Primary Health Care and Universal Health Systems: inseparable commitment and fundamental human right

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Fundação Oswaldo Cruz (Fiocruz), Conselho Nacional de Saúde (CNS)

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Executive summary

In the 40th anniversary, we restate the commitments of the Alma Ata Declaration with social justice, health for all, and the overcome of social inequalities between countries and intra-countries. Our 40 years led to undeniable advances on health rights; however, new challenges are evidenced with the persistence of inequalities, demographic and epidemiological changes, technological transformations, and environmental and climate threats.

Under the inspiration of Alma Ata, the Brazilian Federal Constitution of 1988 recognizes the connection between economic and social development and environmental conditions to determine the health-disease process and to promote health. It provides for "health as a right of all and a duty of the State" through the creation of a universal health system, the Brazilian Unified Health System (SUS), which complies with the universality, integrality, equality, and social participation for 30 years.

In the Brazilian experience, primary health care is the heart of the universal health system. The care model of the Family Health Strategy with 41 thousand multidisciplinary professional teams now attends 130 million Brazilians. Universal health systems founded in a comprehensive PHC, such as the SUS, include individual care and collective actions for promotion and prevention, cure, and rehabilitation. They ensure the continuity of care coordinated by the PHC by providing access to secondary and tertiary specialized and hospital care, as needed. Their populational focus requires the promotion of intersectoral transversal public policies to cope with social and environmental determinants of health.

Over three decades of SUS provided experience with their relevant impacts in improved access and people health, allowing us to elaborate the following proposals:

The social determination of health and disease stated by the Alma Ata has become the hegemonic conception and requires the political commitment of governments to ensure maximum egalitarian welfare for citizens. The downturn in social policies following the economic austerity programs has been an unbearable burden for societies, mainly in the periphery countries, with increased poverty and inequalities, worse health conditions, corrosion of social cohesion, and authoritarianism threats.

The PHC subsumption to the proposal of universal health coverage (UHC) restricts the possibilities to guarantee the human right to health, as defined in the Alma Ata.

Financial protection by private or public insurances coverage does not ensure access and results in different service packages per income groups and reupdates the selective PHC, with its minimum packages that perpetuate social inequalities.

The usufruct of the health right implies the ability to share the power in the health system management. Health Councils in all government levels form the democratic architecture based on social participation. The strength of such institutionalized participative structure is expressed herein, ratified by the Brazilian National Health Council.

New epidemiological challenges and improved quality of care require investment in the qualification of health professionals to act in the PHC, combining clinical training for individual care and collective health for the population approach. Ensuring material conditions with fair wages and labor rights for PHC professionals values and provides professionals with dignity and facilitates the fixation and quality of care processes.

The reduction of global CT&I health asymmetries is a decisive factor to ensure comprehensive right to health and access to health systems. The construction of health economic-industrial complexes oriented to respond to the needs of the population breaks the barrier imposed by commercial interests, that make inputs, drugs, and technologies inaccessible for most countries in the world, intervening in the health commercialization, mercantilization and privatization trends.

Health is not a commodity, but a good of public relevance. Universal health systems, free and with fiscal funding, which has the PHC as the heart of the service network, materialize the most effective and efficient path to promote equity and ensure the universal right to health, 'leaving no one behind'.

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Primary Health Care and Universal Health Systems: inseparable commitment and fundamental human right

Celebrating the 40th anniversary of the Declaration of Alma-Ata on Primary Health Care (PHC), the World Health Organization (WHO), The United Nations International Children's Emergency Fund (Unicef) and the Government of Kazakhstan organized the Global Conference on Primary Health Care to renew a commitment to Primary Health Care to achieve universal health coverage and the Sustainable Development Goals[1].

The Declaration of Alma-Ata called for social justice and advocated health for all and to overcome inter-country and intra-country social inequalities. It promoted a comprehensive approach of PHC as the basis for health systems of universal access and comprehensive care. The Declaration acknowledged the inseparability between health and economic and social development, and called upon the cooperation with other sectors to face the social determinants of health and to promote health. It encouraged social participation to empower citizens in the defense and extension of social rights. However, in the years immediately after the Declaration, the world experienced the rising of conservative governors in Europe and in the United States and the adoption of neoliberal policies. The Rockefeller Foundation and Unicef prepared proposals that served as a foundation for a Selective Primary Care approach focused on specific measures, mainly in children's health, clearly contradicting the ideal notion of equity and health as a universal right[2,3].

Anyway, the legacy of the Conference and its motto "Health for All by the Year 2000" remained relevant for the development of equity and social justice projects.

Thus, inspired by Alma-Ata, the 1988 Brazilian Federal Constitution acknowledges

the connection of economic and social development and environmental conditions in the health-disease determination process and promotion of health, and the governmental responsibility to provide universal and comprehensive health care services, with equity and social participation.

The proposal of health for all through the creation of a public universal health system that ensures the right to health was undertaken by the Brazilian health movement and social movements[4]. The uniqueness of the Brazilian health care reform in the transition to a democratic system was its inclusion into the design of a new and comprehensive model of social protection, with the support of a wide social mobilization towards the expansion of social rights and the democratic changing of the State and the Society[5].

