

Integrative Review on Primary Health Care Financing in National Health Systems: Ensuring Access and Equity

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Abstract

It identifies what the national and international scientific literature has made available on the financing of primary health care (PHC) in national health systems, in terms of expanding access and ensuring equity. This is an integrative literature review, in which the research was carried out in the Virtual Health Library (VHL) and PubMed. Twenty-one publications were analyzed, referring to 16 different countries. The countries with the highest number of publications were: Australia (4), Brazil (4) and Cambodia (4), followed by Argentina (2), Colombia (2) and Laos (2), in addition to another 10 countries with one publication each. The results indicate that there is not a single possible financing model, as well as there is no consensus among the authors for the concepts of access and equity. There is consensus, however, in the belief that PHC should be the guiding strategy of the care model and should be financed appropriately according to the health needs of each population. The financing models were summarized as public, based on taxes, through mandatory social contributions, or through health insurance in the private system. Additionally, the existence of Health Equity Funds (HEFs) in Cambodia proves that it is possible to find alternatives to guarantee access and equity. Each country, in its own way, seeks to guarantee access and equity in the health of its population. However, despite the guidelines of the World Health Organization or the Universal Declaration of Human Rights, with no consensus between the meaning and measurement of these terms, each country seeks to solve it in the way that suits you best. Finally, the compiled evidence allows us to conclude that the topic is very incipient, with a low level of scientific evidence available (levels 4 and 5).

Keywords

Healthcare Financing, National Health Systems, Access to Health Services, Health Equity, Review

1. Introduction

Primary health care financing has been, over the years, a widely debated subject in the scientific community. The debate on the subject is broad, diverse and continuous, especially considering that National Health Systems, which have Primary Care as their gateway, and need an adequate financing model to ensure access and equity. For example, Brazil, which has a universal Unified Health System (SUS), had its financing model changed after 21 years. Such model was replaced by the federal government through Ordinance 2.979, of November 12, 2019 (Brasil, 2019).

Among the considerations made by the Ministry of Health (MS) to justify the change in the current financing model, the following can be highlighted: "...the need to expand the population's access to Primary Health Care services in order to ensure the universality of SUS" (Brasil, 2019). In addition, the following justification is also indicated by the MS: "...the need to equitably review the federal costing funding way related to Primary Health Care" (Brasil, 2019).

However, the justifications of the MH can be widely criticized. Among several opposing arguments, it can be noted that the modification of the Primary Health Care financing breaks with the Fixed Primary Care Baseline, implemented since 1998, which ensured a total per capita value transferred to the municipality, so that it could plan and execute health actions and services at this level of care as a whole, respecting the constitutional principles of the SUS (Mendes & Carnut, 2020). Moreover, it is known that from the equity point of view, the new model does not follow the determinations provided by the Brazilian Law n. 141/2012, article 17 (Brasil, 2012b), in which the guiding criterion for the transfer of federal resources to municipalities refers to health needs (Mendes & Carnut, 2020).

The discussion on the topic of financing primary care essentially passes through the definition proposed by Kleczkowski et al. (1984) who point out that the care model is the guide for the financing process and, therefore, in the case of Primary Health Care (PHC), must be in line with its expanded conceptual basis, which will be discussed below.

For the purposes of our discussion, we will take as the main reference of Primary Health Care the definition proposed by the Brazilian Ministry of Health:

"Primary Health Care (PHC) is the first level of health care and is characterized by a set of health actions, at the individual and collective level, which covers the promotion and protection of health, the prevention of diseases, diagnosis, treatment, rehabilitation, harm reduction and health mainten-

ance with the aim of developing comprehensive care that impacts the health situation and autonomy of people and the health determinants and conditions of communities” (Brasil, 2012a: p. 19).

By principle and definition, this should be the first care that the SUS’s user must receive, that is, the gateway for him to have access to health. For this reason, in a universal health system, it is necessary to expand access to health until there are guarantees that the entire population can access the system through this care model.

Regarding the definition of the term access, there is a wide discussion from a health perspective. As Travassos & Martins (2004) state, “access” is a complex concept that varies among authors and according to the time and context used. According to them, “authors such as Donabedian, use the noun accessibility—character or quality of being easy to approach—while others prefer the noun access—act of entering, entry—or both terms to indicate how easily people obtain health care” (p. 2).

The scientific discussion on the term also goes through the “health needs” issue. That is, access has to do with the ability to produce actions and services that meet the health needs of a given population (Travassos & Martins, 2004). Providing access, therefore, represents not only the distribution of resources or health equipment, but also the equitable allocation of these resources and health equipment according to the health needs of users of the system.

In such a view, the guarantee of equity in the primary health care financing is necessary, given the different health needs that each population has, due to the geographic and socioeconomic conditions to which each one is subjected. The term equity, considered one of the guiding principles of the SUS, has some possible definitions that are worth highlighting. The first, formulated by West, worked on by Porto (2002), discriminates the principles between horizontal equity—where there is equal treatment for all—and vertical equity—which would be unequal treatment for unequals. Porto (2002) summarizes and reminds us that “behind the first concept (horizontal) is the principle of equality, while the second (vertical) presupposes positive discrimination, and, furthermore, that equal treatment may be not equal” (p. 129).

In addition to this, Porto (2002) brings the concept of equity worked on by Julian Le Grand, who distinguishes five types of equity linked to the distribution of public expenditure and Artells and Mooney, who summarize seven possible concepts of equity in health and who, in all of them, consider the distribution of public expenditure as a central point of concern. And despite the vast bibliography on the subject, for the purpose of our discussion, we will also consider the concept of equity by the Ministry of Health, which associates the direct relationship with the concept of equality and social justice, stating that equity means treating unequals unequally, investing more where the need is greater (Brasil, 2020).

This is one reason why there is equitable funding between different regions. Unequally financing unequal regions. However, there is little care, as the criteria for apportioning funding must be precise and consider the health needs of different populations, as recommended by Brazilian Law n. 141/2012 (Brasil, 2012b).

In this sense, it is essential to know the discussion in the scientific literature that deals with financing primary care in national health systems seeking to refer it to the aspects of expanding access and ensuring equity. Thus, it is possible to expand the frame of reference of this theme to reflect on the content necessary to think about the financing model of PHC in the SUS in Brazil.

2. Method

2.1. Objective

The objective of this research is to review the scientific literature on financing primary health care (PHC) in national health systems, in terms of expanding access and ensuring equity. To achieve this objective, an integrative systematic review of the literature was conducted.

2.2. Data Source and Search Strategy

The method chosen for this research was integrative review of national and international literature, with the objective of synthesizing the current knowledge, from different authors and published on the subject and presented as initial basis the following question: “What has the scientific literature made available on financing primary care in national health systems, in terms of expanding access and ensuring equity?”.

From then on, we chose to work in this Review with two repositories of scientific studies, two portals (which bring together different databases), the Virtual Health Library (VHL) and PubMed.

The main question gave rise to three key items, which were searched on the DeCS platform (Health Sciences Descriptors) for the specific Descriptors, according to the applicability of the definitions. In the PubMed database, a translation into English was used, available in Decs for the descriptors identified in Portuguese, and additionally, these same terms were searched in the National Center for Biotechnology Information (NCBI) database. Certain terms, when considering the literal translation, were not found, and therefore were replaced by synonyms in the Medical Subject Headings (MeSh Terms).

The final descriptors, derived from each key item and used for research in the VHL and PubMed, can be analyzed in **Chart 1**.

The search used a methodological technique for combining several descriptors with each other, through Boolean operators, in order to find the best syntax, in order to refine it. In order to improve the search strategy, it was decided to group “Access” and “Equity” in the same Key Item. Starting from the VHL portal, using the Boolean operator “OR”, the result is shown in **Chart 2**.

Chart 1. Definition of key items and descriptors in DeCS/BIREME and MeSH Terms PubMed.

Key Items	Descriptors—VHL/Bireme	MeSH Terms—PUBMED
Primary Health Care Financing	Financiamento da assistencia a saúde Recursos em saúde Financiamento Governamental Gastos em Saúde Financiamento de Capital Financiamento dos Sistemas de Saúde Atenção Primária à Saúde	Health Care Financing Health Resources Financing, Government Health Expenditures Primary Health Care
National Health Systems	Sistemas Nacionais de Saúde Sistema Único de Saúde Sistemas de Saúde Políticas de Saúde Serviços de Saúde	Delivery of Health Care, Integrated Delivery of Health Care Health Services Health Policy Patient Acceptance of Health Care
Access and Equity	Acesso aos serviços de saúde Acesso Universal aos serviços de saúde Acesso Efetivo aos serviços de saúde Equidade Equidade em Saúde Equidade no acesso aos serviços de saúde Equidade na alocação de recursos	Health Service Accessibility Universal Health Care Health Equity Health Care Rationing

Source: author's elaboration.

Chart 2. Search Results by groups of descriptors in the VHL/Bireme.

