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CHALLENGES OF PRIMARY HEALTH CARE IMPLEMENTATION FROM A HUMAN RIGHTS APPROACH

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— Abstract—

This paper is aimed at recognising the guidelines and challenges raised by the implementation of PHC from a Human Rights approach. With this purpose we reviewed and analysed the origins of the primary health care (PHC) concept, its meanings, implementation and interrelationships with the health system, the right to health and the social, political, economic and cultural context. As a result of this analysis we concluded that: a) the implementation of PHC from a Human Rights approach means not just its recognition as a health strategy for organizing the health system and guiding principle for health actions but as a political and social tool for citizenship construction and as relevant concept for the development of national and supranational regulatory frameworks to compel the State to act as a guarantor and promoter of the right to health b) the right to health has to be recognized as a fundamental human right, inextricable from other economic, social and cultural rights and c) public policies and health systems need to be based on PHC in order to guarantee universal health access.

Keywords

Primary Health Care, Human Rights, Public Health Policy; Policy Making, Health Policy, Planning and Management, Social Determinants of Health.

This article aims to recognize the guidelines and challenges posed by the implementation of PHC from the Human Rights approach. With this purpose we reviewed and analyzed the origins of the Primary Health Care's (PHC) concept, its conceptions, way of implementation and interrelations with the health system, the right to health and the socio-political, economic and cultural context. As a result of this analysis we concluded that: a) the implementation of PHC from a Human Rights approach means not just its recognition as a health strategy for organizing the health system and guiding principle for health actions but as a political and social tool for citizenship construction and as relevant concept for the development of national and supranational regulatory frameworks to compel the State to act as a guarantor and promoter of the right to health b) the right to health has to be recognized as a fundamental human right, inextricable from other economic, social and cultural rights and c) public policies and health systems needs to be based on PHC in order to guarantee universal health access.

The first section deals with the conceptualizations about PHC and its more immediate precedents; secondly, the implications of conceiving PHC from a human rights perspective are analyzed; thirdly, the way in which the right to health has been regulated in the national legal order is studied; fourthly, the characteristics of the health system are described and, finally, the context of health commodification in the 1990s and its current re-edition

PHC CONCEPTUALIZATIONS

This section seeks to answer the following questions: How has the PHC been conceptualized? How did it come about? How has it been used? It starts from the premise according to which the concepts are not neutral, but that it is conditioned and conditions concrete practices, delimits the problems that are addressed and the possible solutions or answers that are elaborated and implemented. The conceptions that sustain health and PHC impact on the political legal structure and vice versa. For this reason, it is considered that a restrictive conception of the scope and a PHC extension entails a restrictive response of rights incompatible with the national legal scaffolding.

The milestone of the PHC is established from the Alma-Ata Conference (1978) where an alternative framework is proposed to organize the health system, the health problems of the most vulnerable population. In this framework, PHC is defined as "essential health care based on practical, scientifically founded and socially acceptable methods and technologies, made available to all individuals and families in the community through their full participation and at a cost that the community and the country can support,

in each and every one of the stages of its development with a spirit of self-responsibility and self-determination. Primary care forms an integral part of both the national health system (of which it constitutes the central function and the main core), and of the overall social and economic development of the community" (Pan-American Health Organization, 1978).

Since the 90s, health is considered as a fundamental component of a country's development process in the region, establishing a close link between both concepts. Thus, health is placed as a condition of development and they urge to establish health equity between the different countries and towards the interior of each one. From this conception of health, it begins to intervene in favor of improving the populations' living conditions. Health promotion becomes an effective proposal because it recovers the importance of the social environment.