The new Brazilian social policy constitutional model is characterized by the recognition of social rights, the duty of the State, the universal coverage, the subordination of private practices to the regulation based on the public relevance of such actions, the public orientation (as opposed to market orientation), decentralized governance and government-society co-management, with strong social participation[5].

This broad social movement of the Brazilian health reform enabled the creation of a universal public health system, the Brazilian Unified Health System (SUS – initials in Portuguese), which has since 30 years, the constitutional commands of "health for all as a right and the duty of the State", on the basis of the fundamental principles of universality, comprehensiveness, equity, and social participation.

Primary health care, in the Brazilian experience, is a structural and inseparable part in the construction of this universal health system, the SUS, an effective and efficient model to ensure health as a human right, a condition for materializing the guideline of the 2030 agenda of 'leaving no one behind'. There is a lot of empirical and analytical evidence showing universal systems are better in health quality, efficiency and equity when supported by the following pillars: organization of comprehensive PHC, predominantly public financing and provision, and effective Government regulation to ensure universal access, subordinating the fragmented market logic to the viewing of health as public good[6-9].

Primary health care in the Brazilian SUS is grounded on the health care model of Family Health Strategy, with a territorial basis, multiprofessional team, individual and collective care approach, the first point of contact with the health care system, the beginning of a continuous care process in a regional comprehensive services network. The progress in primary health care in SUS towards universal access is undeniable, with the expansion of the offer, easier access, greater availability of usual sources of care, expressed in the operation of over 41 thousand Family Health teams, attending 5,400 municipalities, with estimated serviced population of more than 130 million people. There is strong evidence that the expansion of the Family Health Strategy, the basis of the universal system, has had positive impacts on the health of the population, with: reduced infant and under-five mortality[10]; cardiovascular and cerebrovascular mortality[11]; hospitalizations due to sensitive primary care conditions[12,13], among others. The broad inclusion of the population, in combination with policies focused on vulnerable and marginalized populations, such as riverine, black, quilombola, indigenous and LGBT tranches, fostered equity and reduced inequalities.

The experience of over three decades of SUS, with its relevant impacts on the improved access to healthcare and health of the population – although implemented in a critical scenario of the global economy and facing major challenges in terms of funding and integration, and new current threats of fiscal adjustment programs – allows us to elaborate the following proposals:

- Health is not a commodity, but a good of public relevance. Public universal health systems, which have PHC as the core of the

healthcare network, are fundamental to guarantee the right to health and equity in the access and use, and should be financed by the whole society, in solidarity. Public universal health systems materialize the most effective, equitable and efficient path to guarantee the social right to access health care services.

• Health is a product of economic and social determinations historically constructed in and between countries. Health is not the product of individual choices, lifestyles and behavior. The health-disease process is ultimately determined by the way how the society is organized. The social determination of health and disease requires political commitment from governments to ensure maximum well-being of the citizens in an egalitarian and indivisible way, in addition to safeguard access to quality healthservices. The reports from the WHO and Brazilian Commissions on Social Determinants of Health have demonstrating the connections between health, determinants and inequities reinforced the need for inter-sector actions towards social determinants to promote health and well-being. The Health in All Policies strategy requires other sectors to consider the health of the population, both when generating knowledge and when implementing actions, creating common grounds ofe interest governance and the establishment of social and economic policies. Therefore, health and education must be considered drivers for the sustainable development instead of social expenditure, which can be limited under adverse circumstances. The downturn in social policies following the ideas of economic austerity has been an unbearable burden for societies, penalizing the poorest population, more intensely in the periphery countries where social inequalities have deep historical roots, which is already reflected in situations of increased poverty and inequalities, with the health consequences of spread epidemics and increased morbidity and mortality. Adjustments cause political consequences as well, which are being already evidenced with the corrosion of social cohesion, delegitimating elected governments and increased risk of searching for solutions through authoritarian regimes.

• Enjoying the right to health implies having the capacity to share with the users the managerial power of the health system, at all levels – national, regional, local, health care units. Thus, the health system plays a central role in the democratization of public policies, in the socialization of information on the functioning of government, and in accountabilities and transparency in the decision-making process. The Brazilian experience has made progress in the construction of a democratic system's architecture based on social participation, with the establishment of Health Councils at all government levels– National, State and Local – and through the Thematic National Conferences and Public Hearings. This document expresses the strength of this institutionalized participatory structure, which integrates and ratifies the axes and theses defended in the stance of the Brazilian National Health Council[14,15].