Key Items	Descriptors/Syntax	Number of studies found
Primary Health Care Financing	“Financiamento da assistencia a Saude” OR “Recursos em saude” OR “financiamento governamental” OR “gastos em saude” OR “financiamento de capital” OR “financiamento dos sistemas de saúde” OR “Atenção Primária à Saúde”	165.721
National Health Systems	“Sistemas Nacionais de Saúde” OR “Sistema Único de Saúde” OR “Sistemas de Saúde” OR “Políticas de Saúde” OR “Serviços de Saúde”	133.587
Access and Equity	“Acesso aos serviços de Saúde” OR “Acesso Universal aos Serviços de Saúde” OR “Acesso Efetivo aos Serviços de Saúde” OR “Equidade” OR “Equidade em Saúde” OR “Equidade no Acesso aos Serviços de Saúde” OR “Equidade na Alocação de Recursos”	82.000

Source: author's elaboration.

Regarding the PUBMED Portal, the key items were also worked on with MeSH Terms. Or the construction, the same syntax construction methodology was used and the Boolean operator “OR” was also used. The results are presented in **Chart 3**.

Chart 3. Search results by MeSH terms groups.

Key Items	MeSH Terms/Syntax	Number of studies found
Primary Health Care Financing	(((((“Healthcare Financing” [MeSH Terms]) OR (“Health Resources” [MeSH Terms])) OR (“Financing, Government” [MeSH Terms])) OR (“Health Expenditures” [MeSH Terms])) OR (“Primary Health Care” [MeSH Terms]))	294.185
National Health Systems	(((((“Health Policy” [MeSH Terms])) OR (“Health Services” [MeSH Terms])) OR (“Delivery of Health Care, Integrated” [MeSH Terms])) OR (“Delivery of Health Care” [MeSH Terms])) OR (“Patient Acceptance of Health Care” [MeSH Terms]))	2.793.795
Access and Equity	(((((“Health Services Accessibility” [MeSH Terms]) OR (“Universal Health Care” [MeSH Terms])) OR (“Health Equity” [MeSH Terms])) OR (“Health Care Rationing” [MeSH Terms]))	110.741

Source: author’s elaboration.

Given the large number of results found, it was decided to continue the search strategy using the Boolean operator “AND”, in order to narrow down the search through the connection between the descriptors and the MeshTerms and the different keywords. However, in order to direct the search to the object of study, from the perspective of the basic guarantees that the financing of the National Health System should offer, the keywords “Acesso”/“Access” and “Equidade”/“Equity” were used in the “title, abstract and subject” of the articles, as additional mandatory criteria for inclusion of the article in the final syntax, resulting in the final syntaxes shown below:

VHL/BIREME Portal:

mh:(mh:(mh:(mh:(“Financiamento da assistencia a Saude” OR “Recursos em saude” OR “financiamento governamental” OR “gastos em saude” OR “financiamento de capital” OR “financiamento dos sistemas de saúde” OR “Atenção Primaria à Saude”) AND mh:(“Sistemas Nacionais de Saude” OR “Sistema Unico de Saude” OR “Sistemas de Saude” OR “Políticas de Saude” OR “Serviços de Saude”) AND mh:(“Acesso aos serviços de Saude” OR “Acesso Universal aos Serviços de Saude” OR “Acesso Efetivo aos Serviços de Saude” OR “Equidade” OR “Equidade em Saude” OR “Equidade no Acesso aos Servicos de Saude” OR “Equidade na Alocação de Recursos”))) AND (tw:(“Acesso”)) AND (tw:(“Equidade”)))

PubMed Portal:

(((((“Healthcare Financing” [MeSH Terms]) OR (“Health Resources” [MeSH Terms])) OR (“Financing, Government” [MeSH Terms])) OR (“Health Expenditures” [MeSH Terms])) OR (“Primary Health Care” [MeSH Terms])) AND ((((((“Health Policy” [MeSH Terms])) OR (“Health Services” [MeSH Terms])) OR (“Delivery of Health Care, Integrated” [MeSH Terms])) OR (“Delivery of Health Care” [MeSH Terms])) OR (“Patient Acceptance of Health Care” [MeSH Terms]))

AND (((("Health Services Accessibility" [MeSH Terms]) OR ("Universal Health Care" [MeSH Terms])) OR ("Health Equity"[MeSH Terms])) OR ("Health Care Rationing" [MeSH Terms])) AND ("Access" [Title])) AND ("Equity" [Title])

The result of the addition of these terms in the search, carried out on July 20, 2020, was the reduction to 51 publications in the VHL/BIREME portal and 47 publications in the PubMed portal, totaling 98 publications.

Of the 98 publications, 6 were excluded for being repeated. After that, publications that did not refer to scientific articles were excluded. Thus, 24 publications were excluded for being monographs, theses, internet resources, complete editorials, book chapters, dissertations, and publications that addressed very specific case studies and/or were not related to the theme of financing primary health care in national health systems, leaving 69 scientific articles. After this stage, 28 articles were excluded when the titles and abstracts were read, and 41 remained. Then, the articles were also excluded because they were not available to be read in full. Finally, of the 24 remaining articles, those that were not related to the research question were also excluded (3). Thus, 21 included articles were considered for this review. The description of each step of this process can be seen in **Figure 1**.

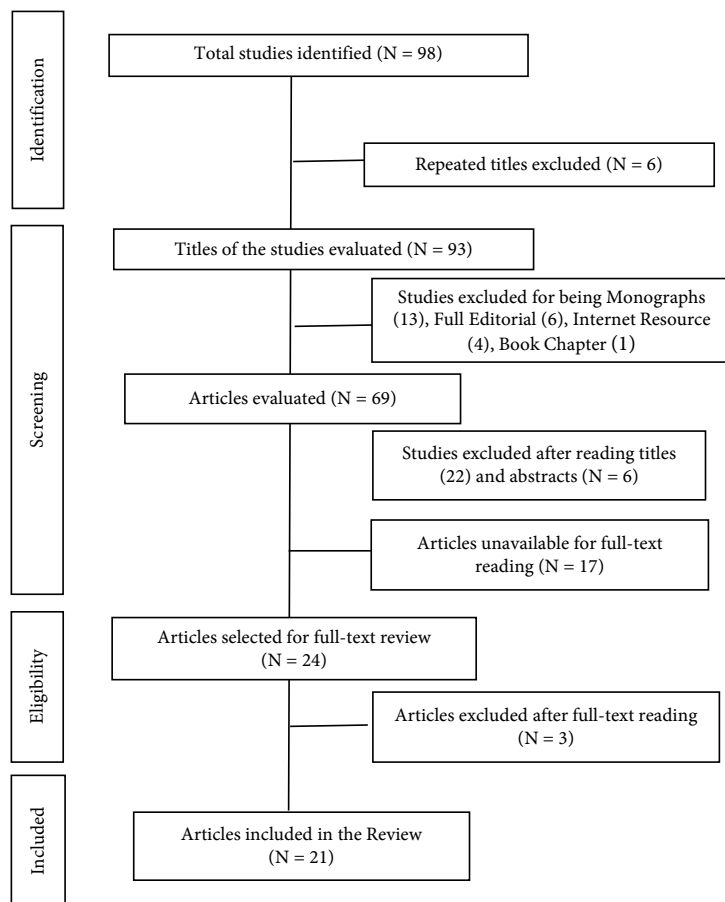


Figure 1. PRISMA flowchart on the selection process of articles included in the review, 2021. Source: author's elaboration.

2.3. Data Analysis

The data analysis process of the included articles followed the integrative review method, including the steps of extracting, visualizing, comparing, and synthesizing the data conclusions. Data extraction was completed by 2 reviewers (D.G.S. and A.M). The data extraction form was prepared based on the research question that guided this review. The articles that generated doubts were consensual among the researchers who jointly arbitrated on their permanence or exclusion.

The following data were extracted from the included articles: author (year of publication), country, objectives, main results, financing of national health systems and Primary Health Care (PHC), access and equity. Data integration was operationalized by the thematic analysis method. This method was chosen because the typology of the articles allowed a more refined integration of the data.

3. Results

Twenty-one publications were analyzed, presented in **Chart 4**, which detail the health system of 16 different countries, with at least one representing each continent, not including Africa, that was mentioned only in one study (McPake et al., 2011) found, but that was excluded from the analysis after full reading for being directed only in a case study on hospital care in Maputo, Mozambique. Two publications present data from regions and contain more than one country analyzed, but mention individual aspects of each country, being them: Araújo et al. (2011) address aspects of Latin American countries (Argentina, Brazil, Colombia and Mexico) and Mcmichael and Healy (2017) who analyze the health systems of the Greater Mekong Subregion (Cambodia, Laos, Muanmar, Thailand and Vietnam).

There was a predominance of countries in Asia, with 8 publications and Latin America, with 7 publications. The countries, object of this study, mentioned in one or more articles with the highest number of publications were: Australia (4), Brazil (4) and Cambodia (4), followed by Argentina (2), Colombia (2) and Laos (2), while Canada, Chile, India, Malaysia, Mexico, Myanmar, New Zealand, United Kingdom, Thailand and Vietnam were in only one (1) publication each. The analyzed publications (21) were published predominantly in English (16), followed by Portuguese (3) and Spanish (2). The results are presented in **Chart 4**.

The presented results show that the publications address not only the issue of PHC financing, but also more broadly the financing of the national health system as a whole, detailing driving aspects, impacts and results in access and equity of policies implemented over the years, especially in developing countries (**Chart 5**). The guarantee of access and equity in national health systems is presented through the perspective of different countries that have different and complementary health financing mechanisms, such as public and private, but

Chart 4. Summary table of the articles included: author, year, country, method, objectives and main results.