In this sense, PHC has been thought of as: a philosophy based on principles such as universality and social equality, equity and social justice, integrity, self-responsibility, participation and community development; a strategy for adapting human resources, social participation, intersectional articulation, programming integrated by needs, appropriate technology, new organization modalities and reorientation of financing; a program that includes plans, objectives, activities, minimum and essential services to maintain the population's health. Another way of conceiving it, not excluding other visions, is that PHC can be a way of organizing the health system, based on the three levels of care, but whose focus is placed on the first level. It can be briefly mentioned that the first level has to do with the activities of promotion, prevention, assistance, diagnosis, treatment and rehabilitation of basic specialties, in the ambulatory modality. The second level of care: includes actions and specialized ambulatory care services, and/or requiring hospitalization.

While the third level of attention: includes actions and services of high specialty and medical and technological complexity, constituting the last level of reference. Some systems that are more inequitable, less promotional and preventive, allocate a large part of the health budget to this last level of care.

Within the PHC the circulation of people must be organized by the different levels of complexity. Following this logic, more must be invested in the first level of attention since it is constituted as the entrance door to the health system, hence some authors suggest that the most qualified and specialized personnel should be at this level (Testa, 1985).

However, PHC implies much more than the first level, it **operates as much as a theoretical, ideological and operational framework in which responses to health problems can be found**. Thus, PHC focuses on the community's main health problems, which is why it focuses on maternal and child care, actions at home, immunizations against major infectious diseases; fight against vectors; medicine supplies, the implementation of the family doctor (territorial organization proposed through the Dawson Report); sexual bio-politics and reproductive patterns; technology applied to health; incorporation of alternative or traditional medicine to health teams; training of community human resources and cross-community programs.

PHC is the initial link or the gateway to the health system, because it is usually located within the communities themselves, where the daily life of individuals is developed. It is designed to provide essential health care, but in the case of a vulnerable population, accessibility at the first level of care is often the only one available (Testa, 1985). However, it must be kept in mind that although the PHC strategy implies revaluing the community as a center for defining health problems, and for drawing up public policies based on it, we must not fall into the myth of the community or address problems of "a fictitious community". This is a community defined from expert knowledge without having a real territorial base; a community homogenized in its differences, in which heterogeneities are not distinguished inwards -for example, considering a village homogeneous from the spatial delimitation and without thinking about the subjective delimitations, ethnic boundaries within the same community (Rodriguez Garavito, 2017).

Thus, the PHC serves as a framework that defines what health interventions, where they are carried out and how they are produced or implemented. To do this, it is necessary to contextualize PHC, since each scenario defines the specific scope it has. Therefore, we can mention that there are as many PHC strategies as there are health systems in which it is inserted. This must be taken into account for effective, efficient and equitable interventions.

It has been used in some social contexts to reduce health system costs and in this sense it was constituted as a "poor strategy for the poor", **focused and selective**, understood by some authors as a specific set of health activities aimed at specific population groups, usually the poor.

In this way there are some limitations that the PHC finds that have to do, on the one hand, with the existence of differentiated services for different social groups and not for the whole population and on the other, with which it can be designed as a form of decreasing social health spending.

In fact, for the PHC will be such, when it is constituted as "a network of interconnected establishments by clear procedures of reference and transmission of pertinent information that orders the patients' internal circulation; a social behavior that follows the rules of income and circulation" (Testa, 1985). Then, if certain conditions are not met: regionalization, organization of circulation and interconnected network of establishments, we would not be in the presence of PHC but rather configuring what this author calls: Primitive health care.

For this reason, the elaboration and implementation of public policies and health systems based on PHC, capable of suppressing barriers and accessibility deficit to health systems is intended.

However, in spite of the fact that different definitions have been elaborated (PHC: selective, PHC as the first level of attention or as a gateway, PHC Integral, PHC from a human rights approach) and different PHC categorizations and classifications have been proposed, there are few studies that account for the interactions that emerge from the configuration of the Health System, PHC, and the right to health.

WHAT DOES THINKING ABOUT PHC INVOLVE FROM A HUMAN RIGHTS PERSPECTIVE? A VIEW LOCATED IN ARGENTINA

Thinking about PHC from a human rights perspective implies that health is conceived as an essential human right and, therefore, must be guaranteed and promoted by positive actions of the state, health as a right cannot and should not be trapped in market logic, cannot be offered as a consumer good.