• Subsuming PHC under the Universal Health Coverage (UHC) proposal restricts the possibilities of guarantee the right to health and the access to health care services according to the needs. UHC's emphasis on financial protection through private or public insurance is not enough to guarantee access and the outcome is coverage segmented by insurances differentiated by social groups according to income, with different covered services groups, re-updating selective primary health care, with its minimal packages and solidifying inequalities. The UHC is the expression of the austerity adjustment programs, removing the accountability of governments and the provision of minimum services and baskets. The UHC is essentially different from the original concept of comprehensive PHC of Alma-Ata, the foundation of universal

public systems. The equitable distribution of public resources according to the needs, the progressive financing with fiscal justice, under governmental control and regulation, the absence of co-payment and guarantee of comprehensive care, in a universal system territorially organized according to the health needs are crucial for the PHC impact on the reduction of social inequalities.

• Considering the restriction of the UHC to the universal right to health, the emphasis on insurance coverage, and the lack of difference between coverage and access, the UHC proposal of the WHO and of the World Bank was questioned at PAHO by South American countries that seek to build universal health systems (including Brazil). Following consultations with its Member States PAHO Directing Council approved, in 2014, the Resolution CD 53/5, which broadened the concept of UHC by incorporating the guarantee of access to health care services and mentioning the right to health, understanding universal access as the ability to use comprehensive (population and/or individual actions for promotion, prevention, protection, treatment and recovery) adequate, timely and quality health care services according to the needs. PAHO adopted and started to disseminate "Universal Health" to designate the strategy to be implemented in the Region[16]. To be representative of the entire UN and WHO system, the Declaration of Astana must adopt and include this position in defense of the universal human right to health.

• Fiocruz is dedicated to develop Science, Technology & Innovation (CT&I) and to qualify human resources at service of universalization of the right to health in Brazil and in international cooperation with developing countries, strengthening universal health systems by producing inputs, drugs and technologies and in the organization of health care production hubs oriented towards providing health care responding to the population's needs, aiming at the well-being and guarantee of human dignity. That will only be possible by breaking the barrier imposed by commercial interests that cause such resources to be inaccessible to most countries in the world, mainly the periphery countries of Latin America and Africa, whose dependent position on the central capitalist countries, produces historical structural inequalities. Nowadays, we have been observing a huge risk of strengthening the private appropriation of knowledge generated in health, mostly developed in public institutions with public resources in several countries worldwide. The reduction of global CT&I health asymmetries is a decisive factor to ensure comprehensive and equitable PHC. Health needs must be the guiding line of national and global research priorities agendas in order to turn knowledge into an instrument for universal access to health and comprehensive primary health care. Recently, the Zika Virus epidemics in Brazil, identified thanks to the PHC, triggered new lines of public health research to identify, monitor, follow-up and organize specialized and referenced services in epidemic surveillance and its repercussions, based on PHC. Neglected diseases and other current epidemics evidence the crucial needs to structure health systems, where PHC plays a fundamental role in their control.

• Health is a right for all and is a State duty to guarantee it through integrated social and economic policies (Brazil, 1988). The current scenario is quite complex and presents contradictory characteristics in relation to the goal of achieving health for all, under equal conditions. On one hand, the increased number of players and agents can favor the increment of resources, and also dilute the governmental responsibility in a plural network of governance that cannot hide problems of conflict of interests and difficulties in coordination and regulation, due to the public relevance of health and

contradictions inherent to market expectations in services profitability.

• Urges the strengthening of regional integration initiatives among the periphery countries, especially in Latin America and Africa, with a view to international solidarity practices and strengthening policies that favor public PHC, core of universal health systems, as a right of all and the duty of the state[17].

Primary Health Care is the core of the universal health systems

Tax funded national health care systems as SUS, in which health is a right for all and the duty of the State, are aimed at ensuring the fulfillment of people's needs without access restrictions. PHC is the core of universal health care systems. In those systems, recognition of the universal right implies the supply of health care services according to individual and populational needs. The comprehensive care is one of its principles: each person should receive care according to his/her needs, not merit or income.

Universal systems as SUS comprise individual care and collective actions to promote health and prevent diseases, guarantee the continuity of care based on the PHC, providing access to specialized and hospital care at the secondary and tertiary levels as needed.

Its focus in the population requires the promotion of inter-sector, transversal policies to face the social and environmental determinants of health, such as access to quality education, decent and safe employment, adequate income, quality public transport, public safety, healthy housing, quality supply of drinking water, appropriate sewage system, urban drainage, garbage collection and proper disposal, clean air and other public services, focused on health, well-being and quality of life, in the spirit of the Agenda 2030 and the SDG 3 and others health related SDGs. The States' commitment to guaranteeing the right to health includes efforts to improve people's living conditions and the set of fundamental social rights.

To promote the universal right to access health care services, PHC must be people's first point of contact with the health care system, be easily accessible, timely attend to resolve with quality, provide preventive and curative actions, both individual and collective, operate in the territory, a dynamic and living space, promoting social participation and community action. It should be the beginning of a coordinated and continuous process of comprehensive care in a regionalized and territorialized service network, in order to ensure timely access to the necessary levels of complexity and specialties. This primary health care configuration is a technological innovation, that involves new forms of work and health care institutional organization and also the generation of new goods and services.

Sometimes, there is a disconnection, from the conceptual and normative point of view, between PHC and low level of knowledge and technology. In fact, primary health care is highly complex and intensive in terms of knowledge and innovations of social processes, products and technologies.

