

Primary health care in Brazil and the 40 years of *Alma-Ata*: acknowledging the challenges in order to move forward

Patty Fidelis de Almeida ¹

doi: 10.1590/0102-311X00136118

The three articles in this *Thematic Section* revisit longstanding and persistent challenges for the consolidation of primary health care in Brazil. The articles simultaneously make an unrelenting defense of a public, universally accessible health system, built on the solid foundations of comprehensive and integrated primary health care.

Celebrating the 40th anniversary of the International Conference on Primary Health Care, which produced the *Declaration of Alma-Ata*, and the unquestionable expansion of the Primary Health Units in Brazil, operated primarily by multidisciplinary professionals in the Family Health Strategy (FHS), Cecilio & Reis debate major pending issues in the still-unfinished project for a strong primary health care. They ask us, “*What is still missing for this policy to succeed, to achieve its implementation in practice?*”, thereby sparking a fruitful debate illuminated by the commentary by Giovanella and Medina. Acknowledging the constraints imposed on federal funding, incapable of ensuring sufficient resource allocation to meet priority health needs with equity and by the shortage of physicians (a problem partially solved by the More Doctors Program), a series of comments serves as the path for reflection on Brazil’s primary health care/basic care and its possible and probable setbacks resulting from a new revision of the Brazilian National Basic Health Care Policy (PNAB).

From the 2006 version of the PNAB to 2013, Brazil’s national policies aimed to respond to problems with the consolidation of primary health care, although incrementally. For example, the 2011 revision of the PNAB strengthened the centrality of primary health care in the health system, updated and expanded the functions of the Centers to Support Family Health, acknowledged the specificities for assembling teams to respond to homeless and riverine peoples’ needs, and provided modest signals of some possibility of institutionalized inter-sector action through the School Health Program (one of the gaps in a comprehensive approach to primary health care). The National Program for Improvement of Access and Quality of Basic Care (PMAQ-AB) and the More Doctors Program, which incorporated activities from the program to Requalify Basic Health Units, combined with emergency provision of physicians and changes in training (the line of action currently under the greatest threat), gave direction and converged towards a more robust primary health care. Although insufficient to induce changes at the local level, these measures signaled a convergence with the principles of the Brazilian Unified National Health System (SUS) based on solidarity.

¹ Departamento de Planejamento em Saúde, Instituto de Saúde Coletiva, Universidade Federal Fluminense, Niterói, Brasil.



Even in the face of widely acknowledged problems for strengthening primary health care, such as its peripheral position in the health system and the training and retention of health workers aligned with a transformative project for the SUS, the revision of the PNAB in 2017 has done nothing to deal with such challenges. On the contrary, the 2017 revision proposes major backstepping. The territories' health specificities that evoked to undercut population coverage, establish a minimal portfolio of services, and create teams working part-time in primary health care are certain to kill any proposal for coordination, continuity of care, and bonding between health care teams and users (key and uncontested attributes of any comprehensive proposal for primary health care).

Perhaps the biggest mismatch in the primary health care policy is between its implementation and the population's health needs. The original formulation provides for an open-door primary health care with the capacity to respond to the most frequent health problems, in which users feel welcomed and cared for even when circulating in other levels in the system. This theme entails one of the most dramatic aspects of users' abandonment in the face of illness, which the authors address from complementary perspectives. It is true that fragmentation of care is a challenge for health systems everywhere and that policies and actions are conditioned by the prevailing model for social protection in health. In countries with segmented and fragmented health systems (the case in most Latin American countries), problems with coordination add to the lack of guarantee for access to treatment backup. As highlighted by Cecilio et al.¹ in another publication, the powerlessness of primary health care teams to guarantee continuity of care with other levels undermines users' assessment of primary health care. When users detect such powerlessness, they devise their own strategies in search of care.

One of the principal "mixes" that users drawn on in their search for care, namely the public-private mix, involves catastrophic expenditures, directly proportional to the size and seriousness of their vulnerabilities. This search is often oriented by health professionals themselves, given the expectation of lack of access and the known failures of the regulatory systems to guarantee clinical priority, transparency, and timely care, thereby leading to hazardous breaks, oftentimes produced intentionally. In addition to siphoning public resources to the private system, the public-private health care mix (usually for outpatient consultations and diagnostic support) introduces an additional degree of fragmentation into the system, this time of a symbolic order. Users access health services with direct entry through specialists in a model that distances itself from the perspective of a comprehensive primary health care that coordinates the system.

Another mix, equally harmful both for chronic conditions and the spontaneous demand not met by primary health care, is the mix consisting of the search for the portal of entry through emergency and Urgent Care Services (UPAs, in Portuguese), part of the web of care woven by users themselves. This raises a crucial issue. Primary health care can only be comprehensive if it is based on regionalized networks, still to be designed, implemented, and acknowledged by health professionals and the other points of care comprising the health system. More autonomous processes in the production of care can only exist with guaranteed, timely, and quality access via the SUS.

Users' centrality in the system is definitely necessary. One issue insufficiently addressed by the normative framework and even by studies on coordination of care is users' active role in building their treatment plan. Successes and failures in the coordination of care are perceived from different perspectives. For users and families, coordination includes any

activity that helps guarantee that their needs and preferences, sharing of information, and points of care (in health and in the territory) can converge and that care is continuous. For health professionals, coordination incorporates actions centered on patients, families, and teamwork, planned to meet users' needs while helping them navigate effectively and efficiently through the health system². Some innovations can contribute to better coordination, but the way the health system is organized can either facilitate or hinder such progress. The most efficient structure to promote coordination of care thus involves health systems with a strong base in primary health care, in which providers and users conscientiously take responsibility for the therapeutic experience^{3,4}.

Far from an invitation to discouragement, our reflections on the challenges ahead are an affirmation that Brazil's primary health care, especially with the FHS as the model, with its contradictions and incompleteness, is our closest path to the formulation and implementation of a de-commodified public health policy, consistent with the principles of social justice drafted in the *Declaration of Alma-Ata*. The challenges in no way diminish our recognition of the strategy's success in building the SUS, in the daily experience of millions of users that see primary health care as a regular source of care, as shown by various studies cited by the authors. In current times, no longer merely with threats, but with actual institutional measures aimed at dismantling such care, there is no room for silence and hesitation. Rather, we must defend a strong primary health care as the foundation for a sustainable, effective, equitable, efficient, and accessible public health system, necessarily reflected in the national health policy's formulation and implementation.

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