It also implies the national and supranational guarantee of enforcing the right to health in judicial headquarters to fulfill an elementary right intrinsic to life. Although, taking into account that the human rights' judicial process does not end up being a suitable way, given the structural limitations and the barriers in the access to justice that affects in the majority of the cases, to the same people that are deprived of the right to health - *disadvantaged, fragile* people. In this sense, several authors agree that "Judicial process, up to now, is not actively promoting equity, the right to health and inter-institutional dialogue" (Gotlieb *et al* 2016).

In this sense, Lorenzetti (2008) states that, "anyone who does not have access to the basic primary goods that the market provides, does not have access to the basic legal rights that the justice system offers" (Lorenzetti, 2008: 65). Thus, access to justice ends up being restrictive for vulnerable people, who are

deprived of public health promotion and disease prevention policies, in addition to being passive recipients of targeted measures, which end up stigmatizing poverty and sanctioning, explicit or implicitly unhealthy "lifestyles". With actions that tend to hold people responsible for their own health state.

Following Abramovich (2004), the rights approach does not take as a starting point the existence of people with needs that must be assisted, "but subjects with the right to require certain actions, benefits and behaviors (...) Rights establish correlative obligations and these require mechanisms of enforceability and responsibility". Therefore, in this perspective, actions towards the granting of power through the recognition of rights are addressed. Thus, understanding from the rights approach implies that "the obligation to reduce poverty does not come simply from the fact that certain social sectors have needs, but also that they have rights, attributions that give rise to legal obligations on the part of others and therefore to the establishments of tutelage, guarantee and responsibility mechanisms" (Abramovich, 2004: 11).

Therefore, the rights approach enables judicial actions, in the subjects' ownership to claim, before the corresponding authorities, the lack of fulfillment of an obligation. According to Abramovich (2004) this does not limit the governments' margin of action to "own their strategies" hence it is possible to make compatible, even if different paths are taken "state ownership and self-determination of their actions" with the full realization of Human Rights contemplated in the international normative body. States can choose different strategies, have a wide field of discretion, to carry out actions that guarantee human rights and fulfill their positive obligations. In this way, the human rights approach is compatible with the decisions adopted by the states for health promotion and diseases prevention.

Another implication of the rights approach adoption is that although the State enforces its obligations to other non-state actors, it is ultimately responsible for compliance with the obligations imposed by the national or international human rights law (Abramovich, 2004). For example, in Argentina, the Supreme Court of National Justice (SCNJ) considered the federal government as guarantor of the right to health enshrined in the Constitution and in Human Rights Pacts, thus imposing on it the obligation to provide health care services, in the absence of provision by provincial effectors.[1] However, what this failure evidenced was the lack of adequate

1 Supreme Court of National Justice, Argentina. SCNJ: Cause V.625.XLII "Verga, Ángela and others w/ National State and others under precautionary measure"

constitutional mechanisms for the federal government to intervene in the design of public health policies in the provinces (Abramovich, 2004).

In judicial pronouncements, the right to health and its preservation as included in the right to life has been reaffirmed and has highlighted the non-deferrable and non-delegable obligation that the State has to guarantee this right with positive obligations -based on international treaties by empire of the art.75 inc. 22 of the Argentine National Constitution (ANC). It has also been pointed out that the right to life is the first right of the human person that is recognized and guaranteed by the ANC.

Health as a right has indeed been recognized in the national normative body, as an international one. In this way, we can mention some of the international agreements that contain specific clauses that protect life and health and that oblige the national state to ensure compliance and promote all necessary measures -progressively- to preserve the right to health. This is what is established in: American Declaration of the Rights and Duties of Man (art. VII); the Universal Declaration of Human Rights (art. 25, Inc. 2); American Convention on Human Rights (San José de Costa Rica Pact,[2] arts. 4°, Inc. 1 and 19); International Covenant on Civil and Political Rights (art. 24 Inc. 1°) the International Covenant on Economic, Social and Cultural Rights (art. 10, Inc. 3°), linked with the assistance and special care that must be ensured.