The organization of a PHC strategy involves local arrangement of the action, community action and territorial interventions, individual and public health actions, the establishment of regional reference and counter-reference networks, the necessary link with specialized and hospital care, the challenges of permanent care of an elderly population with chronic diseases and multi-morbidity, interaction with other services such as social services and those of long-term care, the need for intelligent prediction and vigilance systems that enable anticipating resolutive actions at local, regional and national levels (as revealed by the recent case of the Zika virus), and many other requirements for comprehensive health care, embedded in a universal health care system.

Such complexity demands that health needs to be the guiding lines of the national and global research priority agendas so that knowledge becomes an instrument for universal access to health care and comprehensive primary health care[18].

Coordinating care is the primary function of PHC, which requires strengthening of its capacity for resolution and its central position as the coordinator of the integrated and comprehensive universal systems assistance network. Only a strong PHC, integrating a structured and connected network of health care services and actions, capable of mobilizing support, political, economic, financial and human resources, can be responsible for coordinating care across different health care levels. For effective coordination, the health care network must be established territorially with population, roles and functions defined for all health care services that comprise it – a function that reaches beyond the capacity of a specific level of the system.

In this sense, the existence of a regional network is a fundamental strategy for equitable universal health care systems, whose principles are based on the notion of health as a public good. PHC is part of this regional network with the role of facilitating timely and adequate access to diagnostic and therapeutic services, whether for outpatient or in hospital treatment, as needed, for the whole population that is circumscribed to the regionalized territories. Therefore, PHC's position in the health care network, whether more central or peripheral, would determine its possibilities of coordinating the health care in an extended perspective.

The reorientation of training and regulation of the health care workforce to work in the PHC combining clinical training for individual care and public collective health training with populational focus, ensuring the provision of professionals to PHC, also in remote and disadvantaged areas, and reforms focused on improving the capacity for resolution and quality of the PHC and expanding the scope of services in order to meet 90% of the population's health needs, represent fundamental technical and symbolic elements for the recognition of PHC's strategic position in the network, the core of the universal health care system.

Public management of universal systems implies holding the State accountable for ensuring the social rights and the commitment to the centrality of training processes for PHC workers. Its defense includes the management of labor aimed at facing the harmful effects of progressive privatization intensifying the precariousness of work from the outsourcing of social security services provision that cause suffering and sickness at work. Guaranteeing material conditions, fair salaries and labor rights provide health workers with dignity and is crucial for valuing professionals, their stability and comprehensive quality production for PHC[19].

Training processes in the perspective of comprehensive PHC must include the daily services routine, aim to expand the knowledge of workers connecting health care work and the labor world, general training and specific training. In this sense, it is based on the valorization of knowledge produced in practices, popular knowledge, and on the investment in permanent training processes, and on a critical analysis to address the different forms of precarious work[15], supported by information technologies that promote the integration of workers from different professional categories in the sector, and the understanding of contradictions and challenges of the social and technical health care work division. For this, the information technologies should be used as complementary to the training and formative process in health that should be mainly face-to-face.

The implementation of a comprehensive PHC requires governance arrangements that include actions combined among multiple players, based on the social determination of health to face de social inequalities. It involves a set of health intervention strategies

that go beyond the health sector and promote multidisciplinary approaches as health promotion, health surveillance, environmental health, human rights, and equal access to health education, social protection services and human security.

The WHO and the Brazilian Commissions on Social Determinants of Health, and the recent PAHO Commission on Health Equity and Inequality in the Americas have exhaustively studied the most diversified public health approaches in relation to other fields of knowledge and other doctrines originating in the social, political and economic sciences. The synthesis of those studies led to the so-called "Health in All Policies" strategy, which promotes that population health must be considered by other sectors both in knowledge generation and in the implementation of actions, thus creating a common space of interest in governability and in the establishment of social and economic public policies.

Local level and sectorial primary actions and marginalized populations are common elements to the interests of various sectors accountable for the sustainable development. Thus, the territory is a basic issue and one of the first common health interests with other sectors, leading PHC to go beyond their relevance to the health care system to play a fundamental role also in the overall dynamics of local sustainable development.

PHC in universal systems and the universal health coverage

The Declaration of Alma-Ata convened governments to formulate national policies, strategies and action plans to implement the primary health care as part of an integral/comprehensive national health system and in coordination with other sectors, mobilizing political willingness and resources[20].

The 2018 Primary Health Care Global conference aims to renew PHC's commitment to achieve the UHC – universal health coverage.

The Universal Health Coverage (UHC) in an ambiguous term that has been leading to different interpretations and approaches by national health authorities and civil society, especially in periphery countries. The concept of universal coverage was shaped between 2004 and 2010 through connections between the WHO, the Rockefeller Foundation and the World Bank, bringing together a set of pro-market reform guidelines, including: reduction of state intervention, subsidies to demand, selectivity and focus on health policies. The WHO Assembly approved Resolution 58.33 on this topic in 2005 "Sustainable health financing: universal coverage and social health insurance"[21].