Base/Portal	Author, Year	Country	Language	Method	Objectives	Main results
VHL/Bireme	Singh & Chokshi, 2014	India	English	Narrative Review	Outline the ways in which Universal Health Coverage can contribute to the achievement of the right to health in developing countries.	It justifies the defense of the thesis based on Article 19 of the Constitution of India, which recognizes the right to health as an integral part of the right to life, as well as Article 25 of the Universal Declaration of Human Rights and, additionally, the National Health Bill 2009 which identified a series of aspects related to the right to health.
VHL/Bireme	Díaz, 2013	Argentina	Spanish	Case Study; Qualitative	Describe and redesign the challenges of Primary Health Care in order for it to become the main entry point into the Argentinean health system.	It discusses six points to answer the question “what should be done, from management, to solve health inequities?” It considers that PHC should be the main way to enter the Argentine health system, stating that there is still a long way to go and that it requires joint and coordinated decisions, which are oriented towards strengthening PHC with efficient allocation of resources to achieve this objective.
VHL/Bireme	Corscadden et al., 2016	Australia	English	Case Study; Quantitative	Provide evidence on how nations vary in terms of access to PHC, describing what barriers adults in Australia experience in accessing PHC compared to other countries.	It presents a detailed analysis of a 2013 survey conducted by a fund (IHP), putting the results into perspective with the conceptual framework of Levesque et al., 2013. It details that the item <i>Affordability (Ability to be paid)</i> was where Australians stated that there are barriers, and this can be attributed as a reflection of the different levels of financing applicable to PHC services and the increase in co-payments.
VHL/Bireme	Gómez, Jaramillo, & Beltrán, 2013	Colombia	English	Case Study; Quantitative	Assess variation in five dimensions of equity in health in the Colombian Health System. These are health conditions, social health insurance coverage, use of health services, quality and health expenditures.	It details the 1993 Colombian health system reform that implemented social health insurance, expanding coverage through a universal health system and harmonizing health benefits for poor populations. Having as a mechanism to subsidize the demand and guarantee the benefit. Results show progress in terms of equity related to the adoption of health insurance, access to medicines and curative services, and the perception of quality of the health care service.
VHL/Bireme	Sisson, 2007	Brazil	Portuguese	Narrative Review	Develop a reflection on equity and the assistance model of the Family Health Program (FHP), through a review based on authors who discuss the topic.	It reports the evolution of the conceptual debate on health financing. From 1980, when the international agenda showed neoliberal characteristics, until the reforms to control costs, to the guidelines of universalization and public financing of health that were maintained until 1990. The main difference after the reforms was the incorporation of “three main proposals: the separation between provision and financing of health actions; the inclusion of market mechanisms through managed competition; and the emphasis on clinical effectiveness”.

Continued

VHL/Bireme	Lima et al., 2015	Brazil	Portuguese	Case Study; Qualitative	Analyze the elements that influence access to primary care services in the city of Recife, from the perspective of professionals and users. This is a case study carried out in the city of Recife (Brazil), through semi-structured interviews with 46 respondents.	It details barriers to access related to network management, where political influence changes the priority of the use of financial resources and, as a consequence, impacts on continuity of care, making it difficult for professionals to work. Another barrier associated with management is presented in the speech of the interviewed managers and is related to the financing of services in PHC, which have scarce funds.
VHL/Bireme	Ir et al., 2019	Cambodia	English	Case Study; Quantitative	Investigate abusive health financing practices and associated factors among Cambodian households. Primary data from the national household representation survey with 5.000 respondent households was used.	In the data analyzed, practically 1/3 of the homes used loans to pay for health care and 55% of them were through emergency loans. Approximately 50.6% of health care-related loans were used to pay the costs of outpatient care in the previous month. It reports that emergency loans are strongly associated with poverty. The poorer the household, the more likely it is that it will take out this loan, fall into debt and not be able to pay the debt owed.
VHL/Bireme	McMichael & Healy, 2017	Greater Mekong Subregion- Cambodia, Laos, Myanmar, Thailand and Vietnam.	English	Narrative Review	Examine the health needs, access barriers, and policy responses for migrants from neighboring borders of five countries in the "Greater Mekong Subregion" (GMS) by conducting a literature review and research on migrant health and access to health services in Cambodia, Laos, Myanmar, Thailand, and Vietnam.	It shows substantial diversity in the capacity of national GMS health systems. Due to the high health risk to workers, and without health coverage, there is high out-of-pocket spending on health care. They estimate that 3 to 5 million workers migrate between countries. It argues that migrants have a right to health, guaranteed by the international declaration of human rights, which countries have an obligation to respect, protect, and guarantee to individuals under their territorial jurisdiction, regardless of nationality or origin.
VHL/Bireme	Ensor et al., 2017	Cambodia	English	Narrative Review	Describe the evolution of financing policies in Cambodia and analyze data to help assess the impact of the combined policies of public health use and per capita health expenditure.	It presents in a table the system's financing policies and laws since 1996. Between 1999 and 2004, the proportion of communities with some health financing policy implemented rose from 14% to 55%. With exceptions, the impact of the combined policies on what is paid directly by households was not substantially different. While specific policies have different objectives, most require strengthening the overall health system—improving human resources, financial management, quality of care, and information systems.
VHL/Bireme	Andrade, Bezerra, & Barreto, 2005	Brazil	Portuguese	Narrative Review	Analyze the Family Health Program (FHP) as a primary care policy of the Unified Health System (SUS), its expansion in population coverage and the improvement of indicators of access to health care services.	It discusses the process of formulation and evolution of the FHP in Brazil, highlighting innovative aspects of the proposed care and management models, and visualizing their impact on the health of the population of Brazilian municipalities, as well as citing the challenges that this represents for public health policy. It considers that the expansion of the Brazilian population's access to FHP happened along with the process of adequacy of PSF financing.

Continued

VHL/Bireme	Fajuri, 2012	Chile	Spanish	Narrative Review	First, defend the thesis that supports the criteria of health rationing, which are typical of health economics, and which seek to maximize scarce resources, can only be applied at the macro-distributive level of health and not at the micro level. And, as a secondary objective, to propose a model of rationing health resources.	It considers that utilitarian distribution models and criteria should be reduced to the micro-distributive level, and that criteria such as age and income should not be used when defining access rules. At the macro-distributive level, the set of services that a national health system should offer as a minimum must be defined. It suggests replacing the current GES guidelines (Chilean guide) with a basic plan that grants the right to health to 100% of the population, on uniform terms and conditions and that are provided without barriers of any kind.
PubMed	Bigdeli & Annear, 2009	Cambodia	English	Narrative Review	Examine Health Equity Funds (HEFs) and their benefits in terms of expanding access to the service by the low-income population.	HEFs in Cambodia were able to increase public service use and expand access. They have contributed to reducing inequity in health. The impact is even better when a service delivery agreement is made with a third party involved in the community. The role of the third party is usually played by NGOs or local HEF committees, or social or religious institutions. Local government authorities can also play an effective role as HEF holders.
PubMed	Javanparast et al., 2018	Australia	English	Narrative Review	Examine the scope and potential value of Community Health Workers (CHWs) programs in Australia and the challenges involved in integrating them into the national health system.	It considers that CHW are demonstrably effective in low- and middle-income countries, with many examples of successful programs, such as in Brazil, Iran and Indonesia. It signals that there is a growing interest in implementing CHW programs to address inequities in access to health in the most vulnerable groups. However, restrictions on funding CHW programs are a key limitation.
PubMed	Thomas, Wakerman, & Humphreys, 2015	Australia	English	Case Study; Quantitative	Define population thresholds that govern which PHC services would be best provided by a worker residing on site and outline the corresponding issues for implementation.	Good PHC is related to improved health outcomes, lower costs, and better health equity. The principles that underpin the implementation of effective PHC include equity; consideration of the social determinants of health; flexibility, effective distribution of resources, personalized services to ensure consumer acceptability, prioritizing services according to need, and providing services as close to home as possible.
PubMed	Collins & Klein, 1980	United Kingdom	English	Case Study; Quantitative	Analyze access to health, based on data from 27.154 people who accessed PHC and to prove that the income criterion does not influence the Equity of Access to PHC services in the National Health Service (NHS), United Kingdom.	It contradicts existing publications at the time and proves that the NHS managed to achieve equity in terms of access to PHC. This reinforces that there is no consistent bias against lower-income socioeconomic groups. The results also show that different socioeconomic groups have different patterns of behavior when seeking health care.

