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# Basic health care or primary health care?

## Atenção básica ou atenção primária à saúde?

## ¿Atención básica o atención primaria en salud?

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The authors' invitation to reflect on the current challenges in basic health care is certainly very timely, raising questions that touch the core of current problems with basic care in the Brazilian Unified National Health System (SUS). The debate is urgent, due to the threats to the SUS and basic care from an illegitimate government, with a draconian fiscal adjustment policy and an assault on social rights, all underscored by the celebration, in 2018, of the 40th anniversary of the Alma-Ata International Conference on Primary Health Care.

The authors acknowledge various strides in basic care and the SUS, with positive impacts on access, less inequality, and improvement in the population's health conditions. They warn of the current threats to the SUS resulting from the imposition of a cap on health expenditures, freezing budget funding for health for 20 years (only readjusted for inflation), with heavy budget cuts for the SUS and aggravation of the system's chronic underfinancing, placing growing pressure on local governments.

The authors ask what is missing for the effective implementation of basic health care as the backbone for the sought-after universal, public, and high-quality SUS. They list four obstacles to the system's consolidation.

First, they explain why the term "basic health care" was adopted as opposed to the hegemonic and consecrated use of "primary health care". The use of "basic health care" by the Brazilian Health Movement aims to mark an ideological difference vis-à-vis the implicit reductionism in the idea of primary care, with the objective of building a universal public system in keeping with a concept of expanded citizens' rights. I agree with the authors on this perspective, emphasized in a previous study, pointing out that the Brazilian policy's formulation sought to establish a distance from a kind of selective primary care with a limited and targeted basket of services, one of the most widely disseminated concepts at the time [1]. However, I identify imprecisions in both terms (which can refer to very distinct policies), with serious implications for guaranteeing the right to health.

The benefits of health systems based on quality primary health care are known worldwide, and there is a certain consensus among policymakers that primary care should be strengthened. However, imprecisions predominate in its definitions, and there are disputing approaches in the formulation and implementation of primary health care policies [2]. The priority of primary health care is evoked with disparate discourses and includes initiatives that are sometimes mutually contradictory. The conceptual imprecisions have stemmed from the diverse influences on primary care over the decades [3].

The article by Mello et al. [4], cited by the authors, accurately portrays the historical processes in the construction of these concepts, besides discussing their differences.

The definition of primary health care at Alma Ata includes three essential components: universal access and first point of contact with the health system; inseparability of health from economic and social development, acknowledging the social determinants of health; and social participation – three fundamental components of the SUS. This broad concept of primary health care, which the Latin American social medicine movement has called "integral primary health care" [5], is consistent with the guidelines of the SUS in guaranteeing the right to health. However, it has not been the approach to primary health care that has usually been implemented in Latin America. Encouraged by international agencies, a "selective" approach was deployed, with a "cost-effective" basket of services for the poor that Mario Testa [6] appropriately referred to as "primitive", 'poor medicine for the poor'. It was to oppose this concept that the term "basic health care" has been defended for the SUS. However, basic care can also be similar to the idea of "basic health services", a basket of limited medical services that preceded the *Declaration of Alma-Ata* [4] and that informed the "PrevSaúde" proposal in Brazil in the late 1970s, which aimed to expand the coverage of these services in the country.

The international literature sometimes distinguishes between *primary health care* (corresponding to the integral conception of *Alma-Ata*) and *primary care*, to designate, in the countries with universal public systems, the services of first contact with care centered on general medical practitioners [7], leading some authors to question this approach as *primary medical care* [5]. This concept of first-level care differs from selective primary health care, since it is generally linked to a universal system with solidarity. An indispensable component of integral primary health care is to serve as the preferred portal of entry that guarantees timely care with case-resolution capacity.

In Brazil, although I agree with the authors that there is a certain consensus behind the idea of basic care as the backbone for SUS with quality, I also see a discursive tension between the approaches in Brazil's basic care/primary health care, sometimes with such oppositions as "promotion/prevention versus care"; "collective health versus clinical practice"; "programmed action versus spontaneous demand"; "community orientation versus health service"; "population needs versus timely access"; or "general medical care versus multi-professional care". Besides, at its origins, the Family Health Program (FHP) definitely displayed characteristics of targeting, selectivity, and implementation in parallel to the preexisting network of care.