The global debate on the issue gained visibility with the publication in 2010 of the WHO Report on Health Systems Financing – The Path to Universal Coverage[22]. Based on this report, the WHO Assembly approved, in 2011, a resolution on sustainable financing and UHC[23], which urged countries to ensure that health financing prevents direct out-of-pocket payments from the families recommending early financial contributions as a form of risk sharing to prevent "catastrophic expenditures" with health, which generate impoverishment. Later on, in 2015, the UHC was defined as one of the goals (3.8) of the ODS 3 of Agenda 2030. Its main monitoring indicator is the proportion of the population that incurs catastrophic expenditures (defined as high health expenditure at the instance of using as a proportion of domestic income)*, in addition to suggesting a minimum basket of services included in the proposed "essential services index", which is not yet being monitored[25].

The indicator of catastrophic expenditures has been questioned about its capacity to measure the performance of the health system, to the extent that people under severe poverty will be excluded from the figure (health expenditure), since they do not have expenses

*Brazil, with its universal health care system (SUS), presents low catastrophic expenditures. A research based on population survey of household budgets in twelve Latin American countries evidenced Brazil as the country showing the lowest population incurring catastrophic expenditures with health care (2.2%) (Knaul et al, 2012)[24].

as they do not have the money, although they need health care. In addition, this indicator carries along the assumption of some (expressive) participation of the private sector in the health sector, thus generating unequal access and avoiding effective use of health care services.

The trajectory of the UHC proposition evidences that it privileges financial coverage, which is very different from ensuring the universal right to health. The financial coverage expresses the holding of insurance. This means that all people can buy or be affiliated to some kind of insurance (private or public), which does not guarantee access and use as needed, nor equity. This conception of coverage differs from the concept of coverage as a health measure that associates provision with effective access and use[26].

Therefore, the UHC proposal has three main components: focus on financing by pooling funds managed by private or public insurers; affiliation by modality of insurance; and definition of a limited services basket[27]. The main purpose of the UHC proposal is the financial protection in health care, that is, that all people can access health care services without incurring financial difficulties, by reducing out-of-pocket payments upon use (OOP) and avoiding catastrophic expenditures. However, this results in coverage segmented by insurance differentiated by social groups according to their income. Citizens are eligible or not according to the rules of each insurance and the covered services depend on their ability to pay and correspond to different individual health care services baskets/packages, crystallizing the inequalities[28]. Insurance contracts cover specific interventions and do not consider the design of a comprehensive and integrated health care system. Thus, in the conception of the UHC, the right to health is restricted to ensuring a limited basket of services to be contracted, thereby reissuing the selective PHC.

Universal health systems guarantee universal access as a condition for citizenship; they promote redistribution and ensure access of the most disadvantaged individuals on equal terms. The proposal of UHC, in turn, reduces the role of the State to the regulation of the health care system. The State should promote insurance and/or contract private services to offer them to people who cannot buy them in the market.

The myriad and diversity of contracts between insurers and providers, in the UHC conception, increases operational and administrative costs, resulting into lower system efficiency. Market-based health care systems – as properly exemplified by the USA case – are more expensive, do not guarantee access, produce greater iatrogenesis and inequities, are less effective, with negative impacts on the health of the population when compared to public universal health systems based on the strong PHC[6-9].

Provision is fragmented in the UHC because it is based on the financial logic and does not include components of the health care system design such as territorial organization and networking, thus prevents the continuity of care and coordination among and within services, with loss of effectiveness of the PHC. Furthermore, the focus of insurance protection is oriented to the individual medical care, since contracts are individual, with premiums calculated according to each person's risk and the range of the contracted package, disregarding population and territorial focus.

The guarantee of comprehensive care (person centered and population health) including promotion, prevention, cure and rehabilitation, and public health measures aimed at the public and the environment, require the design of a health care system coordinated by primary, secondary and tertiary services, organized as networks, integrated and arranged by territories, distributed with scale saving and oriented by the PHC, with predominance of public administration and services provision, resulting into better quality, lower costs and higher level of efficiency[6,7].

The proposal of universal coverage is

aligned with the approach of pro-market health reforms and managerial reforms of the "new public administration", which defining purchaser - provider split, the withdrawal of the State from provision of services and the subsidies to the demand (i.e., subsidies for the purchase of insurance) as opposed to the subsidies to the supply, through the public provision of health care services. It reaffirms the proposal of selectivity and focus of international financial agencies social and health policies disseminated since the 1980s[29].

The UHC proposal corresponds to a conception of citizenship restricted to the liberal view, a modality of residual governmental intervention[30]. The State should subsidize the insurance and guarantee a restricted basket of benefits for those poor groups that have 'failed' to guarantee their basic needs in the market.

Emphasis on demand subsidies implies in private provision of health care services seen as more efficient. However, there is no consensual evidence on the greater efficiency and quality of private health care services. Systematic reviews of the literature show that private providers respond to the demands and not the population health needs; they establish their business in areas of greater socioeconomic development; they offer more profitable services; they provide more unnecessary services and more often violate good medical practice standards; they are less efficient and have lower results in health care than public services. However, they can provide more timely services and more personalized care[31,32].