The commitment assumed by the states parties obliges them to have up to "maximum resources" to achieve the full effectiveness of the rights recognized in the International Covenant on Economic, Social and Cultural Rights[3] (art. 2, Inc. 1; art. 12, International Covenant on Economic, Social and Cultural Rights).

THE RIGHT TO HEALTH IN THE ARGENTINIAN JURIDICAL SYSTEM

The Legal System, as we know it, is supported by the full validity of the ANC, which is the Supreme State Law, which sets formal and material limits

2 CN Argentina, art.75. inc. 22. Available in: http://servicios.infoleg.gob.ar/infolegInternet/anexos/0-4999/804/norma.htmLey 23.054 Approves the San José de Costa Rica Pact. Available in: http://servicios.infoleg.gob.ar/infolegInternet/verNorma.do?id=28152

3 CN Argentina, art.75. inc. 22. Available in http://servicios.infoleg.gob.ar/infolegInternet/anexos/0-4999/804/norma.htm.Ley 23.313. Approves the Economic, Social and Cultural rights International Pacts and its Optional Protocol. Available in: http://servicios.infoleg.gob.ar/infolegInternet/anexos/20000-24999/23782/norma.html

to political power. The rights and guarantees enshrined in the ANC, are characterized by their breadth and universality (reach all the inhabitants of the State, whether national or foreign). This characteristic derives as much from the preamble as from articles 14 and 20 of the ANC. Thus, the ANC feels an egalitarian principle for nationals and foreigners.

It should be noted that, with the 1994 Constitutional reform, the right to health was included explicitly through article 42 of the ANC. However, several authors consider that the right to health did not have adequate constitutional treatment in the country, or was regulated in an unsatisfactory manner (Moyano and Escudero, 2011), basing its main criticism on the fact that although it refers to the right to the protection of health, it does so in relation to the consumption of goods and services.

On the other hand, other authors believe that since the aforementioned reform the existence of the right to health in the courts has been made visible and judicial activism has been generated in order to assert that right (Abramovich and Pautassi, 2008).

Despite the aforementioned, it can be discussed that even before the constitutional reform the SCJ's jurisprudence, which acts as the last interpreter of the ANC, understood that the right to health is an essential Human Right. In numerous failures the SCJ even considered the right to health more hierarchically than other rights[4]. Priority in case of collision of interests the rights to life, health, physical and psychological integrity over property rights.

Despite the above, the fact that the right to health was not included, or was not expressly contemplated, even before the constitutional reform, did not prevent its existence from being recognized in numerous judicial decisions[5], considering it a right attached to life, detaching it from art. 33 of the ANC (Bidart Campos, 2005).

Indeed, as Bidart Campos (2005) argues, article 33 ANC[6] serves as a matrix to admit new rights, or to expand those enumerated, the "*content calls for a*

4 Supreme Court of the National Justice, Argentina. SCNJ (Court decision, 255: 330); (Court decision, 263.453; 306: 1892).

5 Supreme Court of the National Justice, Argentina. SCNJ "Ponzetti de Balbín" (Court decision 306: 1907); "Baricalla" (Court decision 310: 112)

6 Article 33 SC.- The declarations, rights and guarantees that the constitution enumerates, will not be understood as a denial of other rights and guarantees not enumerated; but that they are born of the principle of people's sovereignty and of the government's republican form.

flexible and progressive interpretation consistent with the purposes and values established in the constitution".

