Potentialities of Primary Health Care in the consolidation of universal systems

Potencialidades da Atenção Básica à Saúde na consolidação dos sistemas universais

Maria Fátima de Sousa[1], Elizabeth Alves de Jesus Prado[1], Fernando Antonio Gomes Leles[1], Natália Fernandes de Andrade[1], Rogério Fagundes Marzola[1], Fernando Passos Cupertino de Barros[1,2,3,4], Ana Valéria Machado Mendonça[1]

DOI: 10.1590/0103-11042019S507

ABSTRACT This essay presents a theoretical-conceptual discussion about the potentialities of Primary Health Care as an imperative strategy for the development of universal health systems. It reflects the current scenario of the Brazilian health system, exposing its main advances regarding the guarantee of the right to health and access to public health services and, furthermore, its challenges that permeate social problems and health of a complex nature, in a country marked by great social and economic inequalities between its regions, states, and municipalities. The serious contemporary challenges for the development of the Unified Health System, for its sustainability as a universal public policy, involve overcoming the hegemony of the biomedical model, overcoming the neoliberal economic policy, and the construction a full citizenship condition so that the population recognizes their fundamental rights, including the right to a public health of quality. In order to achieve universal systems, it is necessary to promote a health care model that has in primary health care and family health care teams the necessary strategies for promoting health for the population and strengthening of citizenship.

KEYWORDS Primary Health Care. Family Health Strategy. Health systems. Healthcare models. Public health policy.

RESUMO *Este artigo apresenta uma discussão teórico-conceitual sobre as potencialidades da Atenção Primária à Saúde como estratégia imperativa à consolidação dos sistemas universais de saúde. Reflete a conjuntura atual do sistema de saúde brasileiro, expondo seus principais avanços no que diz respeito à garantia do direito à saúde e ao acesso aos serviços públicos de saúde e, ainda, seus desafios que perpassam problemas sociais e de saúde de natureza complexa, em um país marcado por grandes desigualdades sociais e econômicas entre as suas regiões, estados e municípios. Os sérios desafios contemporâneos à consolidação do Sistema Único de Saúde, para sua sustentação como política pública universal, envolvem a superação da hegemonia do modelo biomédico, a superação da política econômica neoliberal e a construção de uma condição plena de cidadania de forma que a população reconheça seus direitos fundamentais, incluindo o direito à saúde pública e de qualidade. Para o alcance de sistemas universais, é necessário incentivar um modelo de atenção à saúde que tenha na atenção primária e nas equipes de saúde da família estratégias de promoção da saúde da população e de fortalecimento da cidadania.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Estratégia Saúde da Família. Sistemas de saúde. Modelos de assistência à saúde. Políticas públicas de saúde.*

[1] Universidade de Brasília (UnB) – Brasília (DF), Brasil. *mariafatimasousa@uol.com.br*

[2] Universidade Federal de Goiás (UFG) – Goiânia (GO), Brasil.

[3] Fundação Oswaldo Cruz (Fiocruz) – Brasília (DF), Brasil.

[4] Conselho Nacional de Secretários de Saúde (Conass) – Brasília (DF), Brasil.

Introduction

This essay aims to present a theoretical and conceptual reflection on the potentialities of Primary Health Care (PHC) as an imperative strategy for the consolidation of universal health systems, demonstrating how this strategy is necessary to change the Brazilian health care model, which, until today, is hospital-centric, centered on medical care and which expresses care for the disease, and not a health promotion for the population.

Thus, the discussion is organized in three parts, the first one addresses the health challenges for all, demonstrating the gaps that are present in the Brazilian health system; the second one refers to the difficult but necessary change in the health care model in Brazil; and finally, the third one brings primary care – specifically Family Health – as a way to guarantee the universal right to health.

The challenge of universality: health for all and everyone

The crisis triggered since 2008 has been manifesting globally in the various dimensions of society, in the political, economic, social and cultural orders. Its effects have been analyzed by several authors[1,2], including on the health of populations, which makes even more urgent the assurance of social rights already conquered and inscribed in the most different constitutional and infra-constitutional frameworks of the Unified Health System (SUS). In health systems in particular, many countries are seeking to expand their population coverage and access to services. To this end, there are various logics employed for the reorganization of health systems, actions and services, from the broader perspective of guaranteeing the human right to health to a rationalizing logic of a marketing nature, which is limited to offering simplified and selective 'portfolios' (to certain priority or most vulnerable populations), which, rather than guaranteeing the necessary access to services, are intended to limit the use of caring technologies in the human act of preventing and promoting health in its larger sense.