Another recent review of the international literature on outsourcing of health care services in middle-and low-income countries lack evidence that it is more effective in improving the use of health care services than a similar provision by the public sector. There is a lack of well-designed studies assessing these relations, and outsourcing becomes a more political than technical option[33]. For those choices, it is also necessary to consider ethical issues involved in the private sector's control over health systems, emphasizing the reduced equity in systems with predominance of the private sector's participation.

The UHC involves powerful economic interests in the expansion of the private health market for insurance, provision and production of inputs, medicines and equipment, as the Rockefeller Foundation explains by recognizing the pressure of market agents (pharmaceutical industry, service providers, insurance companies) to increase public and private health financing[34].

For Global South countries, it is necessary to acknowledge that the guarantee of the universal right to health and access to health care services requires the addressing of these economic interests, with initiatives for building Health Economic-Industrial Complex oriented to the population's health needs, as opposed to commercialization, commodification and health privatization trends.

Revitalizing the PHC to guarantee the universal right to health requires expressing connections among PHC, universal access, sustainable development and reduction of social inequalities. Universal access is guaranteed by designing integrated universal public systems, in which PHC is the basis and guides the organization of territorial integral care networks.

Governments and societies must be mobilized towards to build public and free universal health systems, designed based on comprehensive PHC models that contribute to reduced social inequalities, organized by territory, with regional distribution according to the population's health needs that guarantee effective and timely quality care to all.

Primary Health Care and Universal Right to Health

The proposal of the Astana Declaration reaffirms health as a fundamental human right enshrined in the WHO Constitution and which was adopted in the Declaration of Alma-Ata

as a goal to be achieved through the PHC, undertaking to guarantee Health for All by the year 2000.

In Alma-Ata, the call to all to commit the pursuit of this goal does not elude the role of governments in their responsibility to provide health and social measures that ensure the health of populations. In the Declaration of Alma-Ata primary health care is placed as the key to achieving the goal of health for all, associating it with the development of societies and the reduction of social inequalities under the principle of social justice.

The current proposed Declaration emphasizes the commitment with the Agenda 2030 and its Sustainable Development Goals. The PHC is seen, in the proposed Astana Declaration, as the basis for reaching the Universal Health Coverage (UHC). In this way, it subsumes the PHC under UHC, and PHC ceases to be a strategy for the right to health.

By transmuting the universal right to health into the right to universal health coverage, a transliteration, or a political transposition from one political order to another was verified, from the right to coverage. The concept of the right to health, based on the egalitarian principle of social justice, which can only be guaranteed by the State, has been transposed into a principle of coverage, free of financial difficulties, which introduces the notion of charging for the provision of health care services by market players.

Health is not a commodity because it has no value in the market, just a use for individuals and societies. As a publicly relevant good, the State must ensure the necessary conditions to enable individuals and society enjoy good health and adequate care, and to address social determinants to promote health. This public accountability towards the citizens cannot be outsourced. Fragmented market logic must be subordinated to the perspective of health as a public good.

The definition of public good is a political choice of the society and not just a technical choice. Being a public good, the State cannot use criteria other than the defense of dignity and health, both individual and collective, when organizing the services and defining the criteria for access to services.

The incompatibility between health as a commodity and health as a right comes from the fact that the right is applied equally with the guarantee of the public authority, and the costs of the provision are socialized according to the principle of social justice. Equality is the foundation of citizenship, which allows for diversity according to the needs, but repudiates difference as the principle of public action organization. Therefore, we can refer to diversified citizenships based on different needs, which bears complex equality. However, it is not possible to speak of the right to health when coverage is limited to a package of basic actions for some, while others will have full attention according to resources that are external to the health criteria, since they are based on socioeconomic differentiations. In this case, instead of materializing the principle of social justice, health policy would then reproduce market inequalities.

Thus, universal health coverage reduces PHC to a set of basic actions, offered by different providers, but it does not ensure the comprehensiveness of health care as the citizenship right to be guaranteed by a universal health system. The different PHC coverages correspond to different links between individuals and providers, some of which will be limited to a selection of basic care, a restricted, selective PHC, while others will ensure other levels of care. The defense of the PHC as the core of the health system requires its connection to the comprehensive health system, in which patients have effective responses according to their needs, deriving based on the entry into the PHC.

It is the certainty that the right to health must be guaranteed by the public authority that makes it enforceable. PHC promotes empowerment by connecting and coordinating the health actions, since it creates objective material conditions for the provision of comprehensive care.

Empowerment means increasing the levels of freedom of individuals and groups to make decisions regarding their health and demanding the right to health. It concerns a process that is both subjective and objective, in which political subjects are established, capable of affirming their will and making decisions about a set of alternatives.