Thus for Bidart Campos (2005) the list of rights listed does not exhaust the list of recognized rights. In this same sense, Zarini (1996) states that every man's fundamental or primary right must be considered included in the ANC, whether or not explicitly recognized as for example: the right to health, life, physical integrity, honor, intimacy of private life. For both authors, there are implicit rights that arise from the democratic ideology of the national constitution and derive both from international treaties and declarations on human rights with constitutional hierarchy (by application of article 75 Inc. 22 ANC), from their political philosophy and from their ideological roof. In effect, the constitutional enumeration is not limitative, but merely exemplary, in no way can we ignore the fundamental rights of man, the republican system and the people's sovereignty, either by imperfect enunciation, or omission, or because they could not be planned (Zarini, 1996, p.140).

So the debate about whether the right to health has express or implicit consecration becomes at least partial, since the interpretative effects that emerge are comparable, and in no way has it limited the right to health recognition in the judicial area as it arises from failures both prior to the reform and as subsequent[7].

The SCJ's doctrine reiterated that the "man has inherent or pre-existing rights to positive law that must be enforced compulsory by judges in specific cases, regardless of whether or not they are incorporated into legislation"[8].

Finally, following Bidart Campos (2005) after the 1994 reform, it can be acknowledge that the right to health has gone from being considered an individual right of each person, to being considered a right of collective incidence, and also, in both cases, as an essential human right. For the author, both of the 1853 constitution, and of the 1994 reform, of the judicial

7 SCNJ "Campodónico de Beviacqua Ana c. Ministry of Health and Social Action, Secretariat of Health Programs and Bank of Neoplastic Drugs" 2000 and "Association Benghalensis and others c. Ministry of Health and Social-National State Action" 2000. The Law, 2001-B, 12."Etcheverry Roberto c. Omint Stock Corporation and Services". 2001; Court decision: 321: 1684 and cause A.186 XXXIV "Association Benghalensis and others c / Ministry of Health and Social-National State Action under protection law 16.986" of June 1, 2000.

8 SCNJ, (Court decision: 241: 291) 1996. Voting by the Minister of the Supreme Court of National Justice, Dr. Fayt, in the case "BRE, c. Argentine Federal Police under protection" (B.77.XXX), of December 17, 1996.

decisions and of the human rights' international law system, it appears that health has the value of a collective legal good. This author, quoting Dr. Rodolfo Vigo, says that "the constitution "text" must be interpreted from a "con-text"; the constitution is more than what its rules say". Always taking into consideration the principle "pro homine", the principle "pro actione" and the principle "favor debilis" (Bidart Campos, 2005).

In this same sense the SCJ considered that the interpretations should contemplate "the particularities of the cases, the legal order in its total harmony, the aims that the law pursues, the right's fundamental principles, the guarantees and constitutional rights, and the achievement of concrete, legally valuable results"[9]. In practice, the right to health is defined by the historical and current configuration of the health system, the type of coverage that it establishes, how it organizes the circulation of people through health services, measures for the promotion and prevention of diseases that it adopts, in short if it implements the PHC (as a universal or selective strategy, comprehensive or restrictive, fragmented, segmented), as well as the link with other sectors and with the structural determinants of the health-disease-attention-care process (H / D / A / C) of the communities.

ARGENTINIAN HEALTH CARE SYSTEM: PHC POSSIBILITIES AND CHALLENGES

According to the World Health Organization (2000), Health Systems include all the resources that a society dedicates to the protection and improvement of people's health and covers all activities whose main purpose is to promote, restore or take care of health (WHO, 2000: 3-12). Health systems articulate three components: management, financing and care.

The health system in Argentina is a complex system, where the same institutional political conformation of the country -federal- generates a division in different jurisdictions and governments (national, provincial and municipal). This demarcation of powers between the Nation and the provinces is based on the ANC, which has translated into practice in superposition and dismantling of laws, resolutions, programs not necessarily coordinated among them. However, the federal organization has not prevented other countries such as Brazil and Canada from organizing their health system in an integrated manner.