Continued

PubMed	Richard et al., 2016	Canada & Australia	English	Case Study; Qualitative	Identify innovative ways to improve access to PHC for vulnerable populations and clarify which elements of health systems, organizations or services, and patient or population skills need to be strengthened to achieve transformative change.	It identifies several innovations to improve access to PHC. As a result of the study, it presents an analysis crossing information about the reported initiatives and the concept of access presented by Levesque et al. and concludes that similar initiatives to improve access were reported in several countries, showing that it is possible that everyone is suffering from problems similar access points, even considering the specific contexts.
PubMed	Nagpal et al., 2019	Laos	English	Case Study; Quantitative	Detail the effects of free Maternal and Child Care (MCH) programs on equity to report on a consolidated basis. Offer a detailed analysis of the effects of free MCH programs, with a focus on health centers.	It presents a series of data that point to large persistent inequalities in the access and financial protection of the population and that need to be resolved. There are significant differences in the use of health services when considering economic class and ethnicity. In addition, they consider that from an equity perspective, the MCH initiative has not reached its full potential.
PubMed	Araújo et al., 2011	Latin America: Argentina, Brazil, Colombia and Mexico	English	Narrative Review	Present analysis made by experts in equity in access to health care in Argentina, Brazil, Colombia and Mexico.	Argentina: Needs to increase equity in access by focusing on: 1) improving capacity, structure and management and 2) disseminating the practice of evidence-based analysis. Brazil: it will only be possible when the current reasoning of distributing insufficient resources for real needs is reversed. Colombia: They provide health insurance for the poor. Mexico: The right to health care is guaranteed by the Constitution, but it has not yet been possible.
PubMed	Juni, 1996	Malaysia	English	Narrative Review	Review and analyze the experience of the Malaysian health system, with a focus on the system's performance in relation to access and equity.	Malaysia's health system has managed to reach the entire population in a low cost, virtual, accessible and equitable way, proving improved health outcomes. It invests about 3% of GDP in health, Thailand (5%) and South Korea (6.6%). Everyone has the right to use public services, but there is the parallel private system that is available to those who can pay. However, given worker benefits, it deprives the public of the best professionals.
PubMed	Whitehead et al., 2019	New Zealand	English	Case Study; Quantitative	Examine patterns of patient engagement in general practitioner (GP) services from a geographic perspective.	Results show that ~68% of patients did not go to the PHC service closest to their home, seeking care in a more distant one. The predictors for this decision were: living in a rural area, patient's ethnicity, patient's age, low income, gender, distance from the nearest PHC clinic, after-hours clinical availability, full-time doctor and nurse. Understanding the relationship between geography and access to health services can lead to a better understanding of equity in health systems.

Continued

PubMed	Ir et al., 2010	Cambodia	English	Case Study; Quantitative	Assess the effectiveness of Health Vouchers and Health Equity Funds (HEFs) in improving access to skilled midwives by poor women in three rural districts of Cambodia.	Health financing through vouchers and health equity funds (HEFs) are a mechanism used to address and reduce maternal mortality. "Vouchers" and health equity funds (HEFs) are financing mechanisms to improve access to health services for the poorest. Results show that the number of deliveries in health facilities increased from 16.3% in 2006 to 44.9% in 2008, after the introduction of vouchers and HEFs, also considering self-paid deliveries.
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Source: author's elaboration.

Chart 5. Summary table of the articles included: author, year, country, financing of national health systems and Primary Health Care (PHC), access and equity.

Base/Portal	Author, Year	Country	Financing of national health systems and PHC	Access	Equity
VHL/Bireme	Singh & Chokshi, 2014	India	According to the National Health Bill 2009 and the Constitution, the Indian government should constitutionally provide financial resources for the well-being of the people, raising nutritional levels and improving the standard of living. The provision of health services should prioritize PHC".	No conceptual definition of the term "Access" is presented. It only mentions that individuals should have access to relevant and necessary health information.	It cites "Equity" as a basic principle of Universal Health Coverage (UHC), along with universality, empowerment and comprehensiveness of health care.
VHL/Bireme	Díaz, 2013	Argentina	The Argentine health system is made up of three subsystems: the public, financed at the federal level. The social security system is financed by contributions from salaried workers, and the private system is composed of insurance and direct pre-payments by families. It defines PHC as essential health care, supported by scientific methods, accessible technologies, full participation, with costs within the reach of the State and the community, with health actions as close as possible to where the population lives.	No conceptual definition of the term "Access" is presented. It considers PHC as a fundamental access to the Health System. It reports that to achieve social protection, equity in health and guaranteed access requires the implementation of political and technical mechanisms that are defined based on the identification of health needs, as well as resource allocation and management by performance, with the population as the protagonist.	It describes health inequities as differences in vulnerability and exposure that contribute to increasing social inequality. It proposes six key points as a solution: 1) ensure that all inhabitants have formal coverage 2) PHC as essential health care 3) PHC as a provider model 4) Guarantee social participation, with information. 5) Empower PHC 6) Ensure financing and investment in PHC
VHL/Bireme	Corscadden et al., 2016	Australia	It does not detail the PHC financing model and characterizes, through the research questions, general PHC characteristics related to access. Such as questions related to how often they use a general practitioner or health center regularly, or the difficulty of getting medical care other than in a hospital or emergency room.	It defines people's ability to obtain appropriate health services in response to care needs. It uses the definition by Levesque et al., 2013, which identified 5 key characteristics of services that contribute to access, and 5 corresponding skills of the population. It details that barriers to access can occur given the attributes of the service or the skills of the population.	A conceptual definition of the term "Equity" is not presented. It argues that Access to PHC is associated with cost-effectiveness and equity in health systems, as well as improved health outcomes, particularly among poor people.

Continued

VHL/Bireme	Gómez, Jaramillo, & Beltrán, 2013	Colombia	<p>The financing system before the reform (1993) was based on a cross-subsidy, where people with higher incomes subsidized the poorer population and the federal government financed it with an equal contribution. The main post-reform changes were the expansion of social health insurance (contributory and subsidized), a benefit package with guaranteed health coverage, and the integration of public and private health providers in a unified competition scheme.</p>	<p>No conceptual definition of the term "Access" is presented. It considers that access should be evaluated by time windows. This study (2003-2008) showed a large expansion of social health insurance coverage and this was only possible due to government investment. It states that an important social aspect of health insurance equity is that population coverage leads to changes in access to health services. Evidenced by the significant increase in the use of outpatient, preventive, and curative services.</p>	<p>It classifies "equity" in five dimensions: health conditions, social health insurance coverage, use of health services, quality and health expenditures. They use concentration and horizontal inequality (HI) indices to compare by socioeconomic groups and type of insurance (contributory or subsidized). It analyzes for each dimension the achievement or not of equity (2003 vs 2008). It suggests that equity outcomes may be an effective way of measuring health outcomes in the Colombian health system.</p>
VHL/Bireme	Sisson, 2007	Brazil	<p>It presents the FHP as a program that is in line with proposals recommended in several countries, by national and international organizations, as a model for the reorganization of health care. This model provides for Community Health, Comprehensive Health Care, Primary Health Care and Primary Health Care. Classified as a strategy and not a program.</p>	<p>A conceptual definition of the term "Access" is not presented. It presents, in the Federal Constitution, the justification that equity in health is guaranteed by free "access" to health services, which presupposes an allocation of resources and a care model to guide. In this sense, it places the FHP as an implementing strategy of access to the health system, and through gratuity, it avoids that any unfavorable economic situation hinders the reach of the population to the system.</p>	<p>It considers equity from the point of view of the social justice principle. It carries concepts of social injustice to analyze inequalities in illness and death, as a reflection of the stratified social structure, and concludes that equity in health, even though it is not the same thing, is reflected in social equity. Because, the same way, these different social groups present different demands among themselves and that need to be considered in the programming of the offer of health services.</p>
VHL/Bireme	Lima et al., 2015	Brazil	<p>A conceptual definition of PHC is not presented. The Family Health Strategy (FHS) is a tool financed by the government, which transfers resources from the Federal Government to the municipal government to execute it. However, the supply of resources is insufficient to meet the needs of the population. And effectiveness is limited by the fragmentation and size of resources, which tend to be directed to already structured locations. It treats the issue of SUS care coverage as one of the challenges to keep regional networks integrated.</p>	<p>The definition chosen is presented in the MH Ordinance n° 4.279, which establishes the guidelines for the organization of the Health Care Network within the SUS. It analyzes access through (I) availability, (II) convenience and (III) acceptability. It adds the concept of Aday and Anderson (1974) who have a proposed behavioral model on the use of health services.</p>	<p>A conceptual definition of the term "Equity" is not presented. However, it cites "equity of access" and efficiency of health services as the ultimate goals of the Integrated Health Service Delivery Network (IHSDN), and in the conclusion of the text, it recalls the concept of "Equity" as one of the principles of the SUS, alongside universality and integrality.</p>
VHL/Bireme	Ir et al., 2019	Cambodia	<p>A conceptual definition of PHC is not presented. In Cambodia, the government finances a public health service, but there is still disbursement by the patients who use it. There is also the private health care system, where the population can access it by paying directly or through health insurance. Additionally, there are the Health Equity Funds (HEF), which are investment funds in health, managed by NGOs that finance the care of the demonstrably poor population.</p>	<p>A conceptual definition of the term "Access" is not provided. There is difficulty in accessing health care by the population due to financial factors. The families that most resort to the loan are those with the lowest income and/or those with a large number of residents. Other authors cite consistent and similar information on the topic in Indonesia, Vietnam, Ethiopia, India, Nepal and Myanmar.</p>	<p>A conceptual definition of the term "Equity" is not presented. The term appears in the discussion due to Health Equity Funds (HEFs). However, what the data show is that the families that hold the poverty title to be used via HEF, still experience loan cases.</p>