After 31 years of the declaration of health as a universal right, in the Constitution of the Federative Republic of Brazil of 1988[3], the current moment of public and social policies in the Country has required double attention. On the one hand, it is necessary to ensure the achievements in the health system to build and guarantee the right to health, such as the processes of municipalization, decentralization, regionalization and expansion of access to health actions and services, with emphasis on the inclusion of large portion of the population that until then was considered sanitary indigent[1]; on the other hand, a significant portion of society – about 54 million Brazilians, or 26% of the population – still has lived below the poverty line[4], as remnants of a policy imposed by the neoliberal model in the conduct of Brazilian State management. This is marked by injustices and regional inequalities, and of populations historically left out of their citizenship rights, in the most different urban and rural territories in Brazilian cities. In this sense, it is imperative to continue proposing actions necessary for the consolidation of public policies that promote equity, seeking the social insertion of vulnerable populations[5], who yearn for respect and for the right to live as citizens, in decent living conditions.

There is no consensus on the concept of public policy. It is a polysemic definition[2], and the great majority of authors point to the explanation that, when talking about public policies, it is necessary to take into account the statements and tacit games of interests of classes, powers, subjects and structures, which are permeated by the interrelationships of political, economic, social and cultural aspects. It also adds that social and health problems are complex in nature and have been expressed in distinct epidemiological patterns and of

great inequalities, in the social and economic spheres, between regions, states, municipalities and localities, especially as regards access to health actions and services. Such inequalities and differences, which historically affect the Brazilian population, such as food and nutritional insecurity, reemergence of already controlled diseases, the emergence of other/new outbreaks, increased morbidity and mortality due to accidents in the countryside and in cities, reveal the serious contemporary challenges to the consolidation of the SUS of the conditions necessary to sustain a universal public policy and a civilizing project of inclusive and solidary society in Brazil[6].

As a right of citizenship, health policy is imbricated and viscerally implicated in the area of social security, as an expression of the close ties with the right of citizenship, as provided in art. 194 of the Federal Constitution of 1988, which states that social security comprises an integrated set of initiatives by the public authorities and society, aimed at ensuring the rights related to health, social security and social assistance[3], and determining that health is duty of the State, and must be guaranteed by social and economic policies (art. 196)[3]. However, the construction of health as a fundamental good to the human condition and the right to life requires efforts in social organization that enable the transition from speech to practice, and this, as a consequence to changes in health and life conditions of the population.

Such efforts need to be expressed as articulated practices and consequent to overcoming barriers, difficulties and challenges, with the implementation of comprehensive policies of social inclusion and fight against poverty, aiming at the reduction of regional and inter-group inequalities and inequities. The recognized efforts of some governments to break this cycle over the decades have been undermined by the economic and political powers of the ruling classes of the Country. Such discrepancies and inequities constitute social determinants of health and can only be reversed through mobilization and the organization of society, founded on a democratic State of law. After all, since the historic VIII National Health Conference, the notion that there is no full health without full democracy. It is not for any other reason that SUS is conceived in the midst of redemocratization processes of Brazil, by the 'idea-proposal-project-movement-process' of health reform, as the 'utopian horizon' of general reform in the Brazilian way of life[7], constituted by the democratization of health, the democratization of the State and the democratization of society[6]. Therefore, a full SUS will be one guided by the political and organizational values and principles capable of building health in its broadest sense, as the right of every citizen and the indispensable duty of the State; with the responsibility of providing the set of social rights constitutionally provided for in its art. 6 and that add to health access to education, housing, employment, land, leisure, culture, food, transportation, security and other social goods, in a social safety net at all cycles of life, and that enable full health that goes beyond the provision of services and actions that enable healing and rehabilitation, also involving risk and disease prevention, surveillance and health promotion.