9 SCNJ: "Saguir y Dib" 1980 (Court decision: 302:1284) Available in: http://falloscsn.blogspot.com.ar/2005/08/saguir-y-dib-1980.html

In Argentina we can distinguish, as in most Latin American countries, three subsectors that coexist in a disjointed and fragmented way: 1) the public subsector, 2) the social security subsector and 3) the private subsector. We have subsectors that are not integrated among each other, but that also towards the interior of each subsector this disintegration and disarticulation that deepen inequities and asymmetries are repeated. Thus, we are in the presence of a segmented and fragmented health system. Segmentation implies: the coexistence of subsystems with different financing modalities, affiliation and provision of health services that will depend on labor insertion (or not), income level, payment capacity and social position, while fragmentation implies: coexistence of several non-integrated units within the health care network (PAHO, 2007).

There is also a multiplicity of financing sources, the public sector is financed with fiscal resources, in general from regressive indirect taxes, the Social Works are financed with a percentage of the salary of the workers and employers and a solidary fund of redistribution is constituted, while private entities are financed with the particular contribution of the people who hire the service (Belló, Becerril Montekio, 2011).

It should be noted that according to the World Health Organization (WHO, 2009), Argentina is the country in Latin America with the highest investment in health; it invests 9.6% of the gross domestic product (GDP). But higher total spending does not necessarily translate into greater health for the population, nor better indicators. Of the total expenditure on health, the public subsector only finances 48%, and the rest between private and social works. It can be mentioned that the United States is the country that spends the most of its gross domestic product (15.3%), almost 46% of this expenditure goes to the public sector, for the implementation of the Medicare and Medicaid systems.

It is necessary to stress that the greater the contribution of public spending, the more equitable and redistributive will be health spending. For ECLAC (2011) in Argentina the main source of inequities comes from: 1) excessive private spending, 2) excessive fragmentation of health spending, and 3) little public sector participation in spending. This gives rise to what they call triple fragmentation at the regulatory, territorial and rights level (ECLAC, 2011).

PHC INSERTION CONTEXT

PHC varies according to the social, economic, political and legal context in which it is inserted and according to the health system configuration in which it is to be implemented (Yavich *et al* 2010).

Thus in restrictive, regressive contexts, where the economic order defines priorities in health has had little extension and development. As mentioned before, the Argentine health system, in its institutional legal framework, was configured, following the principles of universality, gratuity, solidarity, progressivity; those that were distorted in its implementation, widening a gap between what the law prescribed and the form of organization assumed by health services (selective, expulsive, ineffective and inefficient). A gap that is further deepened by the application of neoliberal measures to the health sector -in the 90s and nowadays- based on targeting, fees, digressiveness, sectorial and selective vision and outlining health as a consumer good, defined by a State model with minimum rights.

In the 1990s, a series of reforms took place in the health sector in which neoliberal measures were applied, leading to decentralization, targeting, fees, hospital self-management model, rationing, and free election of affiliates to the social work, allowing the transfer of contributions to the companies of prepaid medicine and the emergence of intermediary providers of health, framed in the guidelines of the Washington Consensus that supposed: fiscal discipline (adjustment), privatizations of public services, tax reform, deregulation, openness to foreign investment (Comes, 2008). These reforms were widely criticized, as they negatively impacted the population's health, widening the inequality gap. This process was called commodification of the health sector (Comes, 2008).

In this sense, Maingón (2000) considers that these measures have deteriorated the standard of living of large population groups and have accentuated the concentration of income and increasing poverty.

The incorporation of neoliberal measures to the health sector was triggered not only by an economic or political process, but ideological, in which a communication matrix was constructed that dominated official and private discourses, in pursuit of the system's effectiveness and efficiency principles but at the expense of equity, where the role of the State was minimized.

As Arce (2010) points out, the paradigm of universal coverage was abandoned, with the adoption of pro-competitive reforms, based on the recommendations

of international organizations, interested in guaranteeing the financial sustainability of the system. These processes are reissued at present.