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VHL/Bireme	McMichael & Healy, 2017	Greater Mekong Subregion-Cambodia, Laos, Myanmar, Thailand and Vietnam.	No conceptual definition of PHC is presented. It highlights Thailand's proposed agreement of understanding with other countries to support the management of migrant workers, which provides a financial basis for access to health services. Countries in the region are looking for sustainable ways to finance their health systems. They are moving toward social health insurance models, which are often subsidized for the poorest by taxes or international donors. However, there are still substantial user-disbursements.	It explores the term through the health needs that migrants have, such as infectious and chronic diseases, accidents at work. There is an inadequate understanding of the vulnerabilities and health needs of migrants, but this is a major challenge. Barriers to access are: Legal/administrative restrictions, language restrictions, cultural constructions on diseases and treatments, discriminatory attitudes and limited experience of health workers.	A conceptual definition of the term "Equity" is not presented. However, it defines Health Inequities as "unfair and avoidable differences that result from some form of discrimination or lack of access to certain resources". (p. 1) It describes the concept of Universal Health Coverage (UHC), based on the sustainable development goals for 2030. To achieve UHC, low- and middle-income countries will need to strengthen their national health systems, with special attention to equity in health.
VHL/Bireme	Ensor et al., 2017	Cambodia	A conceptual definition of PHC is not presented. The existing financing initiatives in the country are: 1) Fee (cost) standardized, regulated by the Government and paid by the user directly to the health service. 2) Outsourcing of different services. 3) Health Equity Funds (HEF), private financing mechanisms, by donors, managed by (NGOs) targeting the poorest. 4) Vouchers, funded by the HEF offer timely access at no cost. 5) Public, non-profit, and voluntary health insurance marketed at low cost to community members.	No conceptual definition of the term "Access" is presented. It evidences that the HEF model was an effective way to stimulate the use of services (hospital, especially) by the poor, even though barriers to access still existed, reduced out-of-pocket spending on health, family indebtedness, and increased use of public health services. However, care must be taken when stimulating demand to also ensure that supply is adequate.	A conceptual definition of the term "Equity" is not presented. Mention is only made of the existence of evidence that health inequities and access to health services decreased in the years analyzed. And this may be related to the financing mechanisms presented.
VHL/Bireme	Andrade, Bezerra, & Barreto, 2005	Brazil	It defines FHP as a PHC model, focusing on the family and community unit. It presents a definition by Hart, Belsey and Tarimo, from 1990, to explain the fundamental role of PHC, which is, in short, "the coordination of the entire health care spectrum", since it is in PHC that care needs are identified. Specialists and the referral to other professionals are coordinated and allows, among other points, a better control of the waste of resources.	No conceptual definition of the term "Access" is presented. It indicates the FHP as an opportunity to expand access to PHC for the Brazilian population and consolidates in a table indicators of Access and Results, putting as indicator of Access: "the percentage of vaccination coverage for measles and poliomyelitis" and of Result the infant mortality rate. It also classifies the number of "SUS medical consultations/inhabitant" as an access indicator.	A conceptual definition of the term "Equity" is not presented. It presents the term in a definition of the Pan American Health Organization, as something desired in the provision of health services. It also recalls the term as a guiding principle of SUS by the 1988 constitution, alongside the term access, hierarchization, integrality, and decentralization of planning, management, and social control.
VHL/Bireme	Fajuri, 2012	Chile	Health systems around the world have adopted a number of strategies to balance equity with sustainable health financing. For example, the Beveridge model, with tax-financed systems, and the Bismarck model, based on social insurance. Health care systems can be classified as "progressive" or "regressive". The first case is when the proportion of costs paid for health care grows as the beneficiary's means grow. The "regressive" model, on the other hand, considers the exact opposite.	It considers it a powerful belief to believe that a just society must pursue a policy of universal access to health care. It defines "universal access" as something that exists when "all inhabitants of the state, regardless of social class, race, or gender, are assured access to a set of basic health care products and services", considering that the state must necessarily bear the costs to ensure a universal health care system.	It considers that there is a prevailing social consensus in the health system of several countries and that it incorporates two key factors: 1) health as a social good, since most services do not generate benefits only for the people who receive them, but also for society and 2) Solidarity, which is presented with five cross-subsidies. They are: 1) caring for the healthy and the sick, 2) Men and Women, 3) Rich and Poor, 4) Young to Old, 5) individuals and families.

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PubMed	Bigdeli & Annear, 2009	Cambodia	<p>A conceptual definition of PHC is not presented.</p> <p>The Cambodian public health system is presented as a whole and details that it is a system financed through three main mechanisms. Being a National Fund (taxes), independent donors and payments made directly by users. Although these three exist, 2/3 of the total health expenditure is financed by the user himself at the time of use.</p>	<p>It deals with the point of view of "Equitable Access", founded by Hardeman et al, who classifies four major restrictions for equitable access: financial, geographic, information and intra-household. He adds that the scarcity of information and the lack of community engagement are major barriers to equitable access. It considers that HEFs can address barriers: Physical, financial, quality, knowledge and sociocultural.</p>	<p>A conceptual definition of the term "Equity" is not presented. The term, unrelated to the concept of "Health Equity Funds", advocates that this system be expanded and included in a strong and structured health policy, so that its role is recognized within an effective and equitable social protection system.</p>
PubMed	Javanparast et al., 2018	Australia	<p>Presents the WHO concept to define CHWs; Characterizes them as members of a community where they live or work, who are selected by and for this community, supported and trained by the health system, but not necessarily part of its organization; Through "Task Shifting" (transferring medical and other specialty tasks to less specialized workers), addresses the lack of human resources, improves access and saves resources.</p>	<p>A conceptual definition of the term "Access" is not presented.</p> <p>It considers that the interest in CHW programs by the richest countries is given the existence of inequities in access to health by different groups of the population and points to the thesis that CHWs are important to provide services in homes, facilitate access to PHC and that there is strong scientific evidence that associates them with increased access to PHC, quality of care and health outcomes.</p>	<p>A conceptual definition of the term "Equity" is not presented. Considers equity as necessary and positions CHWs as part of a coordinated and strategic action to provide an opportunity to increase the performance and efficiency of Australia's health system and improve equity and population health outcomes. It defines Health inequity as disparities between population groups that are avoidable and unfair.</p>
PubMed	Thomas, Wakerman, & Humphreys, 2015	Australia	<p>It does not present, in detail, the operation of the national health system in Australia, but presents a deficit related to the Health System in rural areas (National Rural Health Alliance), clarifying that there is an overspend in the hospital system due to unmet needs in the PHC of rural dwellers.</p> <p>PHC needs to be boosted to offer a range of basic services to the population in remote and rural areas.</p>	<p>It uses Penchansky's definition, which describes access in five dimensions: availability, accessibility, accommodation, affordability and acceptability. accessibility, suitability acceptability, availability and accommodation, ability to be paid and It is necessary to ensure that the use of PHC services is compatible with the health needs of the community. It also analyzes that the disparity and inequity in access to health care demands a systematic and national response. It reinforces the role of the Community Health Agent before evolving the assistance to technology (telecare).</p>	<p>Associated with "Access", its definition is in parentheses as: "any avoidable disadvantages in access that confront those with greater needs and worse health outcomes should be treated as a matter of priority" (p. 4). Additionally: consider health determinants, flexibility, ensuring well-spent resources, services tailored to ensure acceptability, prioritizing services according to needs, and offering services as close to home as possible.</p>

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PubMed	Collins & Klein, 1980	United Kingdom	No conceptual definition of PHC is presented, nor is it detailed how PHC is financed in this system. The only mention of financing is made in the introduction, when it explains that the creation of the NHS, in 1948, aimed, among others, to guarantee equity in the distribution and use of resources. They classify PHC users through the question that indicates people who have talked to or visited a doctor in the last two weeks, but not in a Hospital visit.	A conceptual definition of the term "Access" is not presented. It addresses the issue from the point of view of Access to PHC Services by different socioeconomic groups and the use of the system by people from four health categories: healthy, acutely ill, chronically ill without activity restrictions and chronically ill with activity restrictions. They present data entitled "Use of PHC services by health groups", and the group that had the lowest rate of access (use) to PHC was healthy people.	A conceptual definition of the term "Equity" is not presented. It states the approach to the issue of "Equity", in terms of access to PHC, explaining that, contrary to previous publications, no bias in access to PHC against lower income groups was found in the analysis. It uses the classification of socioeconomic groups as a tool to measure equity. At the end, it presents in parentheses what seems to be considered the principle of equity in publication, which is equal access for equal amounts of morbidity.
PubMed	Richard et al., 2016	Canada & Australia	A conceptual definition of PHC is not presented, nor is it detailed how PHC is financed in this system. Analyzing a strong PHC is essential to improve the health of the population, even if PHC services are not always accessible. Most of the initiatives to improve access to PHC, reported in the survey, are government funded (76.8%), and that around a third receive funding from NGOs.	It defines access as the opportunity or ease with which consumers and communities can use health services in a manner appropriate and equivalent to their health needs. It uses the structure proposed by Levesque et al., which considers social and health aspects of access, within an equity perspective. It summarizes in a table each of the definitions of the dimensions of access proposed by Levesque et al.	It presents equity in access to PHC as an important social determinant of health and considers it a strategy to deal with health inequality. It reports that PHC has a responsibility to promote equity in health as part of its social commitment. That is, developing interventions that support access through fair arrangements based on equitable access to health care for all with equal needs.
PubMed	Nagpal et al., 2019	Laos	A conceptual definition of PHC is not presented. The government developed Reproductive, Maternal, Newborn and Child Health programs and expanded free MCH services from 2013 to 2015. The essence of this initiative was to transfer the user fees and other expenses, which were paid out of families' own pockets, by payments made by the government or donors. Only in 2016, the National Health Insurance (NHI) emerged. However, only 33.2% of total health spending in the country is made by the government. Out-of-pocket spending accounts for the largest funding mechanism for health care spending.	A conceptual definition of the term "Access" is not presented. It considers that even when services are available and affordable, there are still significant barriers to access: adequate information, transportation, and more. Strong monitoring systems are needed to track coverage of essential services, assess the degree of financial risk protection, especially among the poor and vulnerable, to understand the causes of impoverishing health expenditures. In this way, it will be possible to inform the government about what improvements are needed.	A conceptual definition of the term "Equity" is not presented. From an equity perspective, the MCH initiative has not reached its full potential. Several surveys showed that: financial protection was not achieved, equity did not improve, and readiness to provide the service (on the supply side) was inadequate in environments considered poor. It reinforces "an important health policy issue: free care at the point of delivery alone does not equate to universal health coverage.
PubMed	Araújo et al., 2011	Latin America: Argentina, Brazil, Colombia and Mexico	Argentina: Public, financed by taxes and a minimum value in use. Social insurance financed by the worker and employer. Private: Prepaid health plans. Brazil: Public, financed by taxes and private, for those who have health insurance. Colombia: Financed by taxes and solidarity contribution from workers. Mexico: Social Security Institute: compulsory insurance for workers, financed by contributions from employers, federal funds and workers. And popular insurance from the MH.	It depends on the perspective from which it is evaluated. For the patient, access means receiving the best treatment, the best therapeutic option, and at the lowest possible cost, or no cost at all, in a public system. For the physician, it means services for all patients that meet their treatment needs. For technology manufacturers, access would be to offer innovative technologies that can benefit patients' health outcomes.	Mentioned in the title of the article, Equity is defined as the ability to impartially recognize individual rights, with a sense of justice and impartiality as its guiding principles. Therefore, from a social point of view, equity of access means equal rights to the information and resources that are available.