It is worth mentioning that, over these three decades, SUS has been developing and accumulating knowledge, skills and practices among managers, professionals and users of services and other components of the health system, especially at the municipal/local level. Such successful experiences are answers to the local needs built in the daily routine of SUS clinical, surveillance and management teams, demonstrate the vitality and capillarity of the system and have been identified, analyzed, registered, valued and disseminated by various technical and scientific strategies, nationally and internationally, such as, for example, the national exhibitions of municipal experiences 'Brasil, Aqui tem SUS' (whose 16th

edition took place in 2019); in epidemiology, disease prevention and control, ExpoEPI (also in its 16th edition in 2019); in strategic and participatory management, ExpoGEP (two editions, in 2010 and 2014); in primary care (four editions by 2013); the Collective Health Congresses promoted by various associations, such as the Brazilian Collective Health Association – Abrasco (12th edition in 2018) and the Rede Unida (13th edition in 2018) and many others, as well as initiatives such as IdeiaSUS (database of practices and health and environment solutions developed by the Oswaldo Cruz Foundation – Fiocruz) and the Innovation Laboratories (developed since 2008 by the Pan American Health Organization Representation/World Health Organization in Brazil). Such knowledge disseminated throughout the SUS has been generating essential conditions to locally identify social determinants and conduct the decision-making process, recognizing the health needs of communities in the praxis of comprehensive health care, enhancing the overcoming of the dichotomy between curative actions, preventive and health promotion practices, both in the individual and collective autonomous expression spaces, that is, of individuals, families and communities.

Despite these advances, the culture of health promotion as a theoretical and practical field is not yet effective, in which, for the quality of life, strategies capable of operationalizing healthy public policies in the establishment of intersectoral actions and social institutionality are envisaged, achieved in the development of healthy and sustainable territories[8-10]. Within this theoretical-conceptual framework, health promotion must be understood as a contiguous expression that seeks diversity of articulated, intra and intersectoral actions to increase the individual and social potential of the inclusion of all that go beyond the purely and simply clinical care line, in the development of comprehensive public policies for a healthy life, which are strengthened in the establishment of partnerships, the induction of political, social, economic, cultural and environmental changes, the guarantee of citizenship rights and the autonomy of the subjects and the community.

In order to achieve such 'desire', only the supply of programmatic health actions – although some are necessary and strategic on the Brazilian and locoregional morbidity frame – does not strengthen the construction of a new health care model that overcomes the fragmentation of deficiencies, segmentation, exclusion, institutional violence and lack of quality and promote universality, comprehensiveness, quality, efficiency and equity for people and the community. Therefore, it is necessary to meet the legal, constitutional and infra expressed especially in the Organic Health Laws[11,12], which reaffirm and indicate ways for the realization of health as a right of all and duty of the State, as a universal and fundamental right of the human being[2,11,12]. That is, a right that is embodied by the organization of state devices for services, monitoring, adjustment, management and governance[13], but also for the permanent exercise of full citizenship for people, families, companies and institutions, that is, the set of members who build a nation[14].

It is necessary, in this perspective, to change the current scenario of social inequality and injustice that deteriorates the living conditions of the majority of the population, which is in situations of risk of becoming ill or dying. Furthermore, for the achievement of health as a greater good, challenges remain to be overcome in the political, social, economic and cultural fields, and the tireless struggle to break the paradigm of the low-level, fragmented, individual, biomedical care model is also included in this process, of low resolution and strong inequality of access of the population to services and actions[15,16], in addition to being inarticulate from the reality of individuals, families and communities and their expectations and care needs in integrated health networks and, consequently, the permanent pursuit of increased healthy quality of life[17,18].

Changing the health care model: a difficult but necessary way to go

It is known that Brazil has experienced over the last decades a series of attempts to change, in the expression of Sousa[15] and Teixeira[19], the form and content of offering health care. However, all initiatives, no matter how well-founded their proposals in terms of philosophical basis, principles and guidelines, were not sufficient to alter the foundations that underpin the prevailing medical model of health care in the Country.

These bases were unchanged because they brought at their core partial elements of the complex problems faced in the construction of a new model. This complexity has been portrayed over the decades by several authors, among them, Arouca[20,21], Barros[22,23], Castro[24], Donnangello[25,26], Garcia[27], Mendes[28,29], Teixeira[16,19], Paim[30-32] and Sousa[2,15,33]. The scientific technical production of the mentioned authors alert us to the need to understand the factors and social, economic, political and cultural dynamics that determine the hegemony of the sanitary model centered in hospitals, subspecialties, actions of vertical programs and medical practices based on the disease and apparatus of the industrial medical complex. Indeed, these paradigms are socially constructed and consolidated by groups that defend their beliefs, values and position themselves by maintaining the current model, predominating, above all, the interests of business and professional corporations[34].