It is a dialogic process, in which interaction between professionals and users allows the exchange of information, the respect for the knowledge of both, the capacity of acceptance of the other as a subject, that is, the one that can act according to their own needs and desires. This proposition implies that the health care team will be able to recognize individuals as equals, in horizontal relations, although in different functional positions; therefore, capable of responding to information demands, stimulating and sharing new knowledge, understanding and respecting the way individuals create their own way of life and culture. Only then it will be possible for health care to be a source of social transformation.

However, this capacity is only realized if there are material conditions to enable adequate health care. Empowerment requires objective material conditions for rendering the care at all levels of complexity and treatment necessary to meet the needs. In this sense, there will only be true empowerment if the PHC is not limited to a space, or a health care center, but if it is a guideline that connects the set of facilities comprising the health system.

Leveraging the right to health implies the capacity to share power in the management of the health system with beneficiaries, at all levels – national, regional, local, health care units. Hence, the health system assumes a strategic role in the democratization of public policies, in the socialization of information about government functioning, and in rendering of accounts and transparency in the decision-making process. The Brazilian experience has progressed in the construction of a democratic architecture based on social participation, with the establishment of Health Councils at all government levels, an example to be followed.

The PHC and health equity

Equity is a principle of social justice. Social injustices are based on stratified social relations that determine processes by which people gain unequal access to the material resources and social products resulting from the use of those resources. In health, it is important to distinguish equity in health condition from equity in the utilization of health services. The determinants of inequalities in getting ill and in dying are different from those of inequalities in using health services. Inequalities in health conditions dominantly reflect social inequalities and, due to the relative effectiveness of health actions, equality in the utilization of health services is an important but not sufficient condition for reducing the actual inequalities across social groups when getting ill and dying[35].

There is a consensus that health is influenced by various social and environmental circumstances, and not only by health care. Even though health services are only one of the social determinants of health, the expansion of health systems scope and their practices, combined with gains in effectiveness, increases their impact on the health of populations.

The Declaration of Alma-Ata was motivated by the huge social and regional inequality (intra and inter-country) in health conditions. The goal of Health for All by the year 2000 took Primary Health Care as a key to its achievement. Therefore, in the context of the Declaration of Alma-Ata, equity in health and PHC are two sides of the same coin. This means that one is realized through the effectiveness of the other.

In the Declaration of Alma-Ata, PHC implies addressing the social determinants

of health. Although the health system (health care) represents only one of several social determinants of health, in a context of huge inequalities in health and in the access and effective use of health care services existing at the time of the Declaration, the generation of universal health systems guided by the PHC proposal would certainly strongly impact the reduction of these inequalities.

The ability of the PHC to impact the reduction of social and geographical inequalities in health strongly depends on its configuration. A comprehensive and integrated PHC has a greater impact than a narrower and more focused PHC, the conception embedded in the UHC proposal. The PHC can be a policy aimed at reducing social inequalities in health, if it is based on a comprehensive approach and public health policies for the shaping of universal systems, as evidenced by international comparisons[8,36]. Equitable distribution of public resources according to needs, progressive financing with fiscal justice, under government control and regulation, lack of copayment and guarantee of comprehensive care is crucial to the impact in reducing inequalities.

The promotion of equity in health implies overcoming the inequalities, with social justice, concentrating efforts on the provision of public services and universal access to address inequities. Thus, states are urged to implement public policies that face up to the concentration of national and global wealth, as well policies to tackle the root of the profound historical ethnic, sexual, gender inequalities.

An essential assumption is that PHC financing cannot be disconnected from the financing of universal access to health; therefore, of the universal health systems, under penalty of disruption of an integrated viewing and of the PHC's erroneous conceptual and political approach as an alternative basis for financing the universal coverage. The interface of the PHC and of the universal systems involves both a technical dimension of care – the resolution of the interventions in PHC depend on the local PHC organization and its regional and national interaction in structured care networks – and a political dimension of the rights. A structured PHC with multidisciplinary teams strengthens the actions and the voice of the individual subjects and, moreover, of the collective subjects, raising the level of awareness of the population for their rights, including those that are not directly equated in the scope of first level of care. A successful PHC strategy, such as the recent Brazilian experience of Family Health Strategy, at the same time puts pressure on the health system to ensure care at all levels.

Primary care is thus a path of citizenship and rights, the outcome of which in terms of universal access and the required financing can only be achieved with universal systems developed and incorporating PHC as one of their strategic pillars.

PHC is the basis for structuring a universal system and not its refutation or its partial substitution as an access limitation gateway or a minimum package

It is necessary to overcome a bureaucratic vision of the specific financing of PHC for a vision that, technically, points to the need for incorporation, by society and by the State, of health as a right and, therefore, for the political definition of priority in the public budget for the financing of universal systems.

In this sense, it is necessary to submit proposals to cope with the context of limitation of rights and citizenship, under the sign of universal health coverage and the understanding of the PHC as an accounting focus initiative

to relieve health systems with the supply of baskets or access packages at low cost, complexity and technology.