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PubMed	Juni, 1996	Malaysia	Basic health care has been offered since 1957, on a basis of eight free services that make up the PHC, for the population that cannot pay. However, it is a mixed system of private, for those who can pay, being a way of sharing the demand of the public, which offers a series of heavily subsidized services. In rural areas and clinics, it is free, but in urban centers and hospitals, there is a nominal cost established to discourage the population from skipping steps in the referral system.	No conceptual definition of the term "Access" is presented. It considers access to and equity of health services to be a concern of the government. It focuses on providing basic care through a network of physical facilities, prioritizing rural areas. It denominates "Access and utilization of services", to highlight the population coverage of services, consolidating in a table the number of outpatient attendances between the years 1985 and 1993.	There is no conceptual definition of the term "Equity". It details the functioning of the private sector, which is concentrated in more populated areas of the country, where they can maximize profits while the Government, on the other hand, may be concerned with equity issues, and thus continue to reduce differences in the provision of health services and facilities. Recognizes that equity must be combined with increased efficiency and quality of services.
PubMed	Whitehead et al., 2019	New Zealand	A conceptual definition of PHC is not presented. Health financing by the Government of New Zealand is distributed among District Health Boards (DHBs) according to population size and demographic characteristics of each region. DHBs are responsible for allocating resources to PHC organizations. Most of the population is enrolled in one of these organizations, which reduces the costs of visiting the doctor, prescribing medication and other benefits. However, it is common practice for a co-payment for patients over 14 years of age.	It uses the concept of access proposed by Penchansky and Thomas: financial accessibility, accommodation and acceptability of services as non-spatial, essential dimensions of access, together with the availability and accessibility of the service. And cites the abilities of individuals to access and interact with the system. It considers that the assumption that patients will use services closer to home may be wrong. Measuring with indexes of proximity to the residence can create a misleading representation of access and that does not reflect the reality of patients' interaction with the system.	It presents the concept from the perspective of Health Inequities, describing them as systematic, avoidable and unfair differences in health, caused by different opportunities for access and exposure to social determinants such as poverty, housing and the health system itself. Achieving equity in health depends on eliminating disadvantages beyond what is within the individual's control. Ensuring equity in PHC is a critical step, and care must be taken when measuring so as not to give the false impression of equity in the distribution of services.
PubMed	Ir et al., 2010	Cambodia	No conceptual definition of PHC is presented. A complementary system using vouchers and HEFs has been built into Cambodia's health financing model. All public health facilities receive free medicines and supplies from the government, which also pays staff salaries and sends a budget for operating expenses (accounting for about 60% - 70% of total costs). Vouchers began in 2007 to improve access to safe deliveries by poor women. They are considered a demand-side financing mechanism, directly subsidizing the consumer by promoting access to public health services in lower income countries.	A conceptual definition of the term "Access" is not presented. Previous studies conducted in the country have identified several barriers to access related to distance, costs, quality of care, knowledge of users, and socio-cultural practices. Vouchers, used to guarantee access to professional midwives and emergency obstetrics, are two priority and fundamental interventions to prevent maternal mortality. Health vouchers are a financing mechanism to subsidize the price of health services that immediately increase the possibility of accessing and using these services and products.	A conceptual definition of the term "Equity" is not presented. The term appears only in connection with the Health Equity Fund.

Source: author's elaboration.

which are much more complex than this common simplistic classification, evidencing the importance of a national health system being public, financed and

directed according to the health needs and social determinants of its population, having primary health care as its main strategy and guiding model, fully integrated to different levels of care.

Despite extensive dialogue, analysis and historical basis on the importance of ensuring access and equity, the scientific conceptualization of terms for the reader is set aside (**Chart 5**).

According to the information mentioned in **Chart 5**, it is possible to obtain the following synthesis presented in **Table 1** below.

Even so, it is possible to affirm that 100% of the publications explored, in detail, through the literature or a specific case study, initiatives and policies that sought, through different forms of financing, to offer access and increase equity, according to the concepts presented here (**Chart 5**).

The authors analyzed here describe a series of financing models, historical analysis and incentives for primary health care in national health systems. In turn, as diverse as the models presented, is the adoption of the concepts of access and equity addressed.

4. Discussion

The authors analyzed here describe a series of financing models, historical analysis and incentives for primary health care in national health systems. In turn, as diverse as the models presented, is the adoption of the concepts of access and equity addressed.

4.1. Primary Health Care Financing in National Health Systems

The financing models presented vary among the countries analyzed. **Fajuri (2012)**, in his study, faces a challenge similar to this one and makes use of the financing concepts proposed by Beveridge and Bismarck to group the analyzed countries. The first model proposes that national health systems be financed by taxes, as is the case in the United Kingdom, Ireland, Spain, Greece and Portugal and the second, by Bismarck, would be a model financed by social health insurance, as this is the case of countries like Austria, Germany, Belgium, France and Switzerland, for example. By analyzing the publications presented here, we can classify, within this logic, countries such as Brazil and Colombia (**Araújo et al.,**

Table 1. Summary table of **Chart 5** including publications analyzed.

Publications that present conceptual definitions of the terms	Numbers of Publications	%
Access	9	43
Equity	7	33
Primary Health Care	5	24
Total	21	100

Source: author's elaboration.

2011), Chile (Fajuri, 2012), and Australia (Corcadden et al., 2016; Thomas et al., 2015) that are closer to the Beveridge model. And the countries of the Greater Mekong Subregion (Cambodia, Laos, Myanmar, Thailand and Vietnam) (McMichael & Healy, 2017) are closer to the Bismarck model. However, this classification presented here has been subject to controversy, and it is also important to emphasize that in practice, none of these models applied today prevents coexistence with other financing models.

In Brazil, for example, Araújo et al. (2011) report the existence of a public health system, universal, regulated, managed and financed by the Government, available to all Brazilians, without exception, and a private system that offers additional coverage, with different services, to those who adhere to private health insurance (which are also regulated by the Government). Serapioni & Tesser (2019) when analyzing the Brazilian health system against the international typology, conclude that the Brazilian system is mixed/segmented, as it has many Beveridgean aspects, few Bismarckians and adds a new model called Smithians, based on the theory of Adam Smith, and inserted here due to the presence of voluntary private insurance in the Brazilian system.

Following this line of reasoning, Argentina (Araújo et al., 2011), would also fit as a mixed model. The country has a tripartite health system (public, social insurance and private), and the public one, despite being financed by taxes, can charge a minimum amount at the moment of use. Social insurance, on the other hand, is financed by compulsory contributions made by workers and employers, and finally, private insurance, which is organized through prepaid health plans. India (Singh & Chokshi, 2014), on the other hand, constitutionally follows the logic of the health guarantor state, where the government should, as mandated by the constitution, make financial provisions for the promotion of the population's well-being, increased nutritional levels and standard of living. But the government spends only 1.2% of the Gross Domestic Product (GDP) on health, which is very little, leading to increased individual family spending on items such as medication, which could be subsidized, for example.