There is a clear sense that the paradigm that still guides the model of health intervention – represented by medicalization, centralization in the hospital and, increasingly, dependence on technologies – cannot address the proposed challenges. In the meantime, it was found that the 'Health for All by the year 2000' goals, proposed in 1977, at the XXX World Health Assembly, the Alma-Ata Declaration on Primary Health Care[35], given in 1978, and the Letter of Ottawa on Health Promotion[36], of 1986, were not fully achieved. However, the values and principles expressed in this set of commitments coincide with the ideas of SUS and continue to challenge contemporary times.

Brazil, whose estimated population is around 210 million[37], is the only country with a population of over 150 million that has proposed to constitutionally guarantee the right to health for all. Thus, the SUS, which in 2018 completed its 30 years of existence, is the largest public health system, with universal access and incorporating concerns regarding equity and comprehensive care. Despite its weaknesses and challenges, it has become increasingly essential to the population over these three decades[38].

Between 1990 and 2015, a period coinciding with the existence of the SUS, there were important, generally positive, changes in the health/disease profile of the Brazilian population and in the reduction of inequalities observed in health indicators between the states of the federation. Mortality from communicable diseases, maternal and child morbidity and mortality, and preventable causes of death have fallen sharply, and the consequent increase in life expectancy has impacted the longevity of the population in healthy life years. On the other hand, chronic noncommunicable diseases represent, at the same time, the largest magnitude in the total disease burden and the main cause of death, along with the violence and accidents that, in 2015, accounted for 168 thousand deaths, configuring itself as a major challenge for the coming decades[39].

Such changes in the health situation of Brazilians require new responses from the health system, becoming the prevalent care model (reactive, curative, hospital-centric etc.) for a more adequate health needs of the contemporary Brazilian population[40]. In addition to training and continuing education processes for professionals, other issues, such as the distribution and structural organization of health units and services in the Country,

the logic of hiring providers and professionals and financing, influence the transformation capacity of the system.

Another important element to consider when analyzing the capacity of change in the Brazilian health system is its mixed characteristic, in such way that the public subsystem, SUS, coexists with a private subsystem. Constitutionally foreseen, the private sector's complementary participation in the Brazilian health system occurs in two ways: the first, in the provision of health services to the population by non-profit institutions, contractualized as SUS and funded by public resources, which has allowed ensure access to outpatient and hospital care for the population, although certain disparities should be noted:

> The outpatient care of SUS expanded between 1995 and 2015. Based on production data of SUS, the total number of procedures performed increased from approximately eight to 17 per inhabitant, and the public sector grew (performing 80% of activities in 1995 and 88% in 2015). However, during this period, public institutions received relatively fewer resources for their services than the private sector, which increased its share from 21% to 23%, and the philanthropic from 17% to 27%. There is a specialization of sectors for the production of certain procedures. In 2015, the public sector performed the majority of consultations (75%) and diagnostic examinations (59%). The private sector, in turn, was responsible for 72% of nephrology treatments, and philanthropic for 66% of chemotherapies[41(3)].

The second way is the provision of private health services that are purchased on the market through prepayments of health plans and insurance or through direct purchase of services (direct payment of a Government contribution or, more commonly known in English as out-of-pocket). Brazil ranks as the second largest insurance and private health insurance market in the world, second only to the US. There are more than 47 million beneficiaries (24.2% of the total Brazilian population) who hire outpatient and/or hospital medical assistance and/or dental services from 1.009 health care providers of private plans. However, there are many records of negative experiences accumulated with the care offered by the latter, fully demonstrating the inability of the market to solve health and social needs alone more widely[13]. From 2015, as a consequence of the economic crisis in the Country, the supplementary health market has been experiencing subsequent downturns, given that most private health plans are linked to collective corporate contracts. Until June 2019, approximately 3.4 million people left private health plans and started to depend exclusively on SUS[42].