In this context, it is the economic order that defines health priorities, defines a model of democracy and defines a model of citizenship. The implementation of social policies according to the capital logic generates limited democracies, leaving out the social expression of democracy (Zemelman, 1992).

This way a citizen who loses his right's quality of subject emerges to be an object of care and tutelage, the subject is passive, does not participate in the processes of decision making or management. Setting out what Fleury (1997, 2007) calls inverted citizenship or states without citizens, where there is an absence of social integration, dismemberment of the social fabric, exclusion and inequality, marginalization of population sectors that cannot access a formal job, or if they do access it, they do it in informal or precarious conditions, which is solved or pretended to be solved with an emergent nature assistance model, with reeducation characteristics towards the most vulnerable groups, that although they may access certain goods and services, a compensation relationship is established that it ends up stigmatizing the group and they do not form a relationship of right but of assistance. The citizen has to prove that he failed in the market to be the object of social protection, it is in this sense that the author speaks of inverted citizenship.

It should be noted that, as Iriart, Merhy and Waitzkin (2000) maintain, a large part of the reform process was done without discussion in the Legislative Branch and eluded public debate, giving a silent political process. Speeches of "experts" appear who propose that the health sector crisis is due to financial causes and the market would operate as a regulator of costs and improve the effectiveness of benefits, adopting managed care. This involved the adoption of financial and administrative reforms in order to separate the provision of service from the financial administration, based on the assumption that the problem lies in the costs of benefits and their poor administration.

In this sense, according to Abramovich and Pautassi (2008), the reform process' characteristics implemented during the 1990s have to do with the application of fiscal criteria to the health sector and the consequent idea of reducing costs to the detriment of care, the reduction of public expenditure and the recovery of costs through the co-payments system or quotas, the separation of functions of regulation, provision and financing of the sector, the freedom of choice of affiliates and the implementation of a basic package of medical benefits.

In this sector reforms context, health stops being considered a right and is offered as a more available resource for those who can agree to "buy it". In this sense, several authors agree that the 1990's reforms in the health sector in Latin America, implied that health ceased to have the character of a universal right, to become a market good, from being a good public, with the State's mark of responsibility, it became a private good in which the individuals are responsible for their own health status. It is installed as a purpose, as proposed by Rofman and Foglia (2015) to move to the market's orbit the bulk of state services with a clear reduction of the state apparatus. In this complex plot, the idea of a citizen that emerges had to do with a consumer, a subject assisted by the State and immersed in a client-like; welfare-like logic in this scenario, social participation was strongly limited (Comes, 2008; Laurell, 1995, Merhy, Iriart and Waitzkin, 2000). In this way we want to make it clear how the right to health is necessarily linked to the construction of citizenship. Thus, at least two positions have been identified in the bioethical literature. According to Comes and Stolkiner (2000, 2006), a position: based on charity, altruism, presupposes relations of asymmetry and breaks with social equality; and another position, which is based on social redistribution, based on a solidary principle, recognition of citizenship and that in the health sector translates into universal access to health and universal health coverage (WHO, 2014).

IF, AS A STRATEGY, IT PROVED TO WORK, WHAT ARE THE RESISTANCES?

It can be pointed out that the organization of health systems based on PHC would be the path and the strategy for the fulfillment of human rights and in particular the right to health. Some paradigmatic cases linked to the PHC implementation can be found in Cuba, where the morbidity and mortality profile of their population changed and, in particular, in relation to maternal and infant mortality that was drastically reduced after the PHC strategy implementation and crosscutting measures that operated on the main determinants of the H / D / A / C process. In this sense, the PHC, in addition, proved to be a strategy that allows, with low cost, to achieve great results in health. As opposed to the aforementioned, we find cases such as the United States, which, despite a large health budget, does not modify the morbidity and mortality indicators in a positive manner. Another example can be found in the implementation of an Integrated Health System in Uruguay and in particular, with the implementation of the public policy of Community-based Care Systems and the Brazilian Unified Health System - Programa Más Médicos-, both with significant improvements in the people's quality of life expressed in objective indicators (MSPU, 2003, Healthy Uruguay, 2005-2009, Laca, 2013).