The conceptual debate on basic care/primary health care remains current, given the incorporation of universal health coverage by the 2030 Agenda as a target of one of the *UN Sustainable Development Goals* (target 3.8 of SDG 3, "Good Health and Well-Being") and primary care recommended as a strategy for universal coverage. The indicators defined by the World Bank and WHO in 2017 to monitor target 3.8 and the evolution in coverage suggest a minimum basket of services included in the proposed "index of essential services" and are centered on out-of-pocket spending [8]. There is doubt as to the meaning of the intended universality and the scope of primary health care. There is a dispute over guaranteeing universal access with equity according to needs, regardless of income, in universal public health systems like the SUS, and expanding coverage with targeted insurance (private, public, or subsidized) with a basket of selected basic services, thereby crystalizing inequities. According to the concept of universal health coverage (UHC), universality means financial coverage by some type of insurance and a corresponding package of services, differentiated by the capacity to pay. In UHC proposals, the portfolio of services is used to define the selective supply of procedures for implementing targeted insurance.

In this context, the selective approaches to primary health care are reiterated to achieve a basic universalism, and we should be alert to the defense of the expansion of basic care in the SUS according to a concept of integral primary health care.

The authors' second note points to a mismatch between the policy's formulation and its real implementation, presumably resulting from a centralizing process that sets standardized rules while overlooking the broad heterogeneity and diversity of Brazil's local realities.

The authors argue appropriately that the marked sociodemographic differences and diverse characteristics in Brazil's municipalities, public and private supply structures, coverage of health plans, etc., require diversified networks of basic services that respond to local and regional health needs. They argue that although the Brazilian Ministry of Health acknowledges this diversity in the

discourse of its administrators, the Brazilian Ministry of Health nevertheless operates with a homogenizing logic.

The profusion of rulings and norms is certainly an obstacle to local autonomy to respond to local needs, and this discussion is dear to the movement of municipal health secretaries. However, having accompanied the construction of the SUS over these 30 years, I am convinced that the successful expansion of basic care in the SUS and the changes achieved (although partial) in the model of care (with a general medical practitioner, multi-professional team, community health agents, community orientation, and territorialization) result from the continuity, over time, of financial induction under the model of the Family Health Strategy (FHS). Various studies have shown the superiority of the Family Health model compared to traditional Basic Care. The Brazilian National Basic Health Care Policy (PNAB), as reformulated in 2017, eliminates this priority assigned to the FHS and will probably have negative repercussions for the model, potentially jeopardizing the population's health in the process. Federal financial induction is a fundamental mechanism for reducing regional and social heterogeneities and inequalities, as well as for promoting equity. All universal public health systems have guidelines to guarantee the right to health with equity and resource allocation instruments to reduce regional inequalities [9]. In this sense, to expand federal and state transfers based on population criteria and local needs is crucial to reduce inequalities and to allow autonomy in municipal management in the response to local needs. Although federal transfers for basic care nearly doubled in real terms from 2002 to 2016 (from a *per capita* total of BRL 45.00 to BRL 81.00), the Fixed Minimum for Basic Care (*PAB fixo*) remained at a derisory BRL 24.00 per capita/year. It is urgent to increase the fixed minimum in order to expand the capacity and autonomy of Brazil's municipal health departments to respond to local needs. To maintain the priority of the FHS means to expand its funding and improve the financing of basic care as a whole.

The recent process of reformulation of financial transfers to the SUS, eliminating the five costing blocks (basic care, medium and high-complexity outpatient and hospital care, pharmaceutical care, health surveillance, and administration of the SUS), supposedly guarantee the broad autonomy that administrators aim for, while causing apprehension, especially regarding the future direction of basic care. In general, in countries with national health systems that have worked to strengthen their primary care, some protection for its funding is guaranteed, given the growing pressure from the costs of in-hospital and specialized care. Despite the argument that it is only a matter of streamlining financial flows, maintaining the budget processes and outlay according to the municipal health plans, basic care and health surveillance may have their funding affected by pressure from other levels of specialized care and diagnostic and therapeutic procedures, generally with a sizeable private component. This concern is also associated with the adverse context in which the measure was passed, during a severe downturn in municipal revenues and with the imposition of *Constitutional Amendment n. 95*, which will result in loss of funding for the SUS and aggravation of the system's chronic underfinancing. The process involves speeding up the financial flow in an amount frozen for 20 years that has followed the logic of production/supply thus far, rather than the logic of health needs, which would mean a different apportionment of resources, plus additional funds.