Sector financing has been one of the main challenges for SUS consolidation. From 2000 to 2014, Brazil saw an increase in health financing, from 7.0% to 8.3% of Gross Domestic Product (GDP) for the sector, representing an increase of US$ 263 to U$ 947 *per capita*[43]. Even though compared to other countries total health spending in Brazil is close to the average of Latin American countries, the public portion of this funding is only 46% of total spending (whereas in middle income countries it is 55.2%, and in countries of the Organisation for Economic Co-Operation and Development is 62.2%) Despite constant claims about inefficiencies in the SUS, such data show chronic underfunding since its inception[24]. Furthermore, despite the fact that the Union holds 60% of the tax burden in the Country, its participation in SUS financing has been decreasing from 50.0%, in 2003, to 40.8%, in 2016. In opposite movement and aiming to compensate for the removal of the Federal Government, in the same period, the share of State resources increased from 22.3% to 27.0% and, even more serious, the municipalities increased their participation from 25.5% to 32.2%, in such a way that the total municipal spending on health *per capita* grew 226%, going from R$ 315,70 to R$ 716,50 (including

municipal own resources and revenues passed on by federal and state governments)[44]. It is worth noting that the municipalities collect only 17% of the national tax cake.

The current austerity scenario determined by Constitutional Amendment 95/2016 not only keeps the challenge of SUS consolidation but, by deepening financing difficulties, threatens the sustainability of the system which, as pointed out by prospective studies, may reverse important SUS achievements up till now, with negative impacts on the health situation of Brazilians, especially those most vulnerable.

Primary care and family health as a path to universality

In Brazil, the reorganization of Basic Health Care (BHC) – or PHC –, materialized preferably by the implementation of the Family Health Strategy (FHS), with multiprofessional teams, in which the presence of Community Health Workers (CHW) and the inclusion of the community in the organization of services make a big difference, has accumulated knowledge and experiences, on the one hand, locally successful, but on the other, highlight a set of problems to be faced and overcome in the process of development of SUS[2].

Structuring actions and programs, such as the FHS, created in 1994, aim at reorienting the health model from a perspective of comprehensiveness. Based on PHC, it seeks to interconnect the presence of the health system and guarantee universal access to the entire Brazilian population. Its major expansion has been in the last decade, prioritizing vulnerable areas, where 'primary care' (family health), financed with public resources, has grown exponentially, since the number of people registered in 2015, for example, around 116,600, was already five times higher than in 1998, reaching a coverage of 64.05% in 2018, corresponding to just over 133 million people[45]. This denotes the expansion of access to health actions and services.

Barros[22] and Paim[31] express themselves by showing that the number of people seeking primary health care increased by 450% between 1981 and 2008, which can be attributed to a large growth in the size of the health workforce and of the number of primary health care units in the Brazilian municipalities. Other authors report that the expansion of the Family Health strategy, implemented through municipalization, is consistently associated with a reduction in post-neonatal and infant mortality, as well as a decrease in low birth weight, as increased coverage of antenatal care and excellent rates of immunization coverage in most municipalities, and a marked reduction in hospitalizations due to diabetes or cerebrovascular accidents.

As reported by Barros and Lapão[46], although recognized as a successful experience, the FHS, nevertheless, faces different challenges, such as the recruitment and retention of physicians with adequate training to provide PHC services; the heterogeneity of local quality of care; poor articulation of PHC services with secondary and tertiary levels; the greater difficulty of expanding the strategy in large urban centers and the flexible workload of family health team doctors, which undermines one of the pillars of the strategy, which is the creation of a bond of trust by the population with relation to the doctor and a link of responsibility of this professional in relation to the families assigned to him/her.

In this context, it is important to highlight the role of the FHS and, in particular, that of the CHW in the promotion of the health of individuals and communities, as well registered by Barros[22] over more than twenty years throughout their work process, the CHW demonstrated a great capacity to mobilize institutions and individuals on health promoting agendas. This allowed CHW to innovate in the population approach and also in the implementation of intersectoral actions,

through new pedagogical methodologies used in the training of workers, thus, enabling the development of local intervention projects, according to the identified needs. Thus, they can fill some gaps that exist in the field of intersectoral action in health, in addition to the 'routine' agendas in their field. This broadening of agendas implies a review of some activities originally planned for CHW to address key issues in the health-disease process of individuals, families and communities. It should also be noted that with each incorporation of emerging themes and/or a new 'epidemiological risk', CHW are able to establish the necessary correspondences for the formation of collaborative networks capable of establishing a dialogue with other public sectors, so as to seek answers to different needs through intersectoral actions.