Ensor et al. (2017) present a detailed analysis of the historical evolution of Cambodia's health care system and financing and additionally bring light to a mode of financing that is considered complementary, explaining that Cambodia's national health system is composed of three forms different types of financing, the first being the government itself through a public health service, but where there is still a disbursement by the patients who use it. The second way concerns the private health system, where the population can access the service by paying directly or through health insurance. And the third way, to meet a demand that the former do not cover, the Health Equity Funds (HEF) were created, which are health investment funds, managed by non-governmental organizations that finance the specific health care of the population that is demonstrably poor. Other publications (Ensor et al., 2017; Bigdeli & Annear, 2009; Ir et al., 2010) detail and analyze the mechanism and its benefit regarding access and

equity for the population.

Generally, most publications analyzed reinforce the importance of PHC as an effective strategy to provide access to health, but do not detail specific financing models for PHC. However, it is possible to highlight some articles that describe PHC financing initiatives more accurately: 1) the case of HEFs, in Cambodia, where authors (Ensor et al., 2017; Ir et al., 2019; Bigdeli & Annear, 2009; Ir et al., 2010) detail the Vouchers mechanism, which enables effective access to PHC care by specific groups; 2) McMichael and Healy (2017) who compile in a table the different efforts and actions carried out by the countries of the Greater Mekong Subregion, specifically to offer PHC services to immigrants; 3) Juni (1996) reports that in Malaysia, basic health care is provided to the population through a defined base of eight PHC services that are offered free of charge to the population that cannot pay.

Furthermore, different initiatives, strategies and programs focusing on PHC are presented, such as the Family Health Strategy in Brazil (Andrade et al., 2005; Sisson, 2007) and the Community Health Workers program in Australia (Javanparast et al., 2018)—also existing in Brazil—which are programs that work closer to the population through community professionals. Díaz (2013) analyzes PHC as a strategy that should not only have a healing commitment, but also a preventive and social one, acting on the fragmentation between the different levels of care, as well as offering coordinated care continuity among them, especially between the PHC and specialized care. For this reason, he believes that PHC should be the main way to enter the Argentine health system. However, he considers that this objective is still far from being achieved, and it is important to generate joint and coordinated actions with an efficient allocation of expenses.

4.2. Guarantee of Access

With different levels of exploration of these concepts, few authors (9) do so, and, as Araújo et al. (2011) explain, access to health has variables that depend on the perspective from which it is assessed.

Singh and Chokshi (2014), and other authors (Fajuri, 2012; McMichael & Healy, 2017; Araújo et al., 2011; Juni, 1996) describe health as a right, guaranteed and assured by article 25 of the universal declaration of human rights and, by the constitution of some countries, such as Brazil and Mexico (Araújo et al., 2011), Chile (McMichael & Healy, 2017) and India (Singh & Chokshi, 2014), for example. And they point out that recognizing health as a right “is a primary requirement for designing, developing and executing relevant health policies, effective programs, quality products and efficient services available to all, thus leading to the realization of the principle of universality” (Singh & Chokshi, 2014: p. 24).

In this perspective, access, conceptualized by Fajuri (2012), approaches the point of view of universal access, as something that exists when “all inhabitants of the State, regardless of social class, race or gender, have access to a set of essential health products and services” (p. 222), considering that the State must

necessarily assume the costs to guarantee a universal health system.

Richard et al. (2016) consider that, “in general, access can be defined as the opportunity or ease with which consumers and communities can use health services in an appropriate way and proportionate to their health needs”(p. 2), a definition that is supported by other authors (Corcadden et al., 2016; Thomas et al., 2015; Araújo et al., 2011; Whitehead et al., 2019), such as Corcadden et al. (2016) who consider that “the access begins when patients or consumers identify the needs and only ends when they receive a treatment that contributes positively to their health and well-being” (p. 223).

It is worth highlighting two definitions of access that stand out from the others presented. The first is the one that Corcadden et al. (2016) and Richard et al. (2016) use. Both use the concept presented in 2013 by Levesque et al. (2013), which is the result of a synthesis of the published literature on the concept of access to health care and which he concluded by synthesizing a classification of accessibility in five dimensions from the point of view of the service, and five corresponding skills on the population side. They detail that barriers to access can occur given the attributes of the service or skills of the population (Corcadden et al., 2016). The definition by Levesque et al. (2013) refers to the service attributes: accessibility, acceptability, availability and accommodation, ability to be paid and suitability. And the skills that are the result of a synthesis of the published literature on the concept of access to health care, of the population, corresponding: ability to perceive, search/seek, reach, pay and engage/involve.

Whitehead et al. (2019) adopts the concept of Penchansky and Thomas (1981) which is similar to the model by Levesque et al. (2013), and which is even worked on in Levesque’s review. The definition of Penchansky and Thomas (1981) considers as non-spatial, essential dimensions of access: affordability, accommodation and acceptability of services, availability and accessibility of the service. It adds that it is important to consider not only the attributes of the service, but also the abilities of individuals to access and interact with the system (Whitehead et al., 2019).

Other definitions were identified, such as Bigdeli and Annear (2009) who define access from the point of view of equitable access, based on Hardeman et al., classifying four major restrictions for equitable access. They are financial, geographic, information and intra-household restrictions. And they substantiate with other authors that the scarcity of information and the lack of community engagement are the biggest barriers to equitable access (Bigdeli & Annear, 2009). Richard et al. (2016) and Thomas et al. (2015) also mention access associated with the term equity.

Whitehead et al. (2019), however, shed light on a problem also identified in this review. There is complexity in choosing indicators to measure access. Whitehead et al. (2019) point out that there is a major flaw in most accessibility measures, as they tend to be location-based rather than people-based and therefore fail to consider spatial, temporal and social components of access, and sug-

gest that researchers carefully consider the importance of spatial and non-spatial domains in equitable access and incorporate these components into more holistic measures of access.

4.3. About Equity

Regarding equity, the term is conceptually presented by few authors (8), however, as [Sisson \(2007\)](#) begins his text: “Equity is above all a principle of social justice” (p. 86). And it is in this perspective that [Fajuri \(2012\)](#) explains that, although health systems have their particularities, there is a predominant social consensus among the countries, which see health as a social good, since most services generate a collective benefit and not only an individual benefit to those who receive them. [Araújo et al. \(2011\)](#) characterize equity as “the ability to impartially recognize the right of each person, with a sense of justice and impartiality as its guiding principles” (p. S8).

Other authors ([Díaz, 2013](#); [McMichael and Healy, 2017](#); [Javanparast et al., 2018](#)), despite not conceptually defining equity in health, appropriate the term while discussing health inequities. [McMichael and Healy \(2017\)](#) classify it as “unfair and avoidable differences that result from some form of discrimination or lack of access to certain resources” (p. 1), similar to [Javanparast et al. \(2018\)](#) who consider them as disparities between population groups and that are avoidable and unfair. [Díaz \(2013\)](#), for example, suggests 6 key points to solve health inequities, being 1) ensuring that all inhabitants have formal coverage 2) Primary Care as essential health care 3) PHC as a provider model 4) guaranteeing social participation 5) Empower PHC 6) Ensure financing and investment in PHC, paying attention to the distribution of resources and amounts charged so that they are accessible and fair.

Other authors ([Díaz, 2013](#); [Corscadden et al., 2016](#); [Lima et al., 2015](#)) despite not presenting a conceptual definition of the term equity, use the concept in different approaches. Whether considering the term as a basic principle of Universal Health Coverage (UHC) ([Singh & Chokshi, 2014](#)), or considering it as intrinsically associated with access to health services ([Lima et al., 2015](#)) and the improvement of health outcomes ([Corscadden et al., 2016](#)), or that must consider social determinants when being financed or evaluated ([Díaz, 2013](#); [Javanparast et al., 2018](#); [Richard et al., 2016](#)).

It is important to highlight that just as there was little consensus on the concept of access or equity, there is also a notable difference between the indices used to measure access or equity. [Sisson \(2007\)](#) states that, although European countries agree with the importance of the principle of equity, there is no consensus on what this means. Becoming, therefore, next to access, one of the great difficulties of comparing the achievement or not of these objectives through measurement.

It can be noticed that the authors ([Gómez et al., 2013](#); [Ensor et al., 2017](#); [Collins & Klein, 1980](#)) use the term “access to the health system” and its measure-

ment from the perspective of use. [Collins and Klein \(1980\)](#), for example, when faced with the need to identify PHC users in the United Kingdom health system (NHS), classify the data of health service users through a question in the survey questionnaire carried out. The question indicates people who have spoken to or visited a doctor in the last two weeks, but who did not visit a hospital, making them, according to [Collins and Klein \(1980\)](#), PHC users and then using this data to explain the main objective of the work, which is to analyze equitable access to health services by the different socio-demographic and economic groups that make up the population. Meanwhile, [Whitehead et al. \(2019\)](#) defined spatial (Geographic) equity as a key component in the equitable delivery of health services, as it is possible to measure the equitable distribution of health care, using geographic metrics of access to the service.

It is worth noting, within the financing models presented, the cases of Colombia ([Gómez et al., 2013](#)), Brazil ([Andrade et al., 2005](#)) and Australia ([Javanparast et al., 2018](#)) which, according to the authors, proved to be successful or minimally capable of improving the indices used to measure guaranteed access and/or equity.

[Gómez et al. \(2013\)](#) present data that prove a significant change regarding equity of access to the health system, after a reform carried out by the Colombian government, which, among other initiatives, expanded social health insurance (by contribution and subsidized), leading to 5, 6 times greater coverage of the population in later years. They also indicate improvements in access to the Colombian health system, from the point of view of equity, for all social classes, but especially for classes with lower incomes. They also show the positive impact that adequate government financing can have in guaranteeing access and equity in health services.