I also agree with the authors' concern in their third note: the difficulty in overcoming basic care's peripheral position in the health system, for basic health care to effectively act as coordinator of care. The difficulty in coordinating care is certainly a contemporary challenge and a growing concern, shared by health system administrators in various countries, mainly given the need to improve the quality of care for chronic health problems that require the use of various health services and professionals. By providing adequate follow-up, such coordination minimizes the risks of errors, prevents complications, improves patient safety and quality of care, and reduces costs [10]. The responsibility for coordinating the majority of health care has been attributed to primary care [10,11,12].

The authors state that basic care today lacks the objective *material and symbolic* conditions to act as the center of communication between the various points of care and argue that it is necessary to define strategies to better include and connect basic health care in the network. They offer modest proposals for some interventions at the local level to facilitate this communication both within basic care services themselves and between the various points of care, with the creation of regulatory levels with participation by different service providers, representatives of basic care, specialized services, the private sector, and users. They also highlight the need for basic care teams to acknowledge and

learn about the real paths their users take in search of care, in order to orient regulation of the demand.

Meanwhile, it is crucial to improve the supply of services in order to guarantee access. Users' tentative trajectories in pursuit of care do not result in free choices [13]. Their search for care generally become a veritable pilgrimage given the complete disorganization and lack of access to diagnostic and therapeutic backup. Users would benefit enormously from a well-defined, transparent flow with the guarantee of timely access. In addition, without strengthening the health districts, there is no way to promote such integration.

There is a body of research in Brazil focusing on this theme. Based on local studies, this research has identified strategies that promote coordination of care, highlighting the expansion of case-resolution capacity in basic care. The objective is for basic health care to effectively become the service that the population uses regularly, expanding the scope of actions, arrangements for communication and exchange of information between services, direct communication between general practitioners and specialists, clinical dialogue and continuing training with participation by professionals from basic care and specialized care, shared electronic patient files, Telehealth with second opinions, and drafting of standard protocols with participation by professionals from basic care and specialized care [14,15,16,17,18,19].

In the fourth note, the authors point to the insufficient supply of health administrators, managers, and professionals that are prepared for and supportive of a project to transform the prevailing health care model. At the same time, they question the projection of an idealized health worker, who could be trained for the implementation of the *dreamed-of* policy, as if such a worker were not both cause and effect. They ask how to produce these actors, the health professionals and administrators, and defend processes of continuing education, more participatory management formats, and the role of supporters for changes in practices. Beyond the idealized professional, to expand the scope of practices, to make basic care more capable of resolving cases and more incorporated into the network, it is necessary to advance professional training, effectively implementing programs (already under way) such as the training area of the More Doctors Program and the continuing education strategies in the Brazilian National Program to Improve Access and Quality in Basic Care (PMAQ-AB).

The valorization of basic care professionals with guarantee of labor rights in health work, with a unified personnel policy in the SUS and a SUS career plan with fulltime contracts, would contribute to robust high-quality basic care. Although human resources are the backbone of health services, labor conditions have deteriorated over the years in health work, with the lack of effective federal policies.

The authors conclude by emphasizing three main threats from the reformulation of the PNAB in 2017 to Brazil's basic care model. They underscore, appropriately, the fragmentation of the work process and the undermining of coordination and continuity resulting from hiring health professionals for only ten hours a week for "basic health care teams". They also predict that if the support for other basic health care teams happens, it will be concentrated in larger cities in the South and Southeast of Brazil with lower coverage in the FHS, whose administrators resist the change in the model of care. They point to probable reduction in the number of community health agents following the elimination of the mandatory 100% coverage of territory and question the recommendation for two standards of basic care (essential and expanded). They ask whether this formulation is connected to the proposal for the creation of "affordable" health plans. The question is very appropriate, since the definition of a basket or portfolio of services, as suggested by these standards, is a tool that has been developed for hiring targeted private insurance and/or private services in the proposals for universal health coverage, and that may compromise the comprehensiveness of basic care and of the SUS by consolidating as a publicly guaranteed basic basket, corresponding to a neo-selective primary care approach and limiting the universal right to health to a basic universalism.

At the same time that the quality and scope of our basic health care/primary health care defines the course for the SUS, the course of the SUS determines the reach of our basic care/primary health care. Different projects are definitely vying for hegemony in the SUS, as the authors emphasize, but they are not expressed in the opposition between the terms primary health care and basic health care. Both terms can align with a proposal for a universal public system with quality. In fact, the existing universal public systems defend robust primary health care, and the use of the term primary health care is aligned with this literature and the international experience with universal systems.

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