Therefore, CHW have contributed in recent decades to the development of the process of integration between governmental public policies that assist in the promotion of health and social welfare.

The respective dynamics are built from problems identified in the population most vulnerable to the risk of falling ill and dying, and, above all, in a given political and geographical space, in which daily relations between social actors establish true pacts to intervene in reality and develop strategic and integrated projects and actions to promote access to health, in its broadest sense. Therefore, the development of PHC is interrelated to discussions and appropriation of the expanded concept of health among the various actors and sectors of the field of collective health, in the imperative search for the construction of universal health systems.

Final considerations

The theoretical-conceptual discussion exposed in this essay is dedicated to highlighting the contemporary challenges to the consolidation of health as a universal right. It is emphasized, therefore, the overcoming of the hegemony of the biomedical model, the overcoming of neoliberal economic policy and the construction of a full citizenship condition so that the population recognizes their fundamental rights, including the right to quality public health.

Overcoming the hegemony of the biomedical model requires prioritizing health as a right, rather than a product for sale in the market, which is directly related to overcoming neoliberal economic policy, which presupposes minimal State intervention in the promotion of social rights, being this intervention conditioned to the failure of the subject to reach basic rights, such as the right to health. The logic imposed on the Brazilian economic organization translates health into dollar signs, not on quality of life, social justice or citizenship condition.

In the political context, this logic is reaffirmed when there is the scrapping of public health services and the non-prioritization of health as a right of citizenship. In order to reach universal systems, it is necessary to encourage a health care model that has in primary care and in family health teams strategies to promote population health and strengthen citizenship.

In the Brazilian case, given the aforementioned conjuncture, political-institutional actions are still imperative to reach a policy of strengthening health care services, including those of primary, public, quality and strengthened as assets of the Brazilian citizen, in search of a conception and realization of a full condition of citizenship. Thus, one cannot neglect, in the Brazilian case, the effective quality of the work carried out within the scope of the FHS, with well-defined goals and systematic monitoring of its results, under penalty of losing the efforts and successes previously achieved by it.

Finally, it is reiterated with the discussions presented that PHC, within the scope of the FHS, is a possible way to reach a new model of Brazilian health care, since it has a resolutive,

preventive and health-promoting capacity of the population, as well as the potential for linking the population to health services, promoting spaces for the recognition – by the population – of health as a primary and fundamental right to human existence.

Collaborators

Sousa MF (0000-0001-6949-9194)*: elaborated the first manuscript of the article, based on her research. Prado EAJ (0000-0002-2731-5155)*: contributed to the analysis of the raw results, the writing of the theoretical framework and the final revision of the manuscript. Leles FAG (0000-0002-3891-0443)*: contributed to the results, article discussions and review after review by the editors. Andrade NF (0000-0002-6137-4335)*: contributed to the final review and participated in the formatting of the review of the referential of Vancouver style. Marzola RF (0000-0002-7925-5131)*: contributed to the analysis of the results and discussion writing. Barros FPC (0000-0003-1188-7973)*: contributed to the analysis of results and review of the referential of Vancouver style. Mendonça AVM (0000-0002-1879-5433)*: contributed to the writing of the introduction and final revision of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Mendes EV. 25 anos do Sistema Único de Saúde: resultados e desafios. Estud av [internet]. 2013 [acesso em 2019 out 14]; 27(78):27-34. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103401420130002000003&lng=en&nrm=iso.

2. Sousa MF. Programa de Saúde da Família no Brasil. Análise da desigualdade no acesso à atenção básica. Brasília, DF: Departamento de Ciências da Informação e Documentação da Universidade de Brasília; 2007.

3. Brasil. Constituição (1988). Art. 196-200. [internet]. 1988 Brasília, DF: Congresso Nacional; 1988. [acesso em 2019 out 14]. Disponível em: http://conselho.saude.gov.br/web_sus20anos/20anossus/legislacao/constituicaofederal.pdf

4. Instituto Brasileiro de Geografia e Estatística. Síntese de indicadores sociais: uma análise das condições de vida da população brasileira. Rio de Janeiro: IBGE; 2018. p. 62.

5. Oliveira RG. Práticas de saúde em contextos de vulnerabilização e negligência de doenças, sujeitos e territórios: potencialidades e contradições na atenção à saúde de pessoas em situação de rua. Saúde Soc [internet]. 2018 [acesso em 2019 out 14]; 27(1):37-50. Disponível em: http://www.scielo.br/pdf/sausoc/v27n1/1984-0470-sausoc-27-01-37.pdf.