[Javanparast et al. \(2018\)](#), for example, detail the strategy of utilizing Community Health Workers (CHWs) as part of a coordinated and strategic action to provide an opportunity to increase the performance and efficiency of Australia's healthcare system and improve equity and health outcomes for the population, including in countries that are not considered low-income, such as Brazil. In that country, [Andrade et al. \(2005\)](#) historically describe the Family Health Program, an initiative of a primary care model that showed a great increase in the Brazilian population's access to health actions at the primary care level, simultaneously with the process of adaptation of the program financing.

However, it is important to note that not all strategies are successful. [Nagpal et al. \(2019\)](#) describe the Lao Government's initiative to provide free care to pregnant women. It was able to guarantee access, but not equitable, highlighting "an important problem of this health policy, since free care at the place of delivery alone does is not equivalent to universal health coverage and that health system issues require due consideration" (p. i23). This aspect is related to the thinking of [Thomas et al. \(2015\)](#) who consider that the issues of disparity and inequity in access to health care need a systematic and national response to the topic.

4.4. Limitations of This Review

Throughout this review, by means of the research question, there was a search for descriptors that dialogued with this proposed issue. Given the large number of results found, it was decided to continue the search strategy using the Boolean operator “AND”, with the objective of delimiting the search through the connection between the descriptors (VHL) and the MeshTerms (PubMed) and the different key items. However, very high numbers of publications were obtained, being for the VHL, 1.516 and for PubMed, 19.988. With the aim of directing the search to the object of study, in the view of the basic guarantees that the National Health System financing should offer, the keywords “Access” and “Equity” were used in the “title, abstract and subject” of the articles, as an additional mandatory criterion for inclusion of the article in the final syntax. The result of the addition of these terms in the search, although limited to “titles, abstract and subject”, was the sudden reduction to 51 publications in the VHL and 47 publications in the PubMed portal. However, this measure adopted is not what the method of a review advocate, which always suggests using descriptors primarily. But this became necessary to direct the results of the identified studies, in a more precise way, with the research question.

A limiting factor of the review refers to the choice of only two portals (VHL and PubMed). Although these portals have many indexed databases, the search was not carried out exhaustively, as there are other databases that were not used in the research, in addition to other forms of study retrieval that can complement the use of databases such as: ancestral literature, manual search in related journals, the network of researchers, research records, and gray literature (Christmal & Gross, 2017).

The health systems addressed in the results of this study are quite different, which implies different financing schemes. On the one hand, health systems that are closer to the Beveridge model were treated—with a predominance of tax-based financing—such as, for example, Brazil, Colombia, Chile, Australia, etc. On the other hand, there are, for example, the countries of the Greater Mekong Subregion (Cambodia, Laos, Myanmar, Thailand and Vietnam) that are closer to the Bismarck model—financing schemes based on employee/employer contributions. And yet, many of them have mixed health systems—Beveridgian and Bismarckian. There is no doubt that the comparative analysis of the results is limited, as the systems are so antagonistic. Also, it is possible to say that even in universal health systems, such as Australia and Brazil, the financing conditions are very different and difficult to compare. Mainly, in relation to Brazil, it is worth mentioning that in addition to the health system having a historical underfunding and a recent process of unfunding, from the institutional coup of 2016, with the introduction of Constitutional Amendment n. 95, which froze public spending in 20 years, this universality of health is in an intense process of deconstruction (Mendes & Carnut, 2020), bringing more limitations to possible comparisons.

4.5. Implications for Public Policy

This review also presents restricted data on primary health care financing in national health systems, and it is important to produce new studies on this level of health care, with the intention of producing more specific evidence in the area, which, at the moment, after this research, is incipient.

It is important to recognize the limitations that the capture and analysis of the object present. The use of an integrative review, despite demonstrating an approximate overview of how an object has been studied, financing primary health care in national health systems, has the limit of not focusing essentially on the object per se. This demonstrates how some articles included in the review do not directly present financing schemes for primary care and are much more directed to the general financing of health systems, that is, they only “surround” the object, bringing subsidiary elements to think about the allocation of resources for primary health care, without often demonstrating a finished method and its dimensions/indicators. This implies that, in further studies, broadening the scope (through other databases) and using other review methods of greater precision in the apprehension (systematic reviews, for example) may be the way to advance the discussion.

It is noteworthy to recognize that the methodological strategy used for this object (primary health care financing in national health systems) is a challenging research topic, and, precisely because of this, few studies in the literature available in these two revised databases/portals were found. This reveals the importance of adapting the best type of review according to the researched object and its presentation in the scientific literature. Thus, it is understood that, even under the limitations of the method used, this is still the best way to capture this object at this stage of development of scientific research.

Despite these limitations of the present review, the effects on public policies of national health systems are relevant, enabling data on the knowledge of different financing schemes, in terms of access and equity, and their likely adoption by some countries. However, it is understood that more powerful studies are needed to ensure the analyses developed here.

4.6. Advances of This Study and the Research Agenda

After pondering the limitations of this study, it is essential to point out that its possibilities are undeniable in the debate on primary health care financing in national health systems, especially in times of long-lasting economic crisis (Roberts, 2016). As much as it has already been ratified in the scientific literature that the central problem of the macroeconomic health issue in the world, especially in this context of reinforced crisis of the Covid-19 and economic crisis, is the lack of financing of its public sector, allocating resources for primary health care admits a solution, even if palliative. Thus, knowing financing possibilities that guarantee greater access and equitably allocate resources for primary health care, as a guiding model for national health systems, means, in addition to

enabling a fairer distribution of weak resources in the context of crisis, it is ultimately instance, allow attempts to provide health systems that better respond to the health needs of the population.

This study is presented as a baseline study, given the lack of synthesized and organized evidence on the primary health care financing in national health systems (levels 4 and 5), as [Souza et al. \(2010\)](#) comment in relation to the hierarchy of evidence, according to the research design. Thus, this review proposes to present itself as an initial study for new researchers, demonstrating the path of financing articles for primary health care in national health systems, being, therefore, a guide for new research.

To sum up, it is important to highlight the main contribution of this research according to the following aspects: 1) to enable the extensive debate regarding the financing of primary health care in national health systems; 2) to learn about experiences in different countries on ensuring the allocation of resources to primary health care as mechanisms for solutions in a context of economic crisis that has been impacting health systems; 3) to know possibilities for allocating resources for primary health care in national health systems that expand the population's access and ensure greater equity, with a fairer distribution of resources; d) to have information on health systems that, through their financing scheme, have been responding better to the health needs of the population in a scenario of an economic crisis.

5. Final Considerations

This review shows, firstly, that Primary Health Care (PHC) is a fundamental mechanism in national health systems. These can be financed in different and creative ways, having PHC as a guiding strategy, as regulated in the Unified Health System (SUS) in Brazil. However, it is also evident that PHC will only be effective and guarantee the universal right to health once it is adequately financed, offering equitable access to the population, according to the health needs presented.

As [Porto \(2002\)](#) points out, there is no consensus on a single concept of equity or access. In this sense, it is necessary to promote theoretical and conceptual basis of the terms when using them, offering depth and common understanding to the reader.

The countries that indicated improvement in health outcomes when comparing access and equity measurement indices were countries that had extensive government financing, such as Colombia ([Gómez et al., 2013](#)) by expanding cost-free access to health insurance by poorer population, or from Malaysia ([Juni, 1996](#)) that directed resources effectively and, even investing relatively less than neighboring countries, obtained an improvement in the analyzed indexes. However, the indiscriminate availability of the resource alone will not solve the problem of avoidable and unfair disparities between different population groups. It is as indicated by [Araújo et al. \(2011\)](#) who claim that it is necessary to reverse

the distributive logic of resources that is directed towards programs that do not address the real needs of the population.

For sure the solution is not simple. Providing health care facilities that are close to where people live can be a common measure to ensure equity. However, not paying attention to items such as opening hours, customs, cultures, languages, and ethnicities can result in barriers to access. And, despite being geographically close, the service becomes unfeasible, as for the residents of New Zealand, analyzed by [Whitehead et al. \(2019\)](#), who showed no preference for seeking care in the location closest to home, showing that the approach to access, in light of the availability of health care facilities closer to home, has important limitations.

Brazil stands out, along with other national health systems, with its regulated and established financing. Despite different PHC financing mechanisms, throughout the history of the SUS, it is essential to consider the provision of resources according to health needs, as recommended by law n.141/2012 ([Brasil, 2012b](#)). The importance is to ensure not only adequate financing, but also to establish distributive indices that reflect the reality of the population's health needs. In this sense, guaranteeing equity and access means guaranteeing unequal funding for unequal needs and, therefore, any mechanism that does not take this into account cannot be classified as equitable, as it would violate one of the guiding principles of the SUS.

Thus, it is essential to maintain positive and continuous financing of primary health care as the guiding model of national health systems, having as a principle the distribution of resources according to health needs, ensuring access and equity. However, listening to the population and understanding their customs, cultures, and ethnicities has proven to be fundamental to address avoidable barriers. However, executing a plan and not adequately measuring the achievements can lead to serious mistakes. That is why it is necessary to promote the measurement of advances in access and equity through reliable indexes shared between different realities, unifying knowledge on the subject.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this study.

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