A first proposal would be the prioritization, by the national systems and by the international agencies, of public health financing, considering it a public good consequently releasing access from the burden of marketing[37]. In the international experience, some parameters appear as the floor for the possibility of creating universal systems, based on a quality and comprehensive PHC: the need for a minimum public financing of 70% of national and global health expenditures; and the floor of 7% of public expenditure on health in relation to the GDP. These would be an accomplishable target for the less developed countries if there is a political and social base of support[38].

Another proposal is the revoking of all rigid limits of public health expenditure, imposed in the current fiscal adjustment/austerity programs, as in the Brazilian case. Other expenditure variables as financial expenses and tax incentives should be the adjustment variables, without affecting the guarantee of citizenship and human rights.

To provide a concrete financial basis for universal health systems and for the PHC, a guideline for the restructuring of national tax systems is suggested, aiming to implement progressive tax systems, the collection of which is based on income (including profits and dividends) and on real estate (including inheritances), with progressive and differentiated layers to the top of the pyramid of the richest population segments (1% of people own 50% of the global equity – "unsuspected" data from the President of the World Economic Forum).

Revitalizing the PHC within the spirit of Alma-Ata

The austerity policy currently imposed by multilateral financial agencies and developed countries for the global South countries goes far beyond an action for the balancing of public accounts. In fact, it is a proposal to reduce governmental responsibility for the promotion of social justice, containment and regression of rights and the Welfare State, in the benefit of profit interests in the financial market. This policy is strengthened in the health sector when universal coverage is defended, involving restriction of access and supply of minimal service baskets that segment society and crystallize inequalities. It is possible to attain other fiscal balance, with growth, sustainable development and well-being, by overcoming the wicked vision of austerity that threatens the guarantee of human rights.

Instead of universal health coverage, it is mandatory to reaffirm the perspective of developing public universal health systems that, in addition to guaranteeing citizenship, right and equity, have the potential to mobilize the economy and the sustainable development. From this perspective, primary health care is not a means of limiting access, such as in the proposal for universal coverage; it becomes the most structuring and effective action for the development of universal systems that guarantee the right to health, leaving no one behind. Instead of austerity and limited access and rights, Brazil proposes "fair and sustainable development and comprehensive primary health care at the core of universal public systems".

Revitalizing the PHC within the spirit of Alma-Ata, without retreats, from the perspective of the people of the global South requires, therefore, global commitment and the recognition:

- of governments and societies accountability for guaranteeing the fundamental and universal human right to health and to access equitable health services;

- the need to build universal health systems

such as state duty and government responsibility, financed by public funds and services provided by public institutions;

- of the inseparability of sustainable development and its economic, environmental and social pillars from health, acknowledging the social and environmental determination of health and the need to intervene in public policies (Health in All Policies) to foster health and equity;

- of the governments' responsibility of promoting social justice, environmental sustainability and overcoming social inequalities at all levels;

- of the reorientation of the health economic-industrial complex towards the population health needs and the guarantee of the universal right to health, in the defense of life;

- the priority for the government budget for health and social welfare: health is investment, not expenditure;

- of the PHC as the core of universal, comprehensive and quality public health systems;

- of the PHC as the coordinator of a continuous process of comprehensive care in a services network organized by regions and territories;

- of the PHC as an essential element, at the local level, for governance of public policies and social and economic progress;

- of social participation as, shared power in the development of health systems and democratic societies.

Health is not a commodity: against the commercialization, commodification and privatization of health

Public universal health systems anchored in comprehensive PHC, inseparable from sustainable development, in democratic societies, materialize the most effective, equitable and efficient path to guarantee the universal right to health and access to health services, overcoming social inequalities.

Collaborators

Members of the Fiocruz Working Group on PHC: Paulo Buss, Ligia Giovanella, Maria Helena Magalhães de Mendonça, Luiz Augusto Galvão, Arlinda B. Moreno, Carlos A Grabois Gadelha, Cláudia Travassos, Francisco Campos, Guilherme Franco Netto, Gustavo Corrêa Matta, Marcos Cueto, Maria do Carmo Leal, Mariana Setúbal Nassar, Marília Santini, Nisia Trindade, Patricia Canto, Patty Fidelis de Almeida, Paulo Amarante, Roberta Gondim, Sérgio Rego, Sonia Fleury.

Members of the Technical Chamber of Basic Care of the National Health Council (CNS): Ronald Ferreira dos Santos (CNS president), Agleildes Arichele Leal de Queirós, Allan Nuno Sousa, Ana Maria Chiesa, Ana Paula de Lima, Aparecida Celina Alves de Oliveira, Aryel Thomaz Fontenelle de Melo, Bruno Abreu Gomes, Elizabethe Cristina Fagundes de Souza, Heliana Hemetério, José Orlei Santor, José Vanilson, Kátia de Cássia Botasso, Luzianne Feijó Alexandre Paiva Guimarães, Maria Conceição Silva, Mariana Lima Nogueira, Reginaldo Alves das Chagas, Rosa Maria Godoy Serpa da Fonseca, Shirley Marshal Dias Morales, Shirley Santina Gonçalves, Stephan Sperling, Tulio Batista. ■

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