6. Paim JS. A reforma sanitária como objeto de reflexão teórico-conceitual. In: Paim JS. Reforma sanitária brasileira: contribuição para a compreensão e crítica. Salvador: Edufba; Rio de Janeiro: Fiocruz; 2008. p. 153-174.

7. Paim JS. A reforma sanitária como um fenômeno sócio-histórico. In: Reforma sanitária brasileira: contribuição para a compreensão e crítica. Rio de Janeiro: Fiocruz; 2008. p. 35-48.

8. Buss PM. Promoção da saúde e qualidade de vida. Ciênc. Saúde Colet. 2000; 5(1):163-177.

9. Santana PR, Souza MF, Costa AAA, et al. As ações intersetoriais e a estratégia saúde da família na ótica de gestores, profissionais e usuários da saúde no município de João Pessoa, Paraíba. Tempus (Brasília). 2008; 3(2):76-87.

10. Machado JMH, Martins WJ, Souza MS, et al. Territórios saudáveis e sustentáveis: contribuição para a saúde coletiva, desenvolvimento sustentável e governança territorial. Com Ciências Saúde [internet]. 2017 [acesso em 2019 out 14]; 28(2):243-249. Disponível em: http://bvsms.saude.gov.br/bvs/periodicos/ccs_artigos/territorio_%20saudaveis_%20sustentaveis.pdf.

11. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Lei Orgânica da Saúde. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial da União. 20 Set 1990.

12. Brasil. Lei nº 8.142, de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Diário Oficial da União. 29 Dez 1990.

13. Lima LD, Viana ALA. Descentralização, regionalização e instâncias intergovernamentais no Sistema Único de Saúde. In: Viana ALA, Lima LD, organizadores. Regionalização e relações interfederativa na política de saúde do Brasil. Rio de Janeiro: Contra Capa; 2011. p. 39-63.

14. Carvalho GCM. Participação da comunidade na saúde. Campinas: Saberes; 2014.

15. Sousa MF, Hamann EM. Programa Saúde da Família no Brasil: uma agenda incompleta? – Ciênc. Saúde Colet. 2009; 14 (Supl. 1):1325-1335.

16. Teixeira CF. Modelos de Atenção à Saúde: Promo-

ção, Vigilância e Saúde da Família. Salvador: Edufba; 2006.

17. Organización Panamericana de la Salud. Redes Integradas de Servicios de Salud: conceptos, opciones de política y hoja de ruta para su implementación en las Américas [internet]. Washington: OPS/OMS; 2008. [acesso em 2019 out 15]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/redes_integradas_servicios_salud.pdf.

18. Mendes EV. As Redes de Atenção à Saúde [internet]. Brasília, DF: OPAS/OMS; 2011. [acesso em 2012 dez 10]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/redes_de_atencao_saude.pdf.

19. Teixeira CF. A mudança do modelo de atenção no SUS: desatando nós, criando laços. Saúde debate. 2003; 27(65):257-277.

20. Arouca S. Implementação da Reforma Sanitária através do SUDS. Saúde debate. 1988; (22):49-54.

21. Arouca S. O dilema preventivista: contribuição para compreensão e crítica da medicina preventiva. [tese]. Campinas: Universidade Estadual de Campinas; 1975.

22. Barros FPC, Mendonça AVM, Sousa MF. Agents communautaires de santé: un modèle de santé sans murs. Can J Public Health. 2015; 106(3):154-156.

23. Barros FPC. Cobertura universal ou sistemas públicos universais de saúde? An Inst Hig Med Trop, (Lisb) [internet]. 2014 [acesso em 2019 set], 13:87-90. Disponível em: https://anaisihmt.com/index.php/ihmt/issue/view/9/2014-v13.

24. Castro MC, Massuda A, Almeida G, et al. Brazil's Unified Health System: the first 30 years and prospects for the future. The Lancet [internet]. 2019 [acesso em 2019 ago 5]; 394(27):345-356. Disponível em: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(19)31243-7.pdf.

