saúde (BR), Gabinete da Ministra. Portaria GM/MS nº 3.493, de 10 de abril de 2024. Altera a Portaria de Consolidação GM/MS nº 6, de 28 de setembro de 2017, para instituir nova metodologia de cofinanciamento federal do Piso de Atenção Primária

- à Saúde no âmbito do Sistema Único de Saúde (SUS) [Internet]. Diário Oficial da União, Brasília, DF. 2024 abr 11 [acesso em 2026 jul 8]; Edição 70; Seção I:100. Disponível em: https://bvsms.saude.gov.br/bvs/sau-delegis/gm/2024/prt3493_11_04_2024.html
30. Ministério da Saúde (BR), Secretaria de Atenção Primária à Saúde. Nota Técnica nº 122/2024-CGFAP/SAPS/MS: metodologia de cálculo do Índice de Equidade e Dimensionamento [Internet]. Brasília, DF: Ministério da Saúde; 2024 [acesso em 2026 jul 8]. Disponível em: <https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/notas-tecnicas/2024/nota-tecnica-no-122-2024-cgfap-saps-ms.pdf>
 31. Ministério da Saúde (BR), Gabinete do Ministro. Portaria GM/MS nº 7.799, de 20 de agosto de 2025. Altera a Portaria de Consolidação GM/MS nº 6, de 28 de setembro de 2017 e a Portaria GM/MS nº 3.493, de 10 de abril de 2024, bem como revoga a Portaria GM/MS nº 5.668, de 1º de novembro de 2024, para dispor sobre a metodologia de cofinanciamento federal do Piso de Atenção Primária à Saúde – APS no âmbito do Sistema Único de Saúde – SUS e o incentivo financeiro federal de custeio das equipes de Consultório na Rua – eCR e equipes de Atenção Primária Prisional – eAPP, e dispor sobre os eixos temáticos do componente de qualidade para as equipes de Saúde da Família Ribeirinha – eSFR [Internet]. Diário Oficial da União, Brasília, DF. 2025 ago 21 [acesso em 2026 jul 8]; Edição 158; Seção I:97. Disponível em: https://bvsms.saude.gov.br/bvs/sau-delegis/gm/2025/prt7799_21_08_2025.html
 32. Ministério da Saúde (BR), Gabinete da Ministra. Portaria GM/MS nº 3.232, de 1º de março de 2024. Altera a Portaria de Consolidação GM/MS nº 5, de 28 de setembro de 2017, para instituir o Programa SUS Digital [Internet]. Diário Oficial da União, Brasília, DF. 2024 mar 4 [acesso em 2026 jul 8]; Edição 43; Seção I:52. Disponível em: https://bvsms.saude.gov.br/bvs/sau-delegis/gm/2024/prt3232_04_03_2024.html
 33. Ministério da Saúde (BR), Gabinete da Ministra. Portaria GM/MS nº 635, de 22 de maio de 2023. Institui, define e cria incentivo financeiro federal de implantação, custeio e desempenho para as modalidades de equipes Multiprofissionais na Atenção Primária à Saúde [Internet]. Diário Oficial da União, Brasília, DF. 2023 maio 22 [acesso em 2026 jul 8]; Edição 96-B; Seção I:11. Disponível em: https://bvsms.saude.gov.br/bvs/sau-delegis/gm/2023/prt0635_22_05_2023.html
 34. Ministério da Saúde (BR), Gabinete da Ministra. Portaria GM/MS nº 5.350, de 12 de setembro de 2024. Altera a Portaria de Consolidação GM/MS nº 3, de 28 de setembro de 2017, para dispor sobre a Rede Alyne [Internet]. Diário Oficial da União, Brasília, DF. 2024 set 13 [acesso em 2026 jul 8]; Edição 178; Seção I:90. Disponível em: https://bvsms.saude.gov.br/bvs/sau-delegis/gm/2024/prt5350_13_09_2024.html
 35. Ministério da Saúde (BR), Secretaria de Atenção Primária à Saúde. Carteira de Serviços da Atenção Primária à Saúde (CaSAPS): versão profissionais de saúde e gestores – completa. Brasília, DF: Ministério da Saúde; 2019.

Received on 03/30/2026

Approved on 07/19/2026

Conflict of interest: Non-existent

Data availability: The research data are contained within the manuscript itself

Financial support: Non-existent

Editor in charge: Maria Lucia Frizon Rizzotto, Universidade Estadual do Oeste do Paraná (Unioeste), Cascavel (Paraná/PR), Brasil. Lattes: <http://lattes.cnpq.br/7877904356698023> – Orcid: <https://orcid.org/0000-0003-3152-1362> – e-mail: marialuciarizzotto@gmail.com