For this reason, PHC is postulated as an eminently political and social tool from which to design, develop and implement a universal health policy for all.

Finally, it is worth highlighting the two conditions for developing PHC: 1) that is linked to regionalization, paying attention to the inequity in the distribution of human and physical resources and health infrastructure to respond to health problems and their concentration in urban areas, 2) consider the existence of a system that organizes the circulation of people through the health system (Testa, 1985).

From a human rights perspective, PHC is a valid strategy insofar as it can satisfy the conditions referred to by Testa (1985) and to the extent that it guarantees accessibility to the population and health services can be obtained in an equitable manner by it (Hamilton, 2001 in Comes, *et. al* 2007) without accessibility barriers in symbolic, administrative, economic, geographical, linguistic and cultural terms (Solitario, Garbus, Stolkiner, 2008).

In this sense, it is necessary to think about the conditions, guidelines and challenges posed by the implementation of PHC from a human rights perspective. These guidelines are established since the 1970s. Thus, health systems have been organized on the basis of universality, integrality, interdisciplinary nature, intersectorality; regionalization; recognition of community self-care practices and depathologisation of daily life; gender approach. However, the resistance to its application and implementation has been vast, despite the effectiveness demonstrated by the States that implemented PHC as the main strategy to organize their health system.

Resistance to the PHC implementation comes from both the industrial medical complex and the establishment of a hegemonic medical model (HMM) to understand health problems, the medicalization of everyday life, its pathologies, the establishment of a form of care, techno-assistance, the growth of the third sector and the privatization of highly complex services. The neoliberal measures applied to the health sector have implied a restriction of citizenship, have contributed to the consolidation of barriers in accessibility and have weakened a large part of the population as opposed to the national and international normative body on the right to health.

In this sense, to think about the right to health is to think of a system as a whole, in which health and illness appear as political processes. However, it is the political processes that are usually masked (Menéndez, 2005).

CONCLUSIONS

This paper has presented some of the conditions, guidelines and challenges posed by the implementation of PHC from a Human Rights approach. It is necessary to recover this perspective against the advance of the commodification of the right to health.

The health policies that introduce the market logic to the health's field implies a regression in terms of economic, social and cultural rights, and that place health, in general and the PHC strategy, in particular, in a restricted scenario that will reach an impact on the population of Argentina's morbidity and mortality profile, on their quality of life and on the deepening of the system's fragmentation that deepens inequities and existing asymmetries.

It can be concluded that the existence of the right to health in our National Constitution is a necessary and unavoidable condition, although not enough to guarantee health and accessibility to the system, public policies and PHC-based health systems are needed to eliminate barriers and lack of accessibility to health systems. In this way, expand the spaces for citizen participation in the preparation, implementation and evaluation of public health policies, which ultimately will result in a greater and better democracy.

PHC has proven to be a valid strategy due to its effectiveness and efficiency in reversing the main health problems in those countries that have implemented it. However, questions remain about why it is not implemented or extend its scope to other countries and regions? What are the main obstacles and resistances for implementation? The answer emerges from understanding the model of capitalist production, which produces a way of living, getting sick and dying proper to the material conditions of life. In effect, there is a way to produce health and disease characteristic of the capitalist system.

Therefore, PHC is proposed not only as a health strategy, a principle that guides health actions or a way of organizing levels of care; but an eminently political and social tool necessarily related to the constitution of citizenship and, therefore, to the national and supranational legal framework that constrains the State to act.

In this way, PHC is postulated as a health dimension together with a legal, institutional, political and ethical dimension to which a health system must aim to enforce the right to health with equity, for all and without distinction.

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