25. Donnangello MCF. Saúde e sociedade. São Paulo: Duas cidades; 1976.

26. Donnangello MCF. Medicina e sociedade. São Paulo: Pioneira; 1975.

27. Garcia CJ. Pensamento social em saúde na América Latina. São Paulo: Cortez; 1989.

28. Mendes GRB. Tecnologia e organização social das práticas de saúde: características tecnológicas do processo de trabalho da rede estadual de centros de saúde de São Paulo. São Paulo: Hucitec; 1994.

29. Mendes GRB. Medicina e história: as raízes sociais do trabalho médico. [dissertação]. São Paulo: Universidade de São Paulo; 1979.

30. Paim JS. Medicina Preventiva e Social no Brasil: modelos, Crises e Perspectivas. Saúde debate. 1981;11: 57-59.

31. Paim JS. A Reforma Sanitária e os modelos assistenciais. In: Rouquayrol MZ. Epidemiologia & Saúde. Rio de Janeiro: MEDSI; 1994. p. 455-466.

32. Paim JS. Saúde da Família: espaço de reflexão e de práticas contra-hegemônicas? In: Paim JS. Saúde Política e Reforma Sanitária. Salvador: CEPS/ISC; 2002.

33. Sousa MF. A reconstrução da Saúde da Família no Brasil: Diversidade e Incompletude. In: Sousa MF, Franco MS, Mendonça AVM. Saúde da Família nos Municípios Brasileiros: Os reflexos dos 20 anos no espelho do futuro. Campinas: Saberes; 2014. p. 40-77.

34. Conill EM. Ensaio histórico-conceitual sobre a Atenção Primária à Saúde: desafios para a organização de serviços básicos e da Estratégia Saúde da Família em centros urbanos no Brasil. Cad. Saúde Pública. 2008; 24(sup1):7-27.

35. Organização Mundial da Saúde. Declaração de Alma-Ata sobre Cuidados Primários de Saúde. Alma-Ata: OMS; 1978.

36. Organização Mundial da Saúde. Carta de Ottawa – Primeira Conferência Internacional sobre Promoção da Saúde. Ottawa: OMS; 1986.

37. Instituto Brasileiro de Geografia e Estatística. Projeção da população do Brasil e das Unidades da Federação. Rio de Janeiro: IBGE; 2019.

38. Giovanella L, Mendoza-Ruiz A, Pilar ACA, et al. Sistema universal de saúde e cobertura universal: desvendando pressupostos e estratégias. Ciênc. Saúde Colet. 2018; (23):1763-1776.

39. Souza MFM, Malta DC, Franca EB, et al. Transição da saúde e da doença no Brasil e nas Unidades Federadas durante os 30 anos do Sistema Único de Saúde. Ciênc. Saúde Colet. [internet]. 2018 [acesso em 2019 set 10]; 23(6):1737-1750. Disponível em: https://doi.org/10.1590/1413-812320182360.04822018.

40. Mendes EV. As Redes de Atenção à Saúde. Brasília, DF: OPAS/OMS; 2011.

41. Bahia L. Trinta anos de Sistema Único de Saúde (SUS): uma transição necessária, mas insuficiente. Cad. Saúde Pública [internet]. 2018 [acesso em 2019 set 10]; 34(7):1-16. Disponível em: https://doi.org/10.1590/0102-311X00067218.

42. Agência Nacional de Saúde Suplementar. Dados gerais e indicadores do setor: Cadastro de Operadoras e Sistema de Informações de Beneficiários (SIB/ANS/MS). Rio de Janeiro: ANS; 2019.

43. Massuda A, Hone T, Leles FAG, et al. The Brazilian health system at crossroads: progress, crisis and resilience. BMJ. 2018; (3):1-8.

44. Brasil. Ministério da Saúde. Sala de apoio à gestão estratégica. Brasília: Ministério da Saúde; 2019.

45. Duarte E, Eble LJ, Garcia LP. 30 anos do Sistema Único de Saúde. Epidemiol serv saúde [internet]. 2018 [acesso em 2019 maio 10]; 27(1):1-2. Disponível em: https://doi.org/10.5123/S1679-49742018000100018.

46. Barros FPC, Lapão LV. A efetivação do direito à saúde: os casos de Portugal, Brasil e Cabo Verde. An Inst Hig Med Trop, (Lisb). 2016; 15(supl1):S89-S100.

Received on 09/19/2019
Approved on 10/28/2019
Conflict of interests: non-existent
Financial